PSA Call for Evidence – Right-Touch Regulation

Introduction

We welcome the opportunity to comment on the PSA's discussion paper*, Reviewing Right-touch regulation*, to inform an updated version - RTR3. In particular, we welcome the increased focus on the practical application of the RTR principles in an increasingly challenging and complex regulatory context. This discussion paper comes at a time when we are reflecting on the Government's growth agenda and the wider contribution that we and health profession regulation as a whole can make. We are undergoing significant regulatory reform which will enhance our efforts to act as an enabler of innovation and flexibility, rather than a barrier. This will improve our ability to support workforce growth by ensuring that we can enable registrants to start practising more swiftly and easily; train and work more flexibly; and ensure that our approach within fitness to practise is more proportionate, and less burdensome and adversarial for those we regulate.

We do not propose to respond to every question. Instead, we have set out our views on the proposed additional principles; clarifications that it would be helpful for the PSA to make; and next steps.

Proposed additional principles

While it is important that the RTR framework evolves to keep pace with changes in the wider regulatory, social and political landscape, it itself should be proportionate, focused and targeted. To that end, while we think that the existing RTR principles remain relevant, we think that any additional principles should be carefully considered and defined to ensure that they add significant value.

The discussion paper proposes the inclusion of 'fairness' as a principle. We offer some suggestions about how this concept could be more clearly defined, and what should be included within the definition of this as a principle.

The first strand is procedural fairness - ensuring that regulators follow due process when carrying out their regulatory activities, including making regulatory decisions. We agree with the PSA that regulatory decisions can significantly impact those involved and it is therefore essential that regulators are making these decisions with fairness in mind. This is why we have undertaken the Regulatory Fairness Review which will ensure that our existing controls on mitigating bias, monitoring differentials, and promoting fairness across our regulatory functions are as robust as

possible. We therefore agree that it would be merited to include procedural fairness as an additional RTR principle.

The second strand would focus on the wider social responsibility that regulators hold, by virtue of their role. This work is important but, given limitations in regulators' scope of influence and the potential for regulatory overreach, we don't think that it should be included as part of a principle on 'regulatory fairness'. Rather, we'd argue it should be captured as part of regulators' wider responsibilities to understand the context in which we work – potentially in the explanatory guidance the PSA has proposed to develop in support of RTR3.

In practice, this kind of work involves influencing the system in which regulated professionals are educated, trained and work, as well as setting professional standards that outline expectations of how those professionals can play a part in addressing inequalities. It's important that regulators are exerting their influence in these areas to influence positive change, but also are clear about their limitation and the proportionate use of regulation.

We have used this influence in several areas of our work, particularly in relation to professional standards. For example, as part of our work to review and update *Good Medical Practice* in 2024, we made several changes aimed at positively influencing systems within which medical professionals work. We introduced a new 'must' paragraph to 'help to create a culture that is respectful, fair, supportive and compassionate by role modelling behaviours consistent with these values' (paragraph 52, *Good Medical Practice*). And we added strengthened paragraphs to help tackle discrimination and to champion inclusive and compassionate leadership for those in formal leadership and management roles. We will continue to place an emphasis on this as we take forward other planned reviews including of our guidance on personal beliefs and leadership and management.

In terms of the proposal to include a principle on collaboration, we agree that regulatory collaboration is an important way of working to improve patient safety, both routinely in terms of sharing data and intelligence, and where organisations have shared regulatory objectives in particular areas. Our efforts to enhance our approach to regulatory collaboration demonstrate our commitment to collaboration. For example, we successfully sought a strengthened duty to cooperate in the Anaesthesia Associates and Physician Associates Order 2025. We have also developed a Shared Data Platform in collaboration with the NMC and CQC which has enabled us to share and jointly analyse regulatory data more effectively in areas such as maternity care.

Whilst regulatory collaboration is an important way of working that should be encouraged by the PSA, we don't think that this should be framed as an RTR principle. This is because there are many circumstances where regulatory collaboration is not appropriate or proportionate. We therefore suggest that the PSA's focus on regulatory collaboration would be better directed towards producing guidance that covers the features of good regulatory collaboration, barriers to this and how they can be overcome.

Potential areas of focus for PSA

We note with interest the exploration of different approaches to right-touch regulation within the discussion paper. We have additional views on a couple of these areas which may assist the PSA to further develop its thinking.

It would be helpful if the PSA could put its proposed guidance on taking a lighter touch approach to regulation in context (paragraph 2.7), given the risks associated with applying this to the regulation of healthcare professionals. We already take a lighter touch approach in some areas of our work, such as expanding our ethical hub to provide advice that puts our existing professional standards in context in key areas where we are often asked for advice, rather than producing new guidance to cover more specific topics. However, it would clearly be inappropriate to implement this approach within areas such as fitness to practise, so further guidance on how and when the PSA sees lighter touch regulation applying would be useful.

We also agree with the PSA that, to prove its value, regulation must demonstrate its impacts and how these constitute good value. We recognise the challenges with this and have taken steps to try and address this - for example, we have increased our evaluation activities; developed in-house guidance and training on evaluation; and embedded evaluation requirements into our projects to drive consistent and appropriate evaluation. We plan to embed these processes into our ways of working as we develop our next Corporate Strategy and will consider how we can better demonstrate that we consider risk, benefits and value for money in our decision making. However, we recognise that we and other health profession regulators could do more. We therefore think that it's helpful for the PSA to promote the importance of impact assessment and evaluation in RTR3 to help reinforce the importance of cultural change that places a greater emphasis on regulatory learning and measuring impact as an ongoing discipline and practice.

Areas for clarification or development

There are some areas within the discussion paper that would benefit from greater clarity or development.

We note that the PSA proposes to develop guidance on actions at the limits of jurisdiction as part of how it will illustrate application of the principles within RTR3 in practice (paragraph 2.7). The concept of jurisdiction is broad and open to interpretation. The term 'jurisdiction' could imply an overseas or cross-border element which we don't believe is intended, so it would be helpful to clarify the scope of this. Context will also affect the types of issues it can be appropriate for regulators to intervene in - for example, what is appropriate for a regulator to do in a state of emergency, such as during the COVID-19 pandemic, would look different in normal times. When developing the guidance, it would also be helpful for PSA to expand on the impact that context could have.

We agree with the PSA that promoting good practice to registrants is one of the ways in which regulators can add value (paragraph 7.2) and that regulators could do more of this than they currently do. We have championed this approach through initiatives such as our Fair Training

Cultures programme, where we are gathering evidence about and promoting effective interventions that target areas like education performance and inclusivity of learning environments. It would be helpful if the PSA could expand its exploration of sharing good practice within RTR3 to reflect an alternative angle that focuses on promoting this across registrants, as well as between regulatory and systems partners.

We note the reference to regulatory prevention and local lines of defence in section six of the paper, which we've taken to mean effective local resolution of concerns by employers to prevent harm. Our regulatory model depends on local oversight of whether standards are being met and resolution of concerns before they come into our processes, and we are currently considering how best to take forward our work to influence improvements in this space so that we can enhance our contribution to patient safety across the wider health and regulatory system. It would be helpful for PSA to recognise the devolved model of regulation for us and for other regulators, whilst recognising that the exact arrangements will differ for each.

Conclusion

We would be happy to expand on the views put forward in this response and would very much welcome the opportunity to comment on the final draft of RTR3.