National Commission into the Regulation of AI in Healthcare

Unite the Union Submission Jan 2026

Unite the Union is the largest trade union in the United Kingdom and Ireland, representing over 1.1 million members across both the private and public sectors.

Unite is the third largest trade union in the National Health Service and represents 100,000 health sector workers. This includes seven professional associations – the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

Unite also has 80,000 members in local authorities and 50,000 in the voluntary and community sector many of whom work in services directly involved with or linked to public health and social care.

Section One - Respondent Information

Question 1: Are you responding as an individual or on behalf of an organisation?
Organisation
Question 2.1: Which of the following best describes you or your role?
Regulatory Professional
Question 3.1: What is the name of the organisation you are representing?
Unite the Union
Question 3.2: What type of organisation is this?
Professional Organisation
Question 3.3: The MHRA intends to list the names of organisations which respond to this call for evidence in the report to be published on GOV.UK. Can the report identify your organisation as contributing in this way?
Yes
Question 4: We may want to follow up with you - if you are happy to be contacted, please provide us with a contact name, organisation (if relevant) and email address.
Deborah Hopkins. Unite the Union

Section Two: Call for Evidence Questions

Question 1: Which of the following best describes your view about the need to change the UK's framework for regulating AI in healthcare?
Complete Overhaul: The overall framework should be replaced entirely

Question 2.1: To what extent do you agree or disagree that the current regulatory framework is sufficient in the following domains: Safety and Performance Standards Disagree

Question 2.2: To what extent do you agree or disagree that the current regulatory framework is sufficient in the following domains: Data Privacy and Data Governance Strongly disagree

Question 2.3: To what extent do you agree or disagree that the current regulatory framework is sufficient in the following domains: Transparency Strongly disagree

Question 2.4: To what extent do you agree or disagree that the current regulatory framework is sufficient in the following domains: Requirements for clinical evidence Strongly disagree

Question 2.5: To what extent do you agree or disagree that the current regulatory framework is sufficient in the following domains: Post Market Surveillance
Strongly disagree
Question 3: How would you rate the current framework's impact on innovation?
Too loose [risks patient safety]

Question 4: How might the UK's framework for regulation of AI in healthcare be improved to ensure the NHS has fast access to safe and effective AI health technology?

The risk of fast access is that safety for patients and staff is sacrificed in a rush to implementation by a contracted provider of the service. Where low cost is prioritised – rather than balanced by safety.

The Threshold for the safe implementation of AI health technology should be raised not lowered where AI/digital access is to be centred in patient care and professional practice. The impact on workforce of poorly evidenced, rapidly implemented AI is of deskilling, demotivation, loss of professional expertise and loss of discretionary effort as their professional contributions are devalued.

Existing health inequalities are exacerbated where AI and digital access platforms are implemented without active coding for inequalities in rurality and infrastructure, access, language and morbidity. Risks of direct discrimination, exclusion of patient groups in most need, barriers to care for staff, and the risk of mis-translation leading to incorrect treatment are demonstrated but lines of accountability, responsibility and liability are blurred or removed.

Patients and staff have no transparency about who is responsible for outcomes, both good and bad. With a 38% international workforce in the NHS and Social Care, AI and machine learning/new tech which does not code to overtly include these groups and then learn from their language variations and will exclude them and undermine their professional practice and patient safety as a result.

This is not new evidence nor new knowledge, but it has not been applied rigorously in the implementation of new AI /machine learning/digital platforms to date.

Simply put, systems need to be designed towards those with most barriers, in order to actively reverse inequity in health access. Unless designed with active intervention models, digital health will exacerbate current inequities and create new ones in patient access.

Farre A, Fang M, Hannah B, et al. Exploring the use of digital technology to deliver healthcare services with explicit consideration of health inequalities in UK settings: A scoping review. DIGITAL HEALTH.2023;9.doi:10.1177/20552076231185442 Hepburn J, Williams L, McCann L.Barriers to and Facilitators of Digital Health Technology Adoption Among Older Adults With Chronic Diseases: Updated Systematic Review JMIR Aging 2025;8:e80000 doi: 10.2196/80000PMID: 40934502PMCID: 12464506

Yao R, Zhang W, Evans R, Cao G, Rui T, Shen L. Inequities in Health Care Services Caused by the Adoption of Digital Health Technologies: Scoping Review. J Med Internet Res 2022;24(3):e34144. URL: https://www.jmir.org/2022/3/e34144. DOI: 10.2196/34144

Shaw J, Abejirinde I-OO, Agarwal P, Shahid S, Martin D (2024) Digital health and equitable access to care. PLOS Digit Health 3(9): e0000573. https://doi.org/10.1371/journal.pdig.0000573 Editor: Harry Hochheiser, University of Pittsburgh, UNITED STATES OF AMERICA September 25, 2024 Canada

AI-induced deskilling in Medicine: A Mixed-Method Review and Research Agenda for Healthcare and Beyond/ Natali, C., Marconi, L., Dias Duran, L.D. et al. AI-induced Deskilling in Medicine: A Mixed-Method Review and Research Agenda for Healthcare and Beyond. Artif Intell Rev 58, 356 (2025). https://doi.org/10.1007/s10462-025-11352-1 Sezgin E. Artificial intelligence in healthcare: Comp

Question 6: Which statement best reflects your view on the current legal framework for establishing liability in healthcare AI tools?
Insufficient: existing laws are unfit for AI

Question 7: How could manufacturers of AI health technologies, healthcare provider organisations, healthcare professionals, and other parties best share responsibility for ensuring AI is used safely and responsibly?
Ensuring AI is first designed to augment and complement health care professionals, to code for global language users, complex comorbidities, and socio-economic health inequalities is the foundation.

Epistemic sclerosis (Cabitza) or knowledge crystallisation is driven by AI's reliance on historical data & past interpretations. This creates new risks where systems are not coded to allow for new language learning and variability. AI systems reinforce pre-existing diagnostic patterns, they risk solidifying knowledge not expanding it, limiting the ability to challenge prevailing norms or recognise novel cases. This rigidity could be harmful in complex, ambiguous, or low-data scenarios, where innovation and clinical breakthroughs rely on the ability to critically reinterpret existing knowledge rather than passively accept algorithmic outputs

Ensuring human AI collaboration or Human-In-The-Loop (Duratkar, M.G. and Joshi, P.R., 2022), systems can prevent this.

All AI and digital systems have serious consequences where they may be incorrectly used or interpreted. HITL combines the cognitive strengths of healthcare providers with the analytical capabilities of AI.

An HITL approach ensures that the AI systems are guided, communicated, and supervised by human expertise, thereby maintaining safety and quality in healthcare services

Risk is a part of all healthcare intervention – identifying potential risks and managing them are how healthcare practice works on a daily basis. There can be no weakening to this systematic approach to Risk with the introduction of AI.

Additional protocols to ensure authority and accountability at each decision point, must be built into new systems prior to implementation. The opportunity for human intervention, prevents untrammelled AI decision making.

Accountability is integral to regulated practice but often used punitively following poor risk management for non-registered staff, who are likely to be implementing and using AI systems without protection from its failure. Clear authority protocols and oversight structures must be in place at organisational level, and in provider contract agreements, to protect these colleagues.

Fully informed consent must be prioritised as a minimum threshold for all patients who receive treatment or intervention from AI systems. This cannot reasonably be sought or gained by non-regulated workforce – upskilling of regulated workforce to the skills required to seek fully informed consent will need to be implemented.

Where human-in-the-loop decision making is implemented, each stage can be stopped or altered by a suitably registered and qualified staff member only.

Cabitza F, Campagner A, Ronzio L, Cameli M, Mandoli GE, Pastore MC, Sconfienza LM, Folgado D, Barandas M, Gamboa H (2023) Rams, hounds and white boxes: investigating human–AI collaboration protocols in medical diagnosis. Artif Intell Med 138:102506

Duratkar, M.G. and Joshi, P.R., 2024, December. Artificial intelligence & Its effect on employment: Vision 2025. In AIP Conference Proceedings (Vol. 3188, No. 1, p. 100061). AIP Publishing LLC.

Question 8: In the event of an adverse patient outcome where an adverse patient outcome involved an AI tool, where do you think liability should lie?
The blame culture currently in place in healthcare provision is experienced as a burden to the workforce on the clinical frontlines, and undermines safe practice, staff mental health and discretionary effort, where overburdened workforce have not been supported to carry out effective risk assessment in practice.

The language in this question raises concerns that a pre-emptive risk assessment approach is not being applied, and this blame culture is being extended to AI and digital healthcare implementation.

The assessment of any patient outcome that is not embedded in a learning mindset will create a fear of new systems and a lack of trust in their safe application, regardless of the apparent cause of the error.

Where human-in-the-loop systems are applied at all stages, cross checking and dual authentication of interventions which carry a high risk (as with e.g. controlled drug administration) or the overriding of AI by a professional, should be demonstrated by a clear record of decision making and the medical criteria that lead to it.

The liability will be variable according to each situation and each action taken.

There is no blunt answer to liability without a root cause analysis that is prepared to be neutral, and not impacted by considerations of contract with supplier, cost to the provider organisation and is allowed to be carried out free of fear of litigation.

With the attempts (not always successful) to implement Just and Learning Cultures in NHS Trusts and providers, there has been a recent hope that systemic or machine failure should not fall conveniently on the shoulders of the workforce. Unfortunately, this has not been as successful as hoped, and system failures do find themselves placed onto the shoulders of workforce, who are considered more cost effective to replace, than a full review of processes by an employer.

Where national and international contracts for AI and digital intervention are at stake, (at high-cost burden) the risk is that the workforce will be considered the affordable option to replace, where liability is considered.

The issue of liability at each step of implementation of new systems must be meticulously considered in the procurement process, such that poor quality services cannot be sold by the contracted technology provider to the user/Trust, without agreed liability and accountability, at each stage.

As workforce representatives and as a professional organisation we will support a process for AI implementation where healthcare professionals are fully educated, upskilled and supported to ensure safe practice. Where this has not been provided, the use of such systems without education/oversight such that patient outcomes are at risk cannot and should not be imposed on staff.

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This evidence was submitted on behalf of Unite the Union by:
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