Facing up to the workforce crisis and regulation's future role

> 'The UK health workforce needs to double, and care quadruple its growth over the next decade. At current rates of supply, there will be too few, too late.'

The Health Foundation, October 2021[205]

In this chapter we consider the scale and breadth of this problem across the UK, and ask how regulation can become an enabler rather than a barrier to addressing it.

The UK needs over a million extra health and social care workers in the next decade but professional bodies and think tanks warn that this is unlikely to be achieved.[206]

In its 'immediate and essential actions', the Ockenden Review highlighted the issue of safe staffing and called for maternity and neonatal services in England to receive a multi-year settlement from NHS England to ensure the safe delivery of care.[207] Reporting on five year old Logan Mwangi's death, Prof Donald Forrester said, similarly, that the case highlighted critical issues affecting many children's social services in Wales; from social worker capacity and staffing shortages, to high and increasing numbers of children being taken into care.* Eight million operations a year are set to be cancelled or delayed due to consultant anaesthetist shortages across the UK.[208]

Workforce planning is shared among different bodies, and across the four countries of the UK. This has made it hard to keep track of vacancies, or forecast the number of training places needed. Each Government acknowledges that data and planning have not kept pace with demand, and while they are investing in more training places and improving data, it looks likely there will be significant shortages ahead.

Although there are now new ways into the regulated professions such as apprenticeships, widening the pool of potential applicants, the length of training generally remains constant. This time lag between demand and supply means there is a considerable risk that there will be too few people to provide the care needed, and that may compromise patient and service user safety.

At a time of global healthcare worker shortages, what can we do differently to grow our workforce, and adapt to new ways of working? What is the role of professional regulation and registration within this?

* Wales shares with other countries in the UK problems relating to child social worker shortages, with some councils reportedly having vacancy rates of up to 40% and heavily reliant on temporary staff. Wales has not yet undertaken a recent review of children's social care. Scotland's care review reported in 2020, Northern Ireland's launched in February, and England's is due to report in May (See: The Guardian, April 2022, Logan Mwangi's murder: major review of Welsh social care needed, says expert. Available at: https://www.theguardian.com/society/2022/apr/22/logan-mwangi-murder-welsh-social-care-review-needed)

A compelling case for change

> 'The lack of attention given to all parts of both the health and care workforce means that the ability to integrate care to maximise quality and safety is inhibited.'

House of Commons Health and Social Care Committee evaluation of workforce commitments, Third Special Report of Session 2022–23[209]

A problem in breadth and depth

It is widely acknowledged that the UK has a workforce problem in health and care. It is worth restating some key statistics to illustrate the breadth of the issue.

- The children's social worker shortage in England is running at 16%, risking leaving families and vulnerable children without support and protection.[210] In the adult social care sector, the overall vacancy rate of 7.3% is equivalent to 112,000 vacancies, nearly three times higher than the wider UK economy estimated vacancy rate of 2.7%.[211]
- The British Medical Association (BMA) predicts England needs almost 50,000 additional full-time equivalent (FTE) doctors to put it on a standard comparable to today's Organisation for Economic Co-operation and Development (OECD) EU average of 3.7 doctors per 1,000 inhabitants.[212] By January this year, only 9,500 of 26,000 extra physiotherapists, pharmacists, mental health therapists and other clinical staff had been recruited to help GPs in England.[213]
- Scotland fares better than England for GPs, with 76 per 100,000, compared to 58, but still needs to recruit 800 more over the next decade to fill gaps.[214]
- There are major shortages in the nursing workforce as well, including over 4,000 vacancies in Scotland,[215] 1,719 in Wales,[216] 1,800 in Northern Ireland[217] and 39,652 within the NHS in England.[218] Over the past 10 years, only adult nursing and children's nursing have seen increases in FTE nurse numbers, while the numbers in community nursing, mental health nursing and learning disability nursing are all lower than they were in June 2010.[219]
- The UK Government aims to deliver 50,000 extra nurses by the end of this Parliament and reports that it is half-way there.[220] However, this target does not include non-NHS providers such as social care. The Government has acknowledged it will need to recruit well over 50,000 more to account for numbers leaving the profession and not being replaced.
- In March 2021, NHS England said it would recruit an extra 1,200 midwives as part of a £95 million investment. But the official NHS England workforce statistics show that the number of full-time midwives working in the NHS is falling, as a rolling average, with 326 fewer in September 2021 compared to the previous year.[221]
- Figures from Royal College of Nursing (RCN) Wales suggest that each week, nurses in Wales give the NHS extra hours to the value of 914 full-time nurses.[222]
- According to the British Medical Association (BMA) on average, each FTE doctor in the NHS does 1.3 FTE roles, 11-12 hours extra a week for each FTE doctor. This is about two hours above the working time regulations cap of 48 for average weekly hours and 13 hours more than the average hours of work for full-time workers.[223] Such Herculean efforts are obviously unsustainable in the long term.

Some of the inequalities affecting healthcare staff highlighted in chapter 1 may be another factor to explain why people are leaving the professions, and where they are amenable to influence by professional regulation we will advocate for change.

Why we need a rethink

International recruitment has long been used to bolster UK supply. However, it is not without its complications; it can add to workforce shortages in the country of origin, exacerbating global health inequalities, and leaving the world at risk of future pandemics. This supply route is also vulnerable to changes in immigration policy, which is currently decided nationally for the whole of the UK.[224]

The Government is looking at alleviating some of the barriers to international recruitment, and has recently consulted on changes to make it easier for some regulators to adapt their requirements for registering overseas applicants.[225] It has also passed the Professional Qualifications Act which creates a new framework for recognising professional qualifications and experience gained overseas.[226] It is now working on reforms to health professional regulators' legislation to remove prescriptive detail and support a more agile approach to registration of international applicants.[227] We acknowledge these initiatives as helpful contributors to solving the problem, at least in part.

Technology may help to free up capacity too. As we describe in the previous chapter, this poses both opportunities and risks and will require clarity on the lines of accountability when using new technology.

However, the longer-term, more sustainable solution would seem to be to grow our own workforce. To do that quickly and safely, we think a different approach will be needed by professional regulators, governments, and others to educate and train the regulated professions, adapt to difference, and assure unregulated roles. The solution lies in:

- Training more regulated professionals faster – this would need regulators to agree to alter education requirements for entry to the register, or support more flexible career pathways by allowing earlier transition to other roles.
- Altering what people do and how – changing the scope of existing roles, creating new ones, or making better use of un-regulated roles.
- Reviewing existing barriers, such as funding and access, to consider where they may be alleviated.

Alongside this, to adapt to and support this agenda, a new regulatory approach is needed on two related fronts:

1. In the past, we have held the firm view that professional regulation should not be drawn into adapting standards to respond to workforce issues. We now view this stance as unsustainable; the shortages are so great that the lack of workers may pose a greater risk to patient and service user safety than any changes in standards. It may be justifiable to adapt regulatory approaches to allow more people into the workforce – cautiously, and with the appropriate safeguards. Naturally, such a change in policy would need to be implemented with extreme caution, and on the basis of robust risk-modelling.
2. We propose that these decisions should form part of a new strategy for the regulation of people, developed in partnership with patients, service users, providers, professionals and workforce bodies. It should sit alongside workforce plans and align with workforce and service change. A future regulatory framework must be agile enough to meet workforce needs while continuing to prevent harm.

Training more regulated professionals faster

> ‘A regulated profession means that the access to or the pursuit of a professional activity or group of professional activities is restricted, by regulation, to people having specific professional qualifications. This also covers the use of professional titles which are restricted to holders of specific qualifications’.

Directive (EU) 2018/958[228]

The professional regulatory model is both a help and a hindrance to the workforce and its growth. As the quote from the directive shows, it ensures quality by specifying the qualifications needed and controlling entry to a role. The restriction is good for public safety, ensuring both competence and conduct. Setting it high though, and most are at under-graduate level or above, limits the pool of potential workers and restricts numbers coming into the workforce. It also carries with it the risk of restrictive practices and protectionism.

It is to some extent illusory since protection of title can be circumvented by simply giving a role another name. Thus, clinical psychologists are regulated, but psychologists are not. Both may be employed as experts in the family courts, offering opinions on which serious decisions are made about the welfare and custody of children.[229] The model does not, for the most part, restrict activities to titles either.

Nonetheless, it offers a mostly effective, well-established means of controlling risks of harm to the public. Statutory regulation supports the workforce through the holding of a register, which employers access as part of their employment checks; their revalidation processes help to ensure continuing competence by requiring registrants to keep their skills and knowledge up to date. Regulation also acts as a deterrent to misconduct through its standard setting and fitness to practise functions, helping to maintain standards in the workplace.

Statutory regulation helps registrants by giving them standards and guidance to follow and allowing them to resist, by reference to their regulatory standards, pressure to breach them, take undue risks or work in areas outside their competence.

The 10 regulators we oversee (who between them regulate 35 professions) and those set up under Scotland, Wales and Northern Ireland’s devolved powers for social workers and social care workers, each decide which qualifications registrants must have, and for the most part quality assure pre-registration education courses run by educational institutions. Their decisions directly affect the length and type of training and how quickly future practitioners enter the workforce.

Unlike some other jurisdictions, UK regulators do not have a statutory role of ensuring an adequate workforce supply. This is still right, in our view, as there is an inherent tension between ensuring adequate supply, and setting the bar for entry to a profession for reasons of safety; but, as we mention above, we must acknowledge the scale of the issue that the country is facing, and the trade-offs that may have to be made. Risks of safety and quality of care being compromised by workforce shortages may be greater than those resulting from a potential lowering of standards. Regulators should therefore critically re-examine their contribution. It may be that numbers can be increased without undue compromise on standards, but all options need to be considered.

Although numbers on registers have steadily increased* workforce vacancy rates for these roles still remain high, with further shortages predicted. The number of students has not kept pace with rising demand because of gaps in workforce planning, lack of funding and investment, and limits on capacity of staff in the workplace to support training placements. The problem now, is that far higher numbers are needed to overcome the combined effects of high vacancy and attrition rates.

The BMA predicts it will take 25 years to achieve the 50,000 doctors needed at current rates of supply.[230] Despite the Scottish Government's commitment to fund 139 extra training places for doctors at a cost of £32 million,[231] Audit Scotland predicts that it will add just 19 doctors to the primary care workforce by 2027 – just 2% of the 800 target.[232] Training a doctor takes four to six years at medical school, two more years' foundation training to gain experience, and then several years of specialty training: three years for general practice, and around five to seven years for other specialties.[233] It is quicker for other professions but still takes five years to qualify as a pharmacist,[234] and three as a nurse, midwife, or physiotherapist.

Social work now has a wider range of entry routes than some other professions with undergraduate degree courses typically three years full-time, six years part-time. Postgraduate degree courses take between 14 months to two years full-time, and four years part-time. There are some fast-track programmes (including Frontline, Think Ahead and Step up to Social Work) which typically take 14 months. There are also undergraduate social work apprenticeship programmes which are three years full-time.

In 2020 there was a 23% increase in the number of students accepted onto nursing degree courses in England (relative to 2019) – the highest annual number of acceptances since 2011. However, the Health Foundation still predicts that the 50,000 target for nurses is too low to meet demand.[235] The RCN reports similar shortages in Wales, Scotland and Northern Ireland too.[236]

Something needs to change. There may be lessons we can build on from what happened during the pandemic – outlined in our 2021 *Learning from COVID-19 review*.[237] Amongst other changes the NMC introduced emergency education and training standards.[238] These allowed final year students to spend up to 100% of their time in clinical practice if their education provider deemed it necessary. Regulators also used online and simulated training to overcome difficulties in providing workplace-based experience.

Regulators, educators, and professional bodies might therefore explore whether there are opportunities for accelerating training safely. We recognise that there are likely to be risk trade-offs to be made here, but believe that those associated with workforce shortages may at least warrant a fresh look at training length, pace and delivery method. We also understand that the availability of training is in part dependent on staff being available to provide training and supervision – however,in some circumstances, technology may provide some solutions.

Regulators and registers should work together, and in partnership with key stakeholders including patients and service users, to identify opportunities to speed up workforce supply.

* The General Medical Council's register has grown by about 100,000 over the last decade and the Nursing and Midwifery Council's by about 80,000 in a similar period. Social Work England's register has increased from 97,684 in December 2019 to 98,4991.

Speeding up statutory regulation when it's needed

Creating new roles with shorter training requirements and adding them to an existing statutory register is one way to increase workforce numbers more quickly, but it too may need to be achieved faster. For most of the regulators we oversee,*(1) once a government decides to regulate a role it can use secondary legislation under the Health Act 1999 to amend the regulator's legislation allowing them to regulate it. This is a relatively streamlined process, as legislative changes go. However, there is a lot of work that goes into preparing the ground for a new role, and the length of time it takes varies. Despite deciding to regulate Physicians Associates in October 2018, and planning to assign them to the GMC to regulate, the relevant legislation has not yet been passed.[239]

Having a clear policy and approach for introducing new roles and deciding how any risks they present will be controlled could help to standardise and speed it up. It could also help to contain some of the politics that can interfere with these sorts of decisions and processes. We welcomed a recent Government consultation on reform setting out a risk-based methodology for deciding whether and how a group should be regulated using our right-touch assurance methodology.[240] We also asked questions about how it would be put into practice, and are awaiting the outcome. As we see it, this kind of approach would form part of a new regulatory strategy.

Power to regulate new healthcare roles is devolved in Scotland, but not Wales or Northern Ireland. There is a longstanding four-country commitment to UK-wide regulation of healthcare roles though, and to date the only deviation has been for nursing associates, who are only regulated in England.[241] Decisions to regulate social care workers, however, are devolved. This has allowed these groups to be regulated in all UK countries except England. While this variation, may be helpful at a local level, this sort of fragmentation can potentially exacerbate workforce shortages by disrupting the free flow of workers around the UK. Careful thought needs to be given to the risks and benefits of consistency versus flexibility in this area – a point that we highlighted in our report for the Scottish Government on regulating a profession in fewer than all four UK countries.*(2)

There should be a clear process to guide the development of new health and care roles for each UK country, including:

- the scope and purpose of the role
- the process for deciding on the level of assurance required to control risk of harm
- the criteria for evaluating risks and benefits of deviating from a UK-wide approach.

* (1) With the exception of Social Work England and the Pharmaceutical Society of Northern Ireland.

(2) Different groups of social care workers are regulated in Scotland, Wales and Northern Ireland (see: Professional Standards Authority, 2018, *Regulating an occupation in fewer than all four UK countries Implications for policy-makers, the public, and practitioners. Advice for the Scottish Government.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/regulating-an-occupation-in-fewer-than-all-4-uk-countries-2018.pdf?sfvrsn=ce3e7220_11)

Making better use of the unregulated workforce

> ‘New solutions are required … to meet the changing needs of the population. This will need new ways of working, new roles and new behaviours.’

‘NHS Multi-professional framework for advanced clinical practice in England[242]

Planning the workforce is broader than it may seem. Delivery of health and social care depends on huge numbers of unregulated workers who support, supplement and service care. For example, for every four people working in general practice only one of them is a doctor. GPs cannot run their surgeries without practice managers, receptionists, counsellors, social prescribers, care navigators or community link workers, as well as nurses, pharmacists, and allied health professionals.[243]

Almost two thirds of the 4 million people employed in health and care are working in unregulated roles.[244] Some carry out tasks under the delegated authority of regulated professionals, others are supervised either by regulated professionals or employers. Some carry out high risk procedures, such as clinical physiologists*(3) or surgical care assistants. Others may work autonomously, often on their own, such as counsellors and psychotherapists.

The advantage of unregulated roles is that they are flexible, and employers and others can create, change, train and deploy them as they wish. However, when roles are created locally, whether within a country or organisation, the standards they work to and range of tasks they carry out may be different to a similar role, or even a role with the same name, elsewhere.This may make it harder for prospective employers to know what to expect when they recruit someone; for their colleagues to know what their role in the team will be, or what they are competent to do; or for patients to understand where they sit within the healthcare team.

For example, a ‘nurse’, may be a healthcare assistant, not a registered nurse.[245] A ‘sonographer’ may be a post-graduate radiographer or someone who has done a short training course to operate ultra-sound for a limited purpose such as scans in a baby clinic producing souvenir pictures.

Safe care depends on effective teamwork – and that needs familiarity, each member understanding their respective roles. Team members typically change frequently and at short notice. They may never have met before and yet they must make snap judgements about who will do what – sometimes while someone’s life hangs in the balance.

There is no readily accessible taxonomy of health and care roles, or common agreement on titles not protected by law. What people with similar names do may vary considerably. An advanced practice label can be attached to a regulated role, such as a registered nurse, or a nursing assistant. Health Education England (HEE) has worked with other stakeholders in England to develop a national framework for advanced practice, to ensure national consistency and understanding. Intended initially to cover regulated professions, HEE is working to wards extending it to unregulated roles, too.[246]

Technologies such as blood pressure monitors or extra corporeal membrane oxygenation equipment make it possible to delegate a wider range of tasks. In doing so, unregulated, or less highly qualified roles can take over areas of practice previously the domain of regulated

* (3) Clinical Physiologists use specialist equipment and advanced technologies to carry out vital procedures and investigations on patients to help in the diagnosis, monitoring and treatment of a wide range of disease processes. For example, cardiac procedures.

professionals. Introducing blood pressure monitors meant registered nurses could delegate taking blood pressure to healthcare assistants for example. Extra corporeal membrane oxygenation may be carried out by a clinical perfusionist who whilst providing critical care, is also in an unregulated role.*(1)

This can create anxiety for regulated professionals who remain professionally responsible to their regulator for care delegated by them or provided under their supervision, whilst being unclear about supervisees' training, experience, and scope of practice.

They may worry that their role will be undermined, and that the public will be put at risk by people who are less well trained taking over some of their tasks. Regulators have provided guides to help them understand their responsibilities when delegating or accepting delegated tasks, but we appreciate that increasing pressures in the workplace may make it challenging to put them into practice.[247] Those in unregulated roles may also feel anxious if asked to take on tasks they do not think they are trained to do but feel unable to decline.[248] Unlike regulated professionals or those on Accredited Registers, they cannot fall back on their professional registration and requirement to practise within their competence as a reason for refusal.

From patients and service users' perspectives, our research amongst the public has shown that they generally assume anyone caring for them is subject to some form of regulation when this may not be the case.[249]

Broadening the regulatory model

Broadening the regulatory model to include a spectrum of controls rather than solely relying on statutory regulation would allow workforce planners greater flexibility and speed up growth. Having services embrace and make use of these controls would remove disincentives and obstacles, clearing the path for example, for new educational courses. It could also cause other barriers to development to be systematically re-examined and potentially removed.

As workforce planners get to grips with the challenge before them, health and care delivery changes, and roles evolve, services need a way to ensure they protect patients and service users from harm, for example: having workers join voluntary registers, sign up to codes, setting up professional bodies, and requiring certain qualifications or training. They also need a way to help other members of the teams they work with recognise and understand their role and what they can safely do.

Within England's mental health services, new roles are being developed such as psychological wellbeing practitioners and children's wellbeing practitioners who work alongside healthcare professionals to assess and support people with common but sometimes serious mental health difficulties. In Scotland, community link workers now work within GP practices to provide support with personal, social, emotional, and financial issues.

We need safe, proportionate ways to control the risks associated with such roles. One option being considered by NHS England is the use of voluntary registers under our accredited registers programme. Accreditation provides independent assurance that these voluntary registers operate effectively to protect the public. The Authority has recently accredited the British Psychological Society, and has interest from other related registers.

Licensing is another option, with Scotland and England both considering introducing it as an alternative form of control for non-surgical cosmetics.[250,251] While cosmetic surgery can only be carried out by a doctor, non-surgical but still invasive cosmetic procedures such as Botox or injectable fillers can be carried out by anyone.*(2)

* (1) In extracorporeal membrane oxygenation (ECMO), blood is pumped outside of your body to a heart-lung machine that removes carbon dioxide and sends oxygen-filled blood back to tissues in the body. ECMO is used in critical care situations, when your heart and lungs need help so that you can heal. It may be used in care for COVID-19.

(2) Botox must be prescribed by a clinician but can be administered by a non-registered person.

The advantage of licensing is that it can restrict one or more activities rather than an entire role. It can be used independently or along-side either statutory regulation or accredited registers, or both. The Authority accredits two Registers in this area, the Joint Council for Cosmetic Practitioners and Save Face, both of whom support the addition of licensing to strengthen controls.

With the Government's consultation on criteria for statutory regulation – based mainly on the Authority's right-touch assurance model[252] – the question of which roles should be regulated has come to the fore.[253] There has been ongoing debate for example about whether cosmetic practice, counselling and psychotherapy, and social care in England should be regulated. More recently the Ockenden Review has restarted the debate about whether health service managers should be regulated. In our view, not every role can or should be regulated by law, and it is for governments to decide which. The UK Government's recent consultation on regulating based on risk supports this view.[254]

We have previously put forward the idea of a 'continuum of assurance'.[255] The type and level of controls for different groups within health and care should be proportionate to the risk of harm arising from practice, and responsive to the nature of the risks.[256] There are many different ways to control risks ranging from employer controls, credentialing, accredited registration,*(3) and licensing through to statutory regulation for the riskiest occupations. Standard codes, common competencies, national units of learning, national frameworks like HEE, agreed qualification and training routes for entry to roles, and standard naming conventions are other ways to manage risks.

There are other ways too to mitigate risk and prevent harm. Good governance, effective management, making changes to the environment, adapting, or licensing equipment, requiring registration or inspection of premises, and ensuring that those inspecting workplaces check those aspects that are essential to supporting workers' competence, wellbeing and professionalism. Resolving risks requires careful analysis of the problem, using right-touch principles to decide the most appropriate way of controlling it, and collaboration between organisations to close safety gaps.

There should be an agile process for identifying risk, deciding and authorising the form of assurance needed, and firm government and service backing for using a spectrum of regulatory controls. The Authority developed Right-touch assurance to advise on how risks arising from unregulated occupations should be managed.[257] This involves creating a risk profile for each occupation we assess, taking account of the complexity of tasks, the context in which it is practised and the vulnerability of the patient or service user group. Making sure that regulatory measures strengthen public protection, rather than increase burden means understanding what types of controls are already in place. This may be different for roles within managed settings such as schools or the NHS, to those providing services in private homes.

New and changed roles offer us opportunities to address some of the workforce shortages and help relieve workplace pressures. We will need to adopt a proactive approach to addressing the safety gaps that emerge and provide active support for the spectrum of measures that are available to manage risk. This could, if our recommendations are taken forward, be part of the Commissioner role – and so protect patients and service users from harm. Acceptance by those used to operating within the statutory regulatory model that there are other, valid means of assurance will also be essential.

* (3) The creation of the Authority's Accredited Registers programme in 2012, and the legislation underpinning these powers of accreditation, was a big step in introducing alternative forms of assurance. For the first time, organisations that hold voluntary registers of roles in health and care could show they met a set of independently assessed Standards, under a statutory scheme. Since its introduction, the programme has expanded to 26 registers, more than 100,000 practitioners and improved the organisations accredited.

Developing a regulatory strategy to support workforce expansion

> 'the people who run regulation struggle to provide coordinated or coherent oversight of the delivery of care, despite their valiant efforts, because its parts are not designed to work together well'

Professional Standards Authority 2015, *Rethinking regulation*[258]

We have outlined in this chapter why we think we need a broader regulatory model to address key pressures and ensure that risks to patients and service users are managed.

We see a strategy for the regulation of people (or 'regulatory strategy'), as a defined approach to managing risks of harm arising from the practice and behaviour of individuals through regulation in its broadest sense. It should set out regulatory objectives and how they will enable service needs. This basic framework should be the starting point for decisions and assurance mechanisms for new roles, based on risk and workforce trade-offs. It should be acknowledged, though, that while creating new roles can address existing risks, it can also create new ones.

It should be positioned within the Government's approach to other forms of regulation in health and care, and contemplate a wide range of possible assurance mechanisms. It should have the flexibility to be used in the development of as yet unknown future roles.

The strategy would be used in the early development stages for new roles. This would require active consideration from the outset about the likely risks and consequences and the options for averting them. It would support a more coordinated approach to ensuring that professionals have the skill sets required to adapt to the diverse needs of patients and service users, innovations in health and care, and emerging risks (as outlined in the chapters looking at inequalities, and business and technology).

Having a strategy for the regulation of people, to complement and support delivery of the workforce strategy for each UK country, would enable the thinking about how a role should be regulated to happen in tandem with that about new or evolving roles and developments in care. It would also bring transparency to the basis for these important decisions, and how they serve the public interest.

The strategy would:

- Cover regulated and unregulated roles and make clear how risks will be controlled as the system adapts to meet workforce challenges.
- Look forward, supporting the development of specific roles where this is known, and where not, providing a basis for future risk-based decisions about appropriate means of assurance.
- Allow enough control to preserve safety, leave room for innovation, and take into account the impact of regulatory controls on supply.
- Include a visible way for employers and others to recognise and value all roles. For example, using quality marks or an agreed set of titles. This would give regulated professionals the confidence to delegate to and work alongside unregulated roles.
- Require a shared acceptance by workforce leaders, planners, regulators, and governments of a strategic approach that makes use of a spectrum of regulatory measures rather than relying solely on statutory regulation.
- Find a balance between where it is necessary or beneficial to take country-specific approaches, and where four-country coherence takes precedence.[259]

This final point hints at the complexity of making this work UK-wide, something we must acknowledge. Some decisions about which groups in health and care should be regulated are devolved, but many are not. There are benefits to UK-wide regulation, but also arguments for deviating from this model in certain circumstances.*

Whether we should aim for a UK-wide over-arching regulatory strategy with allowances for each country's specific circumstances, or four strategies with degrees of commonality, would need to be determined. What is certain is that close working between the four countries would be essential in establishing principles on which decisions about consistency and divergence could be made.

The workforce and regulatory strategies between them should provide clear pathways and processes for the creation of new roles to include decisions about how these roles and, potentially, activities would be regulated and assured. Those creating new roles should work with the regulators, accredited registers, and the Authority to identify which regulatory or assurance controls will best suit their situation.

The Authority would also use its oversight role, expertise and convening power to support the development of these strategies across the four countries.

* We have previously considered the issues that might arise from diverging from a UK-wide approach to professional regulation in our report: Professionals Standards Authority, 2018, *Regulating an occupation in fewer than all four UK countries Implications for policy-makers, the public, and practitioners, Advice for the Scottish Government*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/regulating-an-occupation-in-fewer-than-all-4-uk-countries-2018.pdf?sfvrsn=ce3e7220_11

Facing up to the workforce crisis and regulation's future role: our conclusions

The UK is facing a serious workforce shortage which it must address if care is not to suffer, and patients and service users come to harm. To address shortages in the statutorily regulated workforce, governments, regulators, and employers must succeed in retaining existing professionals, recruiting from overseas, creating new roles and training professionals in sufficient numbers. The latter may mean regulators challenging conventions about education and training, and governments setting up clear pathways. Another option may be to look at those working in unregulated roles and consider whether they, with appropriate safeguards, might offer a way forward.

Addressing these issues will not be easy. It takes time and money to train more health and care professionals and it may be hard to incentivise existing staff to stay or to recruit quickly enough to relieve the pressure. Alterations to training pathways take time to agree, change and assure.

A coordinated, coherent approach is also needed to up-skill the workforce to prepare them for developing models of care, providing care to diverse groups of patients and service users and to address emerging risks in healthcare provision; for example, through increased use of technology in health and care. These problems need addressing quickly, and safely – and regulatory arrangements should form a key part of this.

Recommendations

We recommend that:

- Regulators and registers work collaboratively to identify opportunities to speed up workforce supply, equip practitioners to deal with future challenges in how care is delivered, close safety gaps and protect patients and service users.
- There is a clear process to guide the development of new health and care roles including the scope and purpose of the role, the process for deciding on the level of assurance required.
- There should also be an agreed way of deciding when to deviate from taking a UK-wide approach based on a review of risks and benefits alongside consideration of the national context.
- Those involved in health and care workforce planning and delivery across the UK actively support additional and alternative means of assurance as a means of managing risks to patients and service users.
- The four UK Governments work together to develop a coherent strategy for the regulation of people, to support delivery of their national health and social care workforce strategies.

Recommendation that could form part of the Health and Social Care Safety Commissioner's role

- Identifying risks relating to workforce shortages and how practitioners are regulated. This would help to inform the regulatory strategies.

The Authority will:

- Use its oversight role, expertise and convening power to support the development of these regulatory strategies.

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Contact

Professional Standards Authority

T 020 7389 8030

E info@professionalstandards.org.uk

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