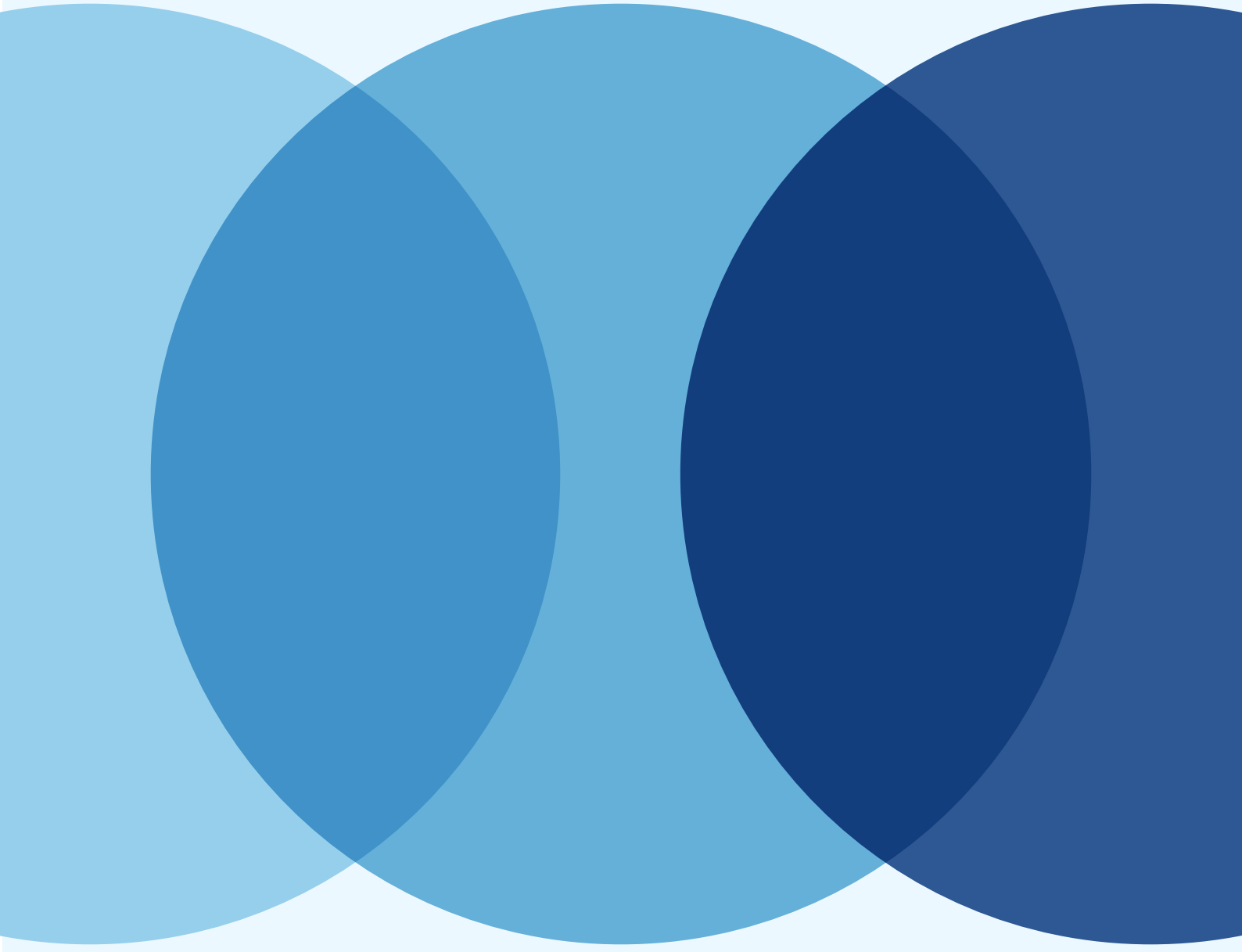
Outcome report

professional standards authority
for Health and Social Care

Evidence review

Reviewing our Standards: findings from our call for evidence

2025



professional standards authority
for Health and Social Care

Report of the Standards Review evidence review: improving regulation and registration

At the Professional Standards Authority (PSA) we, like many others in the sector, want to play our part in encouraging a shift by professional regulators and registers towards a more preventative approach to regulation, creating conditions in which care is better and safer, and harm less likely to occur. Our Standards for the regulators and Accredited Registers (ARs) we oversee are one way we can help support this refocusing of regulation.

Overview

Alongside our public consultation on our Standards for the regulators and Accredited Registers we oversee, we carried out a review of published research, data and other written evidence which suggested ways professional regulation and registration could improve. We also ran a call for evidence. This exercise was intended to inform the changes we will make to our Standards, and help identify how we can drive improvements through other areas of work.

The balance between preventative and reactive approaches in professional regulation and registration tends towards reactive – in particular through dealing with concerns about professionals through 'fitness to practise', after harm has already occurred. The preventative functions of education and training, registration, standards and continuing fitness to practise have arguably not received as much attention from a policy and legislative perspective.

This report summarises our findings from the evidence we reviewed. We hope that it is helpful in setting out the evidence base for the changes we are making for our Standards, alongside what we heard from stakeholders, as set out in the consultation outcome report. But we hope that others with an interest in improving how regulation and registration work, for the benefit of the public, and professionals and member of the public themselves, will also find it useful.

Methodology

A review of published evidence was carried out between October 2024 and May 2025. The exercise included an internal review of evidence obtained from publicly available sources as well as analysis of contributions from a public call for evidence which ran for 12 weeks from

13 February to 8 May 2025.[1,2] Overall 330 pieces of evidence were looked at as part of the review.

Evidence was sought in relation to the core regulatory functions that our Standards have covered to date (standards and guidance, education and training, registration and continuing fitness to practise and fitness to practise) as well new areas of focus relating to governance and leadership and culture within regulators.

The approach taken to the review of evidence was narrative as opposed to systematic.[3] Alongside the material obtained from the call for evidence, evidence was sought from known sources such as the PSA's research archive and regulator websites and use was also made of Google Scholar and the Europe PMC research databases.

For evidence received through the call for evidence and found as part of desk research we carried out an initial review to establish relevance to the exercise and then carried out a detailed review of relevant evidence to establish key findings and recommendations. We also carried out a basic grading exercise using a scale with 'stronger' covering peer reviewed academic, regulatory or scientific research, 'medium' encompassing non-peer reviewed research, reports or surveys from sector bodies, inquiry reports, guidance and standards, policy and discussion papers and similar and 'weaker' referring to informed, expert opinion in the media or elsewhere, outcomes of consultation exercises and briefing papers.

The vast majority of evidence related to the statutory professional regulators rather than the Accredited Registers. This was due to the volume of published evidence available focusing on statutory regulation rather than accredited registration. There was also significantly more published evidence available relating to some regulatory functions that others, however it is unclear whether this demonstrates particular areas of interest/focus for researchers or implies greater impacts and issues arising from some regulatory functions than others.

Key findings

General findings

The review sought out evidence which suggested ways professional regulation and registration could improve and therefore the majority of findings focused on the negative effects of regulation. However, the value of regulation and therefore the need to make it work better was a strong theme alongside the areas for improvement.

- **Public protection, transparency, and trust**: regulation is seen as essential for public protection, ensuring only competent practitioners are allowed to practise. However, concerns exist about the transparency, consistency, and fairness of processes which can affect stakeholder trust in professional regulation.[4]

[1] **PSA Standards Review - Call for Evidence | PSA**
[2] We received seven responses to the call for evidence including 118 pieces of evidence. This included submissions from the Care Quality Commission and NHS England.
[3] **The Difference Between Narrative Review and Systematic Review - DistillerSR**
[4] **Review of research into health and care professional regulation | PSA**

- **Negative mental health and wellbeing impacts**: professional regulation, especially fitness to practise (FtP) processes, can lead to significant psychological distress among practitioners, including anxiety, depression, and, in severe cases, suicidal ideation. Prolonged investigations, lack of support, and feelings of powerlessness or ostracism are common, with some professionals disengaging or leaving their professions as a result.[5]
- **Disproportionality and inequality in regulatory outcomes:** there is evidence of overrepresentation of certain groups—such as Black, Asian, male, older, and overseas-trained professionals—in complaints, referrals, and sanctions. These disparities are influenced by systemic factors, workplace culture, and referral practices, raising concerns about fairness and equality in regulatory processes.[6]
- **Defensive practice and professional behaviour change**: regulatory scrutiny and fear of complaints drive defensive practices, such as hedging, avoidance, and risk aversion. This can undermine open reflection, learning, and patient safety, and may discourage professionals from being transparent about errors or engaging in reflective practice.[7]
- **Complainants and the public**: the evidence highlights the challenges for complainants in accessing complaints processes and receiving timely and empathetic communications about the progress of concerns raised. However, more generally there are a number of areas identified where greater public engagement would help to strengthen regulatory processes and approach.[8]
- **Opportunities for process and system improvement**: proposals for change include more humane, supportive, and proportionate regulatory approaches, better communication, and timely resolution of cases. Emphasis is placed on learning cultures, peer review, and continuous professional development (CPD) to prevent malpractice and support professional growth , as well as improving data collection and analysis to help address discrimination and disproportionality within the regulatory system as well as support wider improvement. Stakeholder trust depends on clear communication, robust oversight, and accessible information on registers, while balancing efficiency and accountability.

Regulatory system

Consistency and Alignment

Evidence, including from the Williams Review[9] and the Francis Inquiry,[10] highlight inconsistencies in regulatory outcomes – particularly in fitness to practise (FtP) – which can lead to perceptions of unfairness. The PSA and others have advocated for greater alignment across regulators, including shared case-handling and decision-making frameworks. The PSA good practice guidance on rulemaking includes a tool to help regulators assess when consistency is desirable.[11]

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[5] **The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey | BMJ Open**
[6] **Fair to refer? – General Medical Council (GMC)**
[7] **An inspector calls: trauma-informed regulation - Abstract - Europe PMC**
[8] **Barriers & enablers to complaining to health professional regulators**
[9] **Williams review into gross negligence manslaughter in healthcare - GOV.UK**
[10] **Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK**
[11] **Good practice in rulemaking – guidance for regulators.pdf**

Collaboration

Multiple inquiries and reviews, including the Francis Inquiry,[12] the Paterson Review[13] and the Cumberlege Review[14] emphasise the need for better collaboration among regulators and with external stakeholders. The Francis Inquiry found that the regulatory system as a whole had failed to protect patients because it did not work together effectively. Cumberlege describes how: 'Each [organisation] worked within the remit required of them. The linkages between them and the oversight of the system as a whole had not worked.' Collaboration is seen as essential to improving patient safety and regulatory effectiveness.

Equality, Diversity, and Inclusion (EDI)

EDI was a key theme in almost every area examined. Evidence highlighted that whilst action has been taken to ensure EDI is addressed within regulation, further work is needed to ensure it is embedded in regulatory frameworks and organisational culture.[15]

Key areas identified for improvement included:

- assigning accountability for tackling inequalities
- communicating a clear vision internally and externally
- ensuring accessibility of processes and communications
- using data to measure impact and track progress
- collaborating with other regulators and stakeholders to address systemic inequalities.

Governance, leadership, and culture

The focus of the evidence reviewed in this area was less on where regulation could improve and more on the value of extending PSA oversight to consider these areas as part of its review of regulators. However, it is worth noting that the impetus for the PSA to consider developing further requirements on governance, leadership and culture also stems from evidence from its oversight, including current work underway at the Nursing and Midwifery Council (NMC) following publication of the Independent Culture Review which highlighted concerns with culture and safeguarding arrangements at the regulator.[16]

Evidence from the Care Quality Commission (CQC)[17] and other sectors highlights the value of assessing governance, leadership, and culture as part of regulatory oversight. Positive culture is associated with openness, learning, and effective governance.

Although the evidence doesn't support a strong link between organisational culture and performance, there is more evidence of its effectiveness when combined with quality

[12] **Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK**
[13] **Report of the Independent Inquiry into the Issues raise by Paterson**
[14] **First Do No Harm**
[15] **Rapid evidence review: Tackling inequalities through the regulation of services and organisations - Care Quality Commission**
[16] **The Nursing and Midwifery Council - Independent Culture Review**
[17] **Evaluation of the health care services Well led framework**

controls.[18] Furthermore, positive organisational culture is associated with greater openness allowing speaking up when things go wrong as well as having a strong link with good organisational governance and leadership.[19]

As well as underpinning the benefits of oversight of this area of regulators operations, the review identified a number of specific areas for potential inclusion within a PSA standard examining governance, leadership and culture.

Regulatory standards and guidance

The evidence review found that regulatory standards and guidance play a critical role in shaping professional identity, influencing behaviour, supporting ethical care, and guiding health systems through technological and cultural changes.[20] However, for them to be effective, they must be clear, contextualised, and supported by collaborative implementation.[21]

Current challenges identified include:

- ambiguity, rigidity, and lack of relevance
- difficulty adapting to emerging issues (e.g. Artificial Intelligence (AI), sustainability)[22]
- overlap and misalignment across multiple regulators.[23]

The review found that standards are most effective when they are:

- clear, practical, and aligned with real-world practice
- co-designed with practitioners and patients
- integrated with systemic support and employer accountability.

Public and professional feedback supports greater consistency in standards, especially around key behaviours like communication and collaboration.[24]

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[18] **Relationship between organizational culture and performance: literature review of the mediating and moderating effects**
[19] **Regulating reliably: building high-reliability regulators in healthcare - Carl Macrae, 2025**
[20] **How does professional regulation affect the identity of health and care professionals: exploring the views of professionals *(Christmas and Cribb)***
[21] **RAND Europe 2012, Factors that encourage or discourage doctors from acting in accordance with good practice Final report for the GMC.**
[22] **https://www.gmc-uk.org/-/media/gmc-site/about/barriersandenablersofgoodpracticefinalresearchreportpdf50388604.pdf**
[23] **Asymmetry of influence | The Health Foundation**
[24] **Perspectives on a Common Code of Conduct for Health and Care Professionals**

Education and training

Education is critical for embedding safety culture and professionalism from the outset of a healthcare career.[25] However, there was limited research on the quality assurance of education and training by regulators.

Findings covered both the content of education and training courses as well as the approach by regulators in ensuring that courses are delivered robustly and registrants are equipped to provide safe and effective care.

Key areas to be strengthened within education and training provision included:

- use of interprofessional learning
- inclusion of patient and carer perspectives[26]
- emphasis on adaptability (e.g. digital, AI, community-based care).[27]

Potential improvements to the approach by regulators and/or providers included:

- addressing differential attainment, especially by ethnicity[28]
- avoiding duplication and burden in quality assurance (QA) processes[29]
- clarifying the regulator's supportive role in professionalism[30]
- ensuring that education and training providers have systems in place addressing new and ongoing areas of risk.[31]

Continuing fitness to practise mechanisms - CPD and revalidation

The evidence relating to revalidation/continuing fitness to practise/CPD was mixed with some studies emphasising benefits whilst others found little impact. There is evidence of some unintended consequences including burden on registrants and some differential impacts on particular groups who may find it harder to meet requirements.

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[25] **How prepared are newly qualified allied health professionals for practice in the UK? A systematic review - Brennan N, Burns L, Mattick K, et al, BMJ Open 2024**
[26] **Faculty of Health, Social Care and Education Kingston University and St George's, University of London, 2016, Preparation for practice: The role of the HCPC's standards of education and training in ensuring that newly qualified professionals are fit to practise.**
[27] **Research on the standards for the initial education and training of pharmacy technicians**
[28] **British Association of Physicians of Indian Origin, 2021, Bridging the Gap - Tackling Differential Attainment in the Medical Profession**
[29] **Professional, statutory and regulatory bodies: an exploration of their engagement with higher education**
[30] **When, where and how should we assess professionalism in undergraduate medical education? Practical tips from an international conference roundtable discussion. - Abstract - Europe PMC**
[31] **Realist evaluation of UK medical education quality assurance | BMJ Open**

Concerns about the impact of such processes included:

- burden on registrants[32]
- unclear purpose of revalidation (improvement vs. enforcement)[33]
- disproportionate impacts on certain groups (e.g. disabled, ethnic minorities).[34]

The evidence suggested a number of areas for improvement:

- clarify purpose and expectations
- provide best practice examples
- encourage peer learning and personal development plans (PDPs)[35]
- consider flexible or tiered revalidation models.

Fitness to practise (FtP)

There is a significant body of evidence relating to the fitness to practise process. Much of this identifies negative impacts on those involved in the process as well as missed opportunities to resolve concerns at an earlier stage or to use the learnings from the fitness to practise process to improve/target other regulatory processes.

There is substantial evidence of negative impacts on registrants including mental health issues, disengagement, and loss of professionals from practice. There is also evidence of re-traumatisation and loss of trust among complainants and witnesses.

The key issues arising include:

- lack of clarity on referral thresholds[36]
- inaccessible and unsupportive complaints processes[37]
- poor communication and support during investigations[38] [39]
- disproportionate referrals of certain groups[40]

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[32] **Effect of Continuing Professional Development on Health Professionals' Performance and Patient Outcomes: A Scoping Review of Knowledge Syntheses**
[33] **Revalidation — what is the problem and what are the possible solutions?**
[34] **NMC, Understanding disabled professionals' revalidation Final report**
[35] **HCPC, Continuing Fitness to Practise - Towards an evidence based approach to revalidation**
[36] **People like us? Understanding complaints about paramedics and social workers**
[37] **New research reveals need for clearer, more accessible complaints systems for healthcare professional regulators | PSA**
[38] **The experience of public and patient complainants through our fitness to practise procedures**
[39] **Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data | BMJ Open**
[40] **Fair to refer?**

- inconsistent outcomes and lack of transparency in decision-making.[41]

The evidence highlights key areas for improvement including:

- improve triage and filtering of complaints
- consider panel composition and training to improve fairness[42]
- make complaints processes more accessible and supportive[43]
- enhance transparency and communication
- provide clearer guidance on seriousness and public confidence[44]
- upport appropriate referral and local resolution of complaints where appropriate.[45]

Next steps

We will publish our revised Standards, informed by this evidence review and the consultation, in early 2026.

As a next step, we will be reviewing the broader findings from the evidence review to consider further key priorities for the PSA in supporting a move to a more preventative model of regulation. This will be picked up in any further actions arising from the Standards Review or work flowing from the PSA's new Strategic Plan 2026-29.

[41] **Professor Sir Normal Williams, 2018, Gross negligence manslaughter in healthcare: The report of a rapid policy review.**
[42] **The experience of doctors who have been through our complaints procedures - GMC**
[43] **A Novel Content and Usability Analysis of UK Professional Regulator Information About Raising a Concern by Members of the Public**
[44] **The concept of seriousness in fitness to practise cases**
[45] **Wallace, Louise M and Greenfield, Mari, Engagement of health and social care employers in professional regulatory fitness to practise – missed regulatory and organisational opportunities?**

Appendix - Detailed findings

This section provides some further detailed findings and key reference sources. References to the Standards either refer to the 'Standards of Good Regulation' (for the statutory professional regulators) or the 'Standards for Accredited Registers' (for the organisations within our Accredited Registers (AR) programme).

Standards ref/area	Findings	Key evidence
General Standards	Whilst the evidence reviewed largely didn't highlight specific deficiencies with the current General Standards (see note on Standard 3 below), there were themes arising relating to the other regulatory functions which may suggest the need for additional/expanded General Standards. **Consistency/alignment** Some of the evidence reviewed suggested there would be merits in greater alignment of approach across regulators. This was particularly the case for fitness to practise where evidence highlighted disparities in outcomes across regulators and the risks of perceived or actual unfairness across regulators. Sir Robert Francis in the Francis Inquiry into failings at Mid Staffordshire Foundation Trust, criticised the professional regulators (mostly of doctors and nurses) for inconsistency and recommended hearing cases jointly to ensure judgements were consistent. The PSA in its guidance for regulators has also highlighted the value of appropriate consistency and provided a tool to help regulators establish whether regulatory consistency is desirable. **Collaboration**	Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Patient, carer, public and professional perspectives on the principle of consistency in health and care professional regulation Professor Sir Normal Williams, 2018, Gross negligence manslaughter in healthcare: The report of a rapid policy review. The concept of seriousness in fitness to practise cases How is public confidence maintained when fitness to practise decisions are made? Perspectives on a Common Code of Conduct for Health and Care Professionals Perspectives on discriminatory behaviours in health and care

Standards ref/area	Findings	Key evidence
	There was also evidence highlighting the value of better collaboration across regulators and with wider stakeholders on regulatory and patient safety issues. Alongside the evidence reviewed as part of this exercise this is a theme which arises frequently in the PSA's engagement with stakeholders and policy work. The Francis Inquiry found that the regulatory system as a whole had failed to protect patients because it did not work together effectively. Although both the Standards of Good Regulation already touch on engagement with stakeholders (Standard five, regulators and Standard eight, ARs) this element isn't drawn out explicitly. Although covered separately, it may also be worth considering whether any new Standard(s) on leadership governance and culture should sit within the general standards or have its own section with the Standards.	Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty
Equality, diversity and inclusion **Standard 3 (regulators) and Standard 9 (ARs)**	The findings relating to EDI are mainly covered against the other Standards where they have relevance. In addition, Standard 3 has been reviewed recently and AR Standard 9 is relatively new therefore there is likely to be reasonably up to date in terms of requirements. However, as noted in the section on education and training there may be more the PSA Standards can do to encourage regulators can do to tackle inequalities within the wider system, for example in relation to the issue of differential attainment when inequalities persist.	

Standards ref/area	Findings	Key evidence
Leadership, governance and culture – summary	The evidence demonstrates the value of assessing governance, culture and leadership within organisations. There was limited research focussing directly on health professional regulation therefore literature reviewed is largely from the wider health sector including the Care Quality Commission who assess governance, culture and leadership within healthcare provider organisations as well as from other regulated sectors. Although the evidence doesn't support a strong link between organisational culture and performance, there is more evidence of its effectiveness when combined with quality controls. Furthermore, positive organisational culture is associated with greater openness allowing speaking up when things go wrong as well as having a strong link with good organisational governance and leadership. EDI being a part of organisational organisational culture, there are recommendations from a study commissioned by CQC into how regulators can encourage EDI improvements that are relevant to this section.	
Leadership and governance	The evidence reviewed shows increasing pace of change in therapeutic methods and development of medicines. This research applies mainly to the regulation of medicines, devices etc, but has relevance to professional regulators. Regulators would benefit from greater monitoring of "global megatrends" – importance of horizon-scanning	Future directions in regulatory affairs

Standards ref/area	Findings	Key evidence
	Regulators should be more attentive to global trends affecting the delivery of healthcare, with leaders who are equipped with the right skills to lead in the current environment. Draws from a range of sources including major inquiries to recommend changes to professional regulator governance. The councils that regulate health professionals have, as a minimum, parity of membership between lay and professional members, to ensure that purely professional concerns are not thought to dominate their work to enable councils to focus more effectively on strategy and the oversight of their executives, they will become smaller and more-board like, with greater consistency of size and role across the professional regulatory bodies	Trust, Assurance and Safety â€“ The Regulation of Health Professionals in the 21st Century CM 7013
Leadership, governance	In this article, Macrae proposes five principles of high-reliability regulators: • Preoccupation with risk • Sensitivity to practice • Engaging with diversity • Enabling of expertise • Commitment to learning These are intended to demonstrate how: 'healthcare regulators might better support the attentive monitoring, constructive challenge and systemic improvement that is required to assure safety and quality across complex healthcare systems.'	Regulating reliably: building high-reliability regulators in healthcare - Carl Macrae, 2025

Standards ref/area	Findings	Key evidence
	These principles are drawn from the five characteristics of high-reliability regulators which were developed in the 1980s based on the study of organisations that operate in *'challenging, unforgiving and dynamic environments*. **Preoccupation with failure**: Organisations foster a deep and widespread preoccupation with failure, in which people are encouraged and supported to notice and speak up about failures and mishaps, and these become the focus of more generalised efforts to understand and improve organisational systems and practices. **Sensitivity to operations**: Organisations work to maintain a persistent sensitivity to operations, where people in all areas and at levels of the organisation pay close attention to front-line operational work, and work to build a clear and detailed picture of the status of those current activities and any problems that might be developing. **Reluctance to simplify:** Organisations aim to foster a reluctance to simplify, encouraging people to avoid simplistic answers to complex questions, remain open to novelty and surprise and seek out divergent and diverse perspectives and viewpoints in an effort to maintain a detailed and nuanced picture of risk. **Deference to expertise:** Organisations are structured to build deep expertise, and enable the most relevant knowledge to be brought to bear on a problem, encouraged by a widespread deference to expertise in which people defer to those with the greatest practical expertise and experience rather than those with the highest rank. **Commitment to resilience**: Organisations aim to sustain a commitment to resilience by designing and maintaining organisational processes and systems that can identify, catch and bounce back from	

Standards ref/area	Findings	Key evidence
	disruptions and failure and that can respond adaptively and flexibly to surprising, unexpected and unplanned events.	
Leadership	The CQC's structural re-organisation has resulted in separation of those responsible for developing policy and strategy related to regulation from those responsible for operational delivery. Operational reality has therefore not been reflected in policy and strategy. This report demonstrates the importance of cohesion between policy/strategy and operational delivery.	Review of CQC's single assessment framework and its implementation - Care Quality Commission
Governance	This report provides an example of where the PSA has assessed the effectiveness of governance arrangements for a professional regulator.	Review of the legislation and governance for Engineers and Geoscientists in British Columbia (June 2018)
Governance	Guidance on the basics of good governance: • Responsibility and accountability, Personal behaviours and the holding of public office • Dealing with disagreement • Roles and relationships • From representation to credibility • Conflicts of interest • Understanding performance • Oversight of complaints For Boards/Councils – the importance of collective and individual accountability, recruiting for skills and expertise rather than representation, professionalism, appraisal, transparency, and	Fit and Proper? Governance in the public interest Board size and effectiveness: advice to the Department of Health regarding health professional regulators

Standards ref/area	Findings	Key evidence
	management of conflicts of interests; the role of the chair in dealing with disagreement. Review of the characteristics of boards that make them more effective: • Membership 8-12 optimal for good decision-making and diversity of thought [though NB regulators would need to amend constitution regs/rules etc] • Moving away from representativeness to skills and competencies	
Leadership	The existing arrangements for the regulation of health and care professionals in the UK are complicated and confusing. They are not informed by a consistent approach to assessing occupational risk of harm. The Professional Standards Authority has analysed the current arrangements and has made a set of proposals for reform. It has also proposed a methodology for assessing risk of harm, to enable the appropriate form of assurance for any given occupation to be identified. Importance of basing decisions about how to regulate on an assessment of occupational risk of harm (Bilton and Cayton)	Reforming the professional regulators: Creating an effective, proportionate and efficient system
Leadership, governance and culture	The use of the CQC well-led framework (WLF) has led to improvements in leadership and governance. It works well when applied with an appropriate balance between culture and leadership, and governance and processes. There are a range of recommendations that could be relevant, including:	Evaluation of the health care services Well led framework

Standards ref/area	Findings	Key evidence
	• Organise the WLF under two broad headings: governance and processes, and culture and leadership • Refine the culture and leadership elements of the framework, including more on measures and prompts for assessing organisational culture. • Expand and consolidate the documentation available surrounding the WLF to include good and excellent practice for each KLOE.	
Culture:	This study demonstrates the importance of culture in public service organisations; makes recommendations for how to improve and assess it.	Institute of Public Administration 2015, Organisational culture and the public service
Culture Standard	The link between organisational culture and performance has not been conclusively proven, as it is difficult to define and to measure. However, a further report suggests there is a clearer link if combined with quality control mechanisms.	Organisational culture and performance: an evidence review. Scientific summary Relationship between organizational culture and performance: literature review of the mediating and moderating effects
Culture	This study sets out tips for how to gain an initial impression of an organisation's culture, e.g. reading their publications, observing how meetings are conducted etc	Understanding organisational culture
Culture	The strategy underlines the importance of open and honest safety cultures, and psychological safety, which enable learning when things go wrong; the absence of these cultures increases the likelihood of repetition.	The NHS Patient Safety Strategy Safer culture, safer systems, safer patients Regulating reliably: building high-reliability regulators in healthcare - Carl Macrae, 2025

Standards ref/area	Findings	Key evidence
	Parallels within regulators' responses to things going wrong. (See also Macrae's High Reliability Regulators.)	
Culture: Evidence and assessment	This report emphasises that positive organisational culture is essential to good leadership and governance and includes a range of recommendations about how to improve and sustain positive cultures	A duty to care? Evidence of the importance of organisational culture to effective governance and leadership
EDI	**Implementation** Approaches used to tackle inequalities are holistic. Regulators could consider how multiple interventions and approaches can be combined and embedded. Regulators could consider how to embed sustainable approaches to tackling inequalities. This includes amongst different service areas or user groups. Regulators could consider focusing on equality in their existing regulatory frameworks. It is important that regulators assign accountability for tackling inequalities within their workforce. It is important for regulators to communicate their vision for tackling inequalities. This includes to their own staff and the organisations they regulate. Regulators need to be realistic about how far they can affect inequalities. They are one (or more) steps removed from service users. **Engagement** It is important for regulators to continue to share learning with other regulators.	Rapid evidence review: Tackling inequalities through the regulation of services and organisations - Care Quality Commission

Standards ref/area	Findings	Key evidence
	It is important that regulators work collaboratively to address inequalities. This includes with partners within the systems in which they work. Regulators need to demonstrate the characteristics they seek from providers in tackling inequalities. Dual 'encouragement and enforcement' functions can support engagement with providers. Regulators could consider how this can be most effective. It is important that regulators continue to assess the transparency of their communications. This will ensure clear expectations are set with a view to building trust and confidence. Regulators may wish to assess the extent to which providers use service user voices. This includes to inform continuous service improvement. Regulators need to reflect service user voices in their approaches to addressing inequalities. It is important that regulators ensure processes and communications are accessible. This includes within their own organisations and their providers. **Data, evidence and impact** Regulators may wish to test and implement approaches to measure	

Standards ref/area	Findings	Key evidence
	their impact on equalities. It is important that regulators contribute to the evidence base around inequalities. This will likely support the providers they work with. It is important that regulators identify the trajectory that a provider is on in tackling inequalities. The reasons for any changing performance need to be fully understood. Tackling inequalities experienced by service users takes time. Regulators could identify expected interim outcomes to ensure realistic expectations.	

Standards ref/area	Findings	Key evidence
Guidance and standards – summary	Regulatory standards and guidance play a critical role in shaping professional identity, influencing behaviour, supporting ethical care, and guiding health systems through technological and cultural changes. However, for them to be effective, they must be clear, contextualised, and supported by collaborative implementation.	
Standards – Standards 6 and 7 (regulators) and Standard 3 (ARs)	There is evidence to demonstrate that that the impact of regulator standards and guidance includes: • supporting professional identity and ethical conduct • enhancing quality and consistency of patient care • influencing what is taught and prioritised in health education. They can have a positive influence on behaviour when they are: • clear, practical, and aligned with workplace realities • encourage reflection and ethical decision-making when tied to CPD and peer support. However, the evidence also highlighted that the impact of standards and guidance can be reduced when: • They are undermined by rigid enforcement, ambiguity, and lack of real-world relevance • They are too rigid, which was especially exacerbated through the pandemic • It can also be difficult to balance due to overlapping standards (i.e. those who are registered with multiple regulators, some things can be misaligned) • They are unable to evolve to address emerging issues such as AI, sustainability, and remote care.	Professionalism in healthcare professionals How does professional regulation affect the identity of health and care professionals: exploring the views of professionals Understanding the relationship between professional regulation and professional identity in healthcare The regulator's role in professional identity: validator not creator Factors that encourage or discourage doctors from acting in accordance with good practice Teamworking: understanding barriers and enablers to supportive teams in UK health systems Regulatory approaches to professional standards and guidance

Standards ref/area	Findings	Key evidence
	The evidence suggests that regulators could drive greater change through standards when they are: • Co-designed with practitioners and patients • Integrated with systemic support and employer accountability • Clearly communicated and distinguishes what is mandatory and what is advisory guidance • Use of up-to-date evidence and real-world insights.	Regulating professional ethics in a context of technological change Ethics in extraordinary times Recent research into healthcare professions regulation: a rapid evidence assessment Health Care Professional Association Agency in Preparing for Artificial Intelligence: Protocol for a Multi-Case Study Professional Ethical Guidance for Healthcare AI Use (PEG-AI)
Standards – Standards 6 and 7 (regulators) and Standard 3 (ARs) **Also - potentially relevant to any wider requirements relating to collaboration/ consistency**	There was some evidence within the literature highlighting potential benefits of greater commonality across professional standards/codes and public expectations that professionals are held to the same standards in key areas. This evidence arose largely from relatively small-scale qualitative research with patient and the public and professionals, commissioned by the PSA, but indicated that greater consistency in regulator requirements particularly around key behaviours such as communication, collaboration, common goals may be desirable. There was also a shared view that professionals should be subject to the same sanctions for discriminatory behaviour, implying they should be subject to the same standards of behaviour on this issue.	Perspectives on a Common Code of Conduct for Health and Care Professionals Perspectives on discriminatory behaviours in health and care

Standards ref/area	Findings	Key evidence
Education and training – summary	Little research (although not none) on the quality assurance / accreditation of education and training in health and social care came through in the literature searches.	Realist evaluation of UK medical education quality assurance A Review of Research into Health and Care Professional Regulation How prepared are newly qualified allied health professionals for practice in the UK? A systematic review Preparation for practice: The role of the HCPC's standards of education and training in ensuring that newly qualified professionals are fit to practise Research on the Standards for the Initial Education and Training of Pharmacy Technicians Preparedness of recent medical graduates to meet anticipated healthcare needs
Standard eight (regulators), Standard four (A) (ARs)	Patient safety Getting it right involves instilling the right culture from the very beginning of a healthcare worker's career. Education and training from undergraduate and apprentice level throughout one's career can not only embed the right approach to preventing and learning from	Improving Safety Through Education and Training: Report by the Commission on Education and Training for Patient Safety, Health Education England, commissioned March 2016

Standards ref/area	Findings	Key evidence
	errors but also keeps the mind receptive to new ideas that could improve safety. Key areas for education and training include: • Robust evaluation of education and training • Engage with patients, family members, carers and the public - the relevant regulators of education to ensure that future education and training emphasises the important role of patients, family members and carers in preventing patient safety incidents and improving patient safety • Duty of candour • Learning environment must support all learners and staff in raising and responding to concerns • Ensuring increased opportunities for interprofessional learning.	Prof Jayne Cutter Swansea University presentation_Welsh Seminar 2025.pptx Telling patients the truth when something goes wrong: Evaluating the progress of professional regulators in embedding professionals' duty to be candid to patients Raising professionalism concerns as a medical student: damned if they do, damned if they don't? Right-touch reform: A new framework for assurance of professions Unveiling the interplay of medical professionalism, mental well-being and coping in medical students: a qualitative phenomenological study
Standard nine (regulators), Standard four (B) (ARs)	Proportionate reactions in the face of disclosing and identifying patient safety risks at an early stage were more likely to occur within a positive trusting regulator-provider context underpinned by openness	Realist evaluation of UK medical education quality assurance
Standard eight (regulators),	Ensuring education and training produces professionals who are adaptable to change (patients as partners, use of digital and AI, focus on prevention, community-based care).	Health and Social Care NI A three-year plan to: stabilise, reform, deliver, 10 December 2024

Standards ref/area	Findings	Key evidence
Standard four (A) (ARs)		The three shifts An NHS fit for the future Medical education fit for the future requires radical change Teaching and fostering change management in medical education
Standard eight (regulators)	Interprofessional education is important in terms of patient safety	Right-touch reform: A new framework for assurance of professions Improving Safety Through Education and Training: Report by the Commission on Education and Training for Patient Safety, Health Education England, commissioned March 2016
Standard nine (regulators), Standard 4(b) (ARs)	Without regulators addressing varying risk contexts, the proportionality of QA is imbalanced, leading to negative outcomes with regulators unable to effectively assure quality	Realist evaluation of UK medical education quality assurance When, where and how should we assess professionalism in undergraduate medical education?
Standard nine (regulators),	There is the risk of duplication of QA processes which can be burdensome	Right-touch reform: A new framework for assurance of professions

Standards ref/area	Findings	Key evidence
Standard 4(b) (ARs)		Professional, statutory and regulatory bodies: an exploration of their engagement with higher education
Standard eight (regulators)	It may be beneficial during education and training to show students and trainees how the regulator is supportive of professionalism and not just a force to be feared.	System failures and learning from the case of Dr Manjula Arora: 21st century regulation needs to be compassionate, caring and supportive. Evaluating the impact of the Duties of a doctor programme
	There is a significant body of evidence of differential attainment linked to ethnicity, particularly in relation to medicine, but also in higher education generally, and in the pharmacy pre-registration exam.	Qualitative research into registration assessment performance among Black-African candidates Bridging the Gap - Tackling Differential Attainment in the Medical Profession Tackling disadvantage in medical education - Analysis of postgraduate outcomes by ethnicity and the interplay with other personal characteristics
Education and training		The role of accreditation in 21st century health professions education: report of an International Consensus Group, BME Medical Education, 2020

Standards ref/area	Findings	Key evidence
Registration and revalidation – summary	There was little evidence arising in relation to registration. The evidence relating to revalidation/continuing fitness to practise/CPD was mixed with some studies emphasising benefits whilst others found little impact. There is evidence of some unintended consequences including burden on registrants and some differential impacts on particular groups who may find it harder to meet requirements.	
Registration Standards 10 & 11 (regulators) and Standard 2 (ARs)	There was little evidence arising from the literature reviewed regarding the regulators' registration function.	Health professional regulators' registers: Maximising their contribution to public protection and patient safety Regulation of Health Care Professionals Regulation of Social Care Professionals in England, Law Commission
Revalidation/ continuing fitness to practise Standard 13 (regulators) and Standard 3 (regulators)	Evidence on the effectiveness of CPD and/or revalidation is mixed, with some studies finding that the impact of CPD is positive. In particular, research points to CPD increasing skills and knowledge, and improving clinical governance (in the case of doctors). However, other studies find no positive impact of for those with good performance, which are the majority (doctors). Revalidation of doctors has resulted in some unintended consequences. Medical revalidation was found to increase the likelihood of consultants leaving the workforce but those leaving do not appear to have provided lower quality care.	Effect of Continuing Professional Development on Health Professionals' Performance and Patient Outcomes: A Scoping Review of Knowledge Syntheses. Academic Medicine 96(6):p 913-923, June 2021 Continuing professional development requirements for UK health professionals: a scoping review

Standards ref/area	Findings	Key evidence
	Research suggests that the purpose of revalidation is often unclear to practitioners – specifically whether it is intended to raise standards or catch 'bad apples' Similarly, some registrants are unclear about what regulators require of them in terms of CPD. Registrants would welcome more guidance, and best practice examples, from regulators CPD undertaken by registrants is not always aligned with best practice. CPD could be improved by all registrants being required to develop a Personal Development Plan (PDP), an increase in peer-to-peer learning, and more interprofessional CPD. Revalidation requirements may be more difficult to meet for people with disabilities (nurses). Research suggests that a more flexible approach may be beneficial – for example a 'tiered' revalidation programme where registrants are revalidated for some areas of practice and not others In the case of medical revalidation, there are higher deferral rates in some groups, including female doctors, younger doctors and those from black and minority ethnic backgrounds, suggesting that these groups find revalidation more challenging Service user feedback is not fully/robustly integrated into CPD/revalidation and this has been a source of criticism (HCPC and GMC)	Evaluating the development of medical revalidation in England and its impact on organisational performance and medical practice: overview report Revalidation — what is the problem and what are the possible solutions? Does regulation increase the rate at which doctors leave practice? Analysis of routine hospital data in the English NHS following the introduction of medical revalidation Social Work and Continuing Professional Development: For Social Work England. Exploring and explaining the dynamics of osteopathic regulation, professionalism, and compliance with standards in practice. Risks in the optical professions: Final report, enventure research for the General Optical Council An assessment of CPD provision for chiropractors in the UK

Standards ref/area	Findings	Key evidence
		Understanding disabled professionals' revalidation Final Report Evaluating Enhanced CPD: Final Report, Cardiff University for the GDC Evaluating the regulatory impact of medical revalidation Continuing Fitness to Practise Towards an evidence based approach to revalidation Experiences of UK clinical scientists (Physical Sciences modality) with their regulator, the Health and Care Professions Council: results of a 2022 survey. Recent research into healthcare professions regulation: a rapid evidence assessment Continuing professional development requirements for UK health professionals: a scoping review.

Standards ref/area	Findings	Key evidence
		Ensuring continuing fitness to practice in the pharmacy workforce: Understanding the challenges of revalidation. "No One Has Yet Properly Articulated What We Are Trying to Achieve" A Discourse Analysis of Interviews with Revalidation Policy Leaders in the United Kingdom Design, delivery and effectiveness of health practitioner regulation systems: an integrative review Can the value and acceptability of a patient feedback tool for revalidating psychiatrists be improved for both patients and psychiatrists through its co-production? An action research approach. The experiences of and attitudes towards continuing professional development: an interpretative phenomenological analysis of UK paramedics.

Standards ref/area	Findings	Key evidence
Fitness to practise – summary	There is a significant body of evidence relating to the fitness to practise process, much of it identifying the negative impacts on those involved in the process as well as missed opportunities to resolve concerns at an earlier stage or to use the learnings from the fitness to practice process to improve/target other regulatory processes.	
Fitness to practise – local resolution of concerns **Not covered by current Standards**	There is evidence that concerns are being referred to the regulator which may be better dealt with by employers at a local level or which may warrant being returned to the local level following investigation. The evidence suggests that there is a lack of clarity/understanding of the threshold for referral to the regulator. The evidence also suggests that poor communication from the regulator during an investigation may be hampering effective local resolution of cases. Although the regulators don't have direct responsibility for local resolution, they have a strong interest in ensuring it works effectively. Evidence suggests that there in some cases regulator actions are impeding local resolution and there is likely to be more that regulators can do to support the local resolution of cases. Regulator actions are also seen to be damaging employer trust and engagement in regulatory processes. There is also evidence of innovative approaches from some regulators in improving the resolution of complaints that do not fall	Engagement of health and social care employers in professional regulatory fitness to practise – missed regulatory and organisational opportunities? Understanding employers' referrals of doctors to the General Medical Council Why do many public concerns that would be better directed to another organisation come to the GMC? People like us? Understanding complaints about paramedics and social workers Social Work England - An update on our analysis of diversity data in our fitness to practise processes

Standards ref/area	Findings	Key evidence
	to the regulators, for example the GDC's support for the Dental Complaints Service.	Finding space for kindness: public protection and health professional regulation Social Return on Investment of the Dental Complaints Service
Fitness to practise – complaints process **Standard 14 (regulators) and Standard 5 (ARs)** **Also Standard 3, EDI (regulators) and Standard 9 (ARs)**	The evidence indicates a number of inadequacies in how regulators are currently handling complaints. This includes uncertainty over what kind of complaints should be made to the regulator, lack of accessibility of regulator complaints processes with restrictions on format or method of making a complaint and lack of support for particular groups. The evidence also suggests that communication with complainants once a complaint has been made is poor with sporadic contact, limited clarity over timescales, no single point of contact, poor signposting to other complaints organisations and advocacy services.	Barriers and enablers to making a complaint to a health or social care professional regulator: a qualitative study A Novel Content and Usability Analysis of UK Professional Regulator Information About Raising a Concern by Members of the Public Expectations of the fitness to practise complaints process The experience of public and patient complainants through our fitness to practise procedures Why do many public concerns that would be better directed to another organisation come to the GMC? NCOR Concerns and Complaints Report 2013-2023

Standards ref/area	Findings	Key evidence
		Independent Review of General Chiropractic Council Fitness to Practise Cases 2010 – 2013 People like us? Understanding complaints about paramedics and social workers Expectations of the fitness to practise complaints process
Fitness to practise – examination and investigation of complaints Standard 15 (regulators), Standard 5 (ARs) **Also Standard 3, EDI (regulators) and Standard 9 (ARs)**	The evidence identified both negative perceptions of the regulators approach to investigation as well as a number of negative impacts arising from this part of the process. Much of the literature focussed on registrants' experience of the FtP process with a number of studies emphasising the toll investigations can take on mental and physical health. However, there is also evidence that complainants and witnesses find the process stressful, protracted and reinforcing trauma suffered. Although relevant to a number of Standards, there was a strong theme arising in relation to disproportionate referral to the regulator of certain groups of registrants leading to perceptions of unfairness of the investigation process. Specific aspects of the examination and investigation process which the evidence suggests could be improved include: • Clarity of investigation thresholds and triage of complaints including filtering out of vexatious complaints • Transparency of the investigation process	The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey. Doctors' experiences and their perceptions of the most stressful aspects of complaints. Experiences of GDC fitness to practise participants 2015-2021: a realist study November 2022 Doctors who commit suicide while under GMC fitness to practise investigation: Internal review Living life in limbo: experiences of healthcare professionals during HCPC fitness to practise investigation process

Standards ref/area	Findings	Key evidence
	• Communication with and involvement of parties to a complaint. Although the findings relating to local resolution of complaints are relevant here this aspect has been covered separately under the proposal for a new Standard. This area also overlaps with Standards 14 and 18 (complaints and support for parties to a complaint), however these elements have been covered in the sections on potential changes to Standards 14 and 18.	Why regulation hurts: balancing the need to maintain standards with the mental health impact on public sector professionals Research Works, Enhancing confidence in fitness to practise adjudication Exploring the experience of doctors who have been through the GMC's complaints procedures The experience of public and patient complainants through our fitness to practise procedures Fair to refer? Encouraging engagement from practitioners during a fitness to practise investigation Experiences of GDC fitness to practise participants 2015 – 2021: A realist study Analysis of fitness to practise case data Protected characteristics of pharmacists involved in the managing concerns process

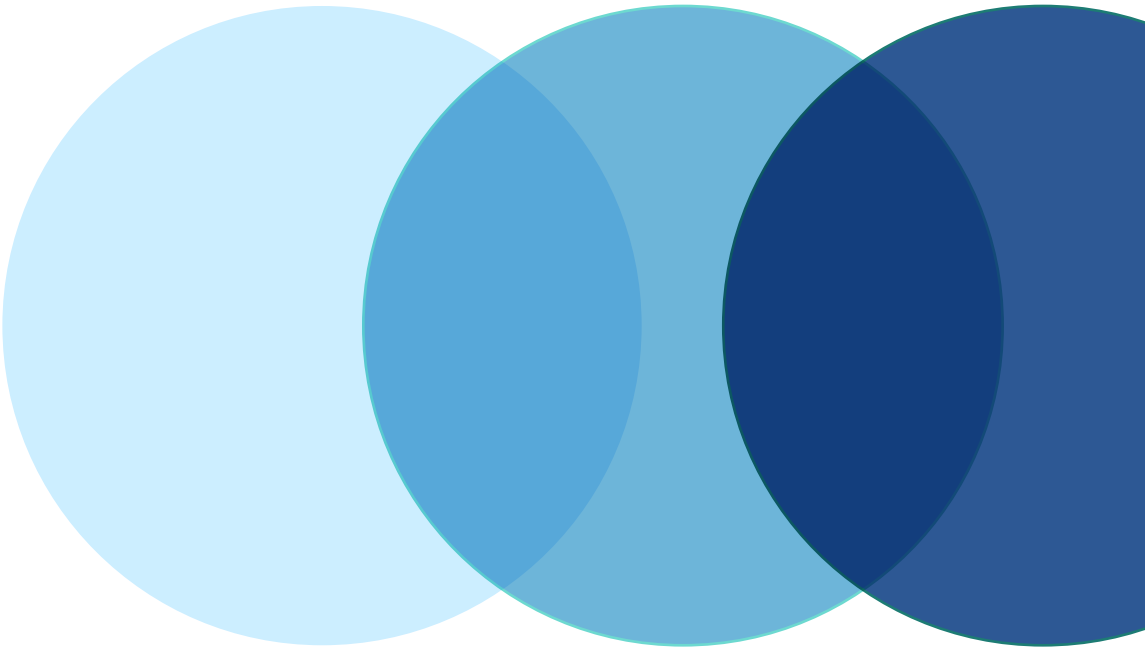
Standards ref/area	Findings	Key evidence
		Ambitious for change Social Work England's fitness to practise process: an initial analysis of diversity data How Readable Is the Information the United Kingdom's Statutory Health and Social Care Professional Regulators Provide for the Public to Engage With Fitness to Practise Processes? System failures and learning from the case of Dr Manjula Arora: 21st century regulation needs to be compassionate, caring and supportive.
Fitness to practise – decisions made Standard 16 and EDI Standard 3 (regulators) and Standard 5 (ARs) **Also Standard 3, EDI (regulators) and Standard 9 (ARs)**	The evidence suggests that improvements may be needed in relation to the regulators' FtP decision-making. The evidence indicated that there were concerns about fairness and transparency of decisions made by some of the regulators, as well as specific elements of the decision-making process where change was felt to be needed. Key themes arising from the literature reviewed include: • Perceived or actual overrepresentation of particular groups within the FtP process and concerns over inconsistency of outcomes across regulators • Lack of transparency of the rationale for decisions made • Quality, fairness and consistency of outcomes	The concept of seriousness in fitness to practise cases Literature Review on Impairment and Serious Misconduct Review of decision making in our fitness to practise procedures - GMC Professor Sir Normal Williams, 2018, Gross negligence manslaughter in healthcare: The report of a rapid policy review.

Standards ref/area	Findings	Key evidence
	• The need for more structured consideration of contextual factors within FtP decision making • The value of a shared view across regulators on seriousness • The merits of guidance on public confidence drawn from a shared understanding/concept • Composition of panels/training of decision makers.	Independent review of gross negligence manslaughter and culpable homicide How is public confidence maintained when fitness to practise decisions are made? Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty
Fitness to practise – identifying and prioritising of high-risk cases Standard 17 (regulators) and Standard 5 (ARs)	The evidence didn't suggest any particular concerns about the regulators' process for identification of high-risk cases. However, some of the evidence did suggest that a better understanding is needed of seriousness which may impact on regulators assessment of what qualifies as a high-risk case. The evidence also suggested that a more coherent understanding across regulators is needed around what types of cases may impact on public confidence (see evidence under Standard 16). See also comments relating to evidence of perceptions of inconsistent outcomes in relation to Standard 16.	
Fitness to practise – support for	There is a substantial body of evidence demonstrating that the FtP process often has an inherently negative impact on those involved in it. This includes registrants who are the subject of a complaint	Witness to Harm; Holding to Account: What Is the Importance of Information for Members of the Public Who Give Evidence

Standards ref/area	Findings	Key evidence

parties to a complaint Standard 18 (regulators) and Standard 5 (ARs)
 	
Also Standard 3, EDI (regulators) and Standard 9 (ARs)
	as well as complainants and witnesses to a complaint and can be caused by the length of the process, lack of support provided or poor information and communication from the regulatory during proceedings.
	
	Some specific impacts suggested by the evidence include:
	• Registrants can become to be fearful of and lose trust in the regulator which can lead to:
	  ○ lack of engagement in the regulatory process
	  ○ discouraging professionals from raising concerns about colleagues
	  ○ defensive practise
	  ○ stress, ill health, mental health issues or suicide
	  ○ professional leaving practice.
	• Complainants may
	  ○ Experience re-traumatisation or secondary harm from the regulatory process
	  ○ lose trust in the regulator and disengage from the regulatory process
	  ○ be discouraged from raising complaints.
	
	There was also evidence suggesting that there is a lack of clarity on whether the employer or the regulator should be providing support to registrants involved in regulatory procedures.
		and May Be Witness in a Regulatory Hearing of a Health or Care Professional?
		
		(Re)constructing 'witness vulnerability': An analysis of the legal and policy frameworks of the statutory regulators of social work and social care professionals in the UK
		
		The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey.
		
		Doctors' experiences and their perceptions of the most stressful aspects of complaints.
		
		Experiences of GDC fitness to practise participants 2015-2021: a realist study
		
		Doctors who commit suicide while under GMC fitness to practise investigation: Internal review
		
		Living life in limbo: experiences of healthcare professionals during HCPC fitness to practise investigation process

Standards ref/area	Findings	Key evidence
		Why regulation hurts: balancing the need to maintain standards with the mental health impact on public sector professionals Exploring the experience of doctors who have been through the GMC's complaints procedures The experience of public and patient complainants through our fitness to practise procedures Experiences of GDC fitness to practise participants 2015 – 2021: A realist study How Readable Is the Information the United Kingdom's Statutory Health and Social Care Professional Regulators Provide for the Public to Engage With Fitness to Practise Processes? System failures and learning from the case of Dr Manjula Arora: 21st century regulation needs to be compassionate, caring and supportive.



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