
Report

Fitness to Practise Data 'Decisions taken this year' Supplementary Report 2 2024-25

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Executive summary

The HCPC collects data relating to its Fitness to Practise processes at different stages to highlight areas of risk, spot trends and inform the sector to support decision making relating to workforce planning. The analysis in this report provides supplementary analysis of decisions made during the Fitness to Practise (FTP) process in 2024-25, it builds on the information provided in our regular [FTP Annual report](#). It focuses on decision-making outcomes across different stages of the process, including triage, Investigating Committee Panel (ICP) decisions and Tribunal outcomes. The data presented relates to decisions made during the financial year, rather than to a single cohort of concerns. As a result, it does not directly align with the cohort analysed in the 'Concerns this year' Supplementary Report 1 2024-25 report, as many decisions, particularly at Tribunal, relate to concerns received in earlier years. For this reason, the findings in this report should be considered separately, and while together they give a more detailed overall picture of our fitness to practise work this year, no direct comparisons or correlations should be drawn between the two reports.

The analysis in this report highlights a number of differences in decision-making outcomes across groups. However, it is important to emphasise that any disproportionality observed in the data should not automatically be interpreted as evidence of unfairness. There are multiple factors that may explain variation, and further longitudinal analysis will be needed to determine whether any patterns identified are of concern.

Key findings from the analysis of decisions in 2024-25 include:

- The proportion of male registrants receiving an ICP decision of 'case to answer' was notably higher than for females. Similarly, a higher percentage of male registrants went on to receive a sanction at Tribunal stage (Table 14b).
- Variation by ethnicity was observed in both ICP 'case to answer' decisions and Tribunal sanctions. However, for some groups the number of cases remains small, meaning there is considerable uncertainty about whether these differences are statistically meaningful (Table 15b).
- Differences by nationality were less evident at the triage stage, where the proportion of concerns was broadly similar across continents. However, more substantial variation emerged at the threshold stage, with particularly high proportions of those meeting the threshold test for those declaring nationalities linked to Africa (76%) and Oceania (78%) (Table 16a).
- Variation by nationality also persisted at later stages of the process, including ICP decisions and Tribunal sanctions. As with ethnicity, small sample sizes for some groups make it difficult to determine whether these differences are statistically meaningful (Table 16b).

Many of these variations are replicated across the sector and are not unique to the HCPC and they may reflect wider societal issues rather than any findings specific to our FTP processes. [1] [2]

Overall, while the analysis identifies areas of variation across different characteristics, the findings should be interpreted with caution. Further work will be required to better understand the drivers of these differences and to assess whether they reflect underlying factors, case mix, or our processes may be a factor.

Context

Superficially the assessment of FTP rates may seem straightforward. However, there are several complicating factors.

An important consideration is the small number of registrants with FTP concerns reported to us, especially when broken down by registration route. HCPC professions are most usefully considered on an individual basis. The split of the number of concerns across 15 professions can lead to small numbers and results that are highly sensitive to change. For example, eight professions had fewer than 10 international route registrants with an FTP concern in 2024-25 and only two had more than 30. Coupled with the small international route registrant population for some professions this meant there was considerable uncertainty in some of the analyses and not all analyses could be undertaken for all professions.

The main issue which can't be fully accounted for is that of risk exposure. A registrant not practising, or not practising in the UK, is unlikely to be subject to an FTP concern but will still appear in the denominator of any calculation. It is important to recognise here that HCPC registrants do not have to be in the UK to register or to remain registered (but all registrants must do their continuing professional development). It is certainly the case that many international route registrants will necessarily register ahead of coming to work in the UK, and in some instances may not end up working in the UK. It is also certain that some registrants from all of the routes are working overseas or have a period where they are not working. It has not proved possible from the data held by HCPC to generate a more accurate risk exposure than time on the register during the period of interest.

A final complicating factor is the observed structural differences in registrant populations for the UK and international application routes. In general, the risk of FTP increases with age and is higher in males than in females. A greater proportion of international route registrants are in the younger, and lower risk, age groups than for UK route registrants. Conversely, a greater proportion of international route registrants are male, and therefore of higher risk, than for UK route registrants. These structural differences vary by profession. Statistical techniques that adjust for these differences have been used where possible in this report, but the small number issue discussed above meant this was not always possible.

The challenges and some broad findings mirror those of other UK healthcare professional regulators who have looked at issues of disproportionality in FTP concerns. The GMC and GDC have both previously reported higher rates in men than in women, in older registrants than in younger ones, in ethnic minority registrants than in white registrants, and in registrants who trained overseas than in those who trained in the UK [1] [2].

Our registration routes

Historically there were four routes through which current registrants could have entered the HCPC register: UK, international, European Mutual Recognition (EMR) and Grandparenting. To come through the UK route the registrant must have received their qualifying education from a UK institution approved by the HCPC. The international route is open to those who trained outside of the UK if scrutiny of their training and experience determines comparability to the standards of proficiency required of UK route applicants. The EMR route was an expedited international type route for those who trained in the EU which closed following Brexit and so for the purposes of the analysis in this report international and EMR have been combined. Grandparenting was a route that enabled the porting of existing registrations with another body into HCPC. As grandparenting is not a current registration route, was a route for only a limited number of professions, and as the number of current grandparenting route registrants is small, the majority of analyses in this report do not include them.

Methods

All FTP concerns passing triage in the financial year 2024-25 were included. The analyses presented here are person based, i.e. they relate to the number of registrants subject to one or more concerns in the period of interest. To take into account the ever-changing nature of the register, rates have been calculated per 1,000 registrants (based on years). This method adjusts for people who were only registered for part of the year rather than arbitrarily taking a count at a point in time in the year. The rate was calculated on a route specific basis, i.e. a rate for international route registrants is per 1,000 international route registrant years, a rate for UK route registrants is per 1,000 UK route registrant years.

Two comparisons of the rates have been conducted. The comparison of the rates without adjustment for any other factors is presented as the rate ratio with its corresponding 95% confidence interval and p value¹. The comparison of the rates after adjusting for age and sex is presented as the standardised ratio with its corresponding 95% confidence interval. For the standardised ratio an interval that crosses the value 1.0 indicates that the difference in the rates is not statistically significant. Because of the very small numbers, and in some instances very small registrant populations, some confidence intervals are very large. This indicates uncertainty as to true value of the relevant measure. All analyses were produced in Stata/BE 19.0.

Concerns passing triage and key decision points

The report describes the association between selected EDI characteristics and the FTP outcomes at four key FTP decision points:

- Triage decision: Triage Met, and Triage Not Met
- Threshold Decision: Threshold Met, and Threshold Not Met
- Investigating Committee Panel (ICP): Case to Answer, and No Case to Answer
- Tribunal (Final Hearing): case concluded (Discontinuance, No Further Action, Not Well Founded), and sanctions (Caution, Conditions of Practice, Suspension, Strike Off, Removed by Consent)

All tables describe decisions made during the 2024-25 financial year, rather than tracking the same cohort of concerns across the FTP process. Some of these concerns, particularly those with Health and Care Professions Tribunal Service decisions, will have been received before the financial year in question. It is not possible, therefore, to accurately draw conclusions or correlations between the data analysis across different reports.

The coverage is very high to complete in most instances (Table 12). Ethnicity data completeness decreases across the decision points to 68% for tribunal outcome data; the EDI portal for registrants was fully implemented on the HCPC register in March 2022, and some of the concerns which reached tribunal in the 2024-25 financial year were received before then or related to registrants who would not have renewed their registration record in that period.

The findings here help provide useful context for the health and care professions we regulate. Any findings from within this report must be considered within the context of the limitations of the data, the different data sets and the inevitable sensitivity created by low volumes. Where possible we have drawn out the current constraints in our findings, while sharing as much information as possible. In some areas the data can only raise questions that we and other stakeholders may wish to explore in more detail in the future.

We are still at the beginning of our journey with using EDI data to understand the impact of our regulatory processes and further work is required to explain the data and compare it to historical trends. Through initiatives such as the Joint Healthcare Regulators' EDI Forum, we have the advantage of being able to work closely with other healthcare regulators, many of which have been working with their own data for a number of years to understand the drivers behind the patterns that they have seen, and we can share that learning. We will be undertaking further work in the next financial year to build on our current analysis to try to derive further insights and where possible understand any correlations between concerns reported to us and decisions at different stages of the FTP process.

This activity sits alongside our ongoing commitment to EDI, which is outlined in our EDI strategy and specific work to support fairness in our Fitness to Practise decision making. For example, mandatory training and Code of Conduct for partners involved in decision making throughout our FtP processes.

Table 12: Coverage of key EDI data items at main FTP decision points, decisions made in 2024-25

Decision point	Concerns				
	count	% with age	% with sex	% with ethnicity	% with nationality
Triage	2,013	99.9	99.3	98.9	89.2
Threshold	1,185	99.9	99.3	99.0	89.0
ICP	466	99.6	93.8	90.8	91.0
Tribunal	212	100.0	94.3	68.4	90.1

Age

There was very little difference between the age groups in terms of the percent of concerns meeting triage but there was a something of a trend in the percent of concerns meeting threshold with the percent broadly decreasing with age (Table 13a). Whilst not linear in pattern, there was a marked difference between the higher percentages in the older age groups having a case to answer at ICP and the lower percentages at younger ages (Table 13b). In terms of sanctions given at tribunals, all age groups other than 60+ had similar percents, with 60+ being noticeably lower (Table 13b).

Table 13a: Outcomes at triage and threshold decision points 2024-25, by age

Age	Triage decision			Threshold decision		
	Total n	Meeting triage n	%	Total n	Meeting threshold n	%
20-29	216	214	99.1	111	66	59.5
30-39	568	560	98.6	334	197	59.0
40-49	536	515	96.1	317	146	46.1
50-59	481	475	98.8	284	133	46.8
60+	210	207	98.6	138	68	49.3
Not recorded	2	2	100.0	1	1	100.0
All ages	2,013	1,973	98.0	1,185	611	51.6

Table 13b: Outcomes at ICP and Tribunal decision points 2024-25, by age

Age	ICP decision			Tribunal decision		
	Total n	Case to answer n	%	Total n	Sanction given n	%
20-29	44	21	47.7	13	8	61.5
30-39	141	63	44.7	60	36	60.0
40-49	138	58	42.0	51	32	62.7
50-59	89	54	60.7	52	35	67.3
60+	52	29	55.8	36	20	55.6
Not recorded	2	1	50.0	0	0	0.0
All ages	466	226	48.5	212	131	61.8

Sex

There was very little difference between the sexes in terms of the percent of concerns meeting triage but there was a very clear difference in the percent of concerns meeting threshold with the percent of males being considerably higher (Table 14a). The percent of males with an ICP decision of a case to answer was considerably higher than for females as was the percent of males receiving a sanction (Table 14b).

Table 14a: Outcomes at triage and threshold decision points 2024-25, by sex

Sex	Triage decision			Threshold decision		
	Total n	Meeting triage n	%	Total n	Meeting threshold n	%
Female	1063	1039	97.7	657	275	41.9
Male	935	919	98.3	519	330	63.6
Prefer not to say	1	1	100.0	1	0	0.0
Not recorded	14	14	100.0	8	6	75.0
All sexes	2,013	1,973	98.0	1,185	611	51.6

Table 14b: Outcomes at ICP and Tribunal decision points 2024-25, by sex

Ethnicity	ICP decision			Tribunal decision		
	Total n	Case to answer n	%	Total n	Sanction given n	%
Female	171	64	37.4	62	32	51.6
Male	266	147	55.3	138	94	68.1
Prefer not to say	0	0	0.0	0	0	0.0
Not recorded	29	15	51.7	12	5	41.7
All ethnicities	466	226	48.5	212	131	61.8

Ethnicity

There was relatively little difference between the ethnicities in terms of the percent of concerns meeting triage but there were some differences in terms of meeting threshold. At this decision point registrants declaring ethnicity as Black, African, Caribbean or Black British had a much higher proportion meeting threshold (Table 15a).

Variation between the ethnicities persisted for ICP case to answer and for Tribunal sanctions given though the small numbers in some groups means considerable uncertainty remains as to whether these differences are statistically meaningful (Table 15b).

Disproportionality in this data should not automatically be seen as unfairness. There are many ways in which disproportionality may well be explained.

Table 15a: Outcomes at triage and threshold decision points 2024-25, by ethnicity

Ethnicity	Triage decision			Threshold decision		
	Total n	Meeting triage n	%	Total n	Meeting threshold n	%
Asian or Asian British	253	246	97.2	150	85	56.7
Black, African, Caribbean or Black British	149	147	98.7	92	70	76.1
Mixed or Multiple ethnic groups	47	46	97.9	30	15	50.0
Other ethnic group	24	24	100.0	18	10	55.6
Prefer not to say	115	112	97.4	63	30	47.6
White	1402	1377	98.2	820	393	47.9
Not recorded	23	21	91.3	12	8	66.7
All ethnicities	2,013	1,973	98.0	1,185	611	51.6

Table 15b: Outcomes at ICP and Tribunal decision points 2024-25, by ethnicity

Ethnicity	ICP decision			Tribunal decision		
	Total n	Case to answer n	%	Total n	Sanction given n	%
Asian or Asian British	59	33	55.9	16	12	75.0
Black, African, Caribbean or Black British	31	14	45.2	11	8	72.7
Mixed or Multiple ethnic groups	9	2	22.2	5	2	40.0
Other ethnic group	5	0	0.0	2	0	0.0
Prefer not to say	30	16	53.3	9	5	55.6
White	289	132	45.7	102	52	51.0
Not recorded	43	29	67.4	67	52	77.6
All ethnicities	466	226	48.5	212	131	61.8

Nationality (continent)

There was relatively little difference between the continents of the nationalities in terms of the percent of concerns meeting triage but there were some substantial differences in terms of meeting threshold with those declaring nationalities falling into Africa (76%) and Oceania (78%), being substantially higher (Table 16a).

Variation between the continent of nationalities persisted for ICP case to answer and for Tribunal sanctions given, though the small numbers in some groups means considerable uncertainty remains as to whether these differences are meaningful (Table 16b)

Table 16a: Outcomes at triage and threshold decision points 2024-25, by continent of nationality

Nationality	Triage decision			Threshold decision		
	Total n	Meeting triage n	%	Total n	Meeting threshold n	%
Africa	121	119	98.3	72	55	76.4
Asia	150	147	98.0	80	51	63.8
Europe (excl. UK)	113	108	95.6	61	37	60.7
North or South America	16	16	100.0	8	3	37.5
Oceania	20	20	100.0	9	7	77.8
UK citizen	1376	1348	98.0	825	414	50.2
Not recorded	217	215	99.1	130	44	33.8
All nationalities	2,013	1,973	98.0	1,185	611	51.6

Table 16b: Outcomes at ICP and Tribunal decision points 2024-25, by continent of nationality

Nationality	ICP decision			Tribunal decision		
	Total n	Case to answer n	%	Total n	Sanction given n	%
Africa	26	13	50.0	6	5	83.3
Asia	37	16	43.2	17	13	76.5
Europe (excl. UK)	30	14	46.7	14	6	42.9
North or South America	2	2	100.0	2	1	50.0
Oceania	6	4	66.7	1	1	100.0
UK citizen	323	158	48.9	151	95	62.9
Not recorded	42	19	45.2	21	10	47.6
All nationalities	466	226	48.5	212	131	61.8

References

- [1] General Medical Council, "Fair to refer? Reducing disproportionality in fitness to practise concerns reported to the GMC," GMC, London, 2019.
- [2] D. Zahra, M. Roberts, M. Bryce, T. O'Brien and J. Archer, "Analysis of fitness to practise case data for the General Dental Council," 2016.