The Essentials – what this report is all about

This report examines the current state of professional health and care regulation in the UK, but it goes beyond that in identifying and proposing solutions to some of the huge challenges in health and social care today.

We set out here what this report is all about – the things the sector needs to know, and what we want to happen.

What are the problems?

Our report considers four main themes:

- **Tackling inequalities:** there are still unequal and unfair outcomes for protected groups in aspects of professional regulation. There is also a lot we still do not know about how inequalities affect all-important complaints mechanisms when care has gone wrong – or indeed what this could tell us about biases in care itself. Professional regulation must work to address its own issues, and support professionals to help tackle inequalities in the design and delivery of care. But as a sector, we also need to be better at hearing diverse voices, and collecting, analysing and sharing data.
- **Regulating for new risks:** changes in the way that care is funded and delivered are sometimes made with limited focus on the risks and impacts on patients and service users, and how to manage them. Reforming the regulators gives us an opportunity to address known problems, and may even build in some agility for the future – if we take the opportunity presented to us. But we also need better, more reliable ways to anticipate these changes.
- **Facing up to the workforce crisis:** workforce shortages are putting patients and service users at risk across the UK. Engrained attitudes to professional regulation and qualifications aren't helping. It is time to rethink the contribution of professional regulation to workforce planning.
- **Accountability, fear, and public safety:** just cultures and individual accountability are both essential to better, safer care, and must coexist. Professional regulation should be clearer about its role, to reduce unnecessary anxiety and inappropriate complaints.

  We need to find ways for these new approaches to safety such as 'safe spaces', to incorporate openness with patients, service users and families, and action against individuals where it is needed for public safety.

Our examination of these themes also identified a sector-wide problem:

- **Structural flaws in the safety framework:** the patient and service user safety landscape is fragmented and complex. Concerns raised often fall between organisations, or are left unaddressed due to jurisdiction issues or insufficient powers. Large-scale failures of care still occur frequently, and inquiries and reviews highlight similar themes and issues, with the system seemingly unable to prevent their recurrence. Each body looks at the problems principally through the lens of its own remit, often prejudging the nature of the solutions as a result. We need a new framework focused on safety that spans organisational and sectoral boundaries.

What are the solutions?

To address the structural flaws in the safety framework across health and social care, we would like to see:

- An independent Health and Social Care Safety Commissioner (or equivalent) for each UK country to identify current, emerging, and potential risks across the whole health and social care system, and bring about the necessary action across organisations.
- With respect to the issues identified across our four themes, they would help to identify:
- Risks affecting protected groups differentially [Tackling inequalities]
- Emerging risks in how care is funded and delivered that are going unaddressed [Regulating for new risks]
- Risks relating to workforce shortages and how practitioners are regulated [Facing up to the workforce crisis]
- Unintended risks arising, or likely to arise, from existing, or proposed, national approaches to patient and service user safety [Accountability, fear, and public safety].

They would also coordinate public inquiries and reviews, and monitor how recommendations are implemented.

To address problems relating to the four themes of the report, we propose:

- A sector-wide initiative to improve collection, analysis and sharing of demographic data of complainants, to help to understand and address inequalities in care and complaints handling [Tackling inequalities]
- That Governments ensure the current reforms to the professional regulators equip them to respond to risks arising from developments in how care is funded and delivered [Regulating for new risks]
- A coherent practitioner regulatory strategy to support delivery of national workforce strategies across the UK [Facing up to the workforce crisis]
- That the Authority brings stakeholders together to find ways for the 'safe spaces' approach of the Healthcare Safety Investigations Branch (HSIB) England, and other local and national initiatives to improve safety culture, and support candour and accountability. This will include patients, service users and families, professionals, regulators, and many others. [Accountability, fear, and public safety]