Council

Meeting Date	27 March 2025
Title	Public inquiries summary
Author(s)	Tom Miller, Policy Manager
Executive Sponsor	Andrew Smith, Executive Director of Education, Registration & Regulatory Standards

Executive Summary

This report provides an overview of our activity relating to public inquiries and reviews, outlining how we monitor and learn from them.

Most inquiries and reviews do not involve the HCPC or contain recommendations specifically targeted towards us. However, we take the opportunity to reflect on recommendations so that learning from inquiries and reviews can inform our ongoing continuous development work.

We have identified emerging themes relevant to healthcare regulation and the environment in which our registrants work to support the HCPC's horizon scanning activity.

Council is invited to note the contents of the paper and provide feedback or seek clarification as appropriate.

Action required	The Council is asked to note and review the information provided and seek clarification on any areas. This will be used to guide and inform our ongoing monitoring of, engagement with and learning from public inquiries and reviews.
Previous consideration	Our previous report to the Council was submitted in March 2021.
Next steps	The paper is to note and does not contain decisions or recommendations. Work around inquiries will continue on a business as usual basis.

Financial and resource implications	There are no direct financial costs associated with the report. Monitoring and responding to public inquiries forms part of our business as usual work requirements.
Associated strategic priority/priorities	Continuously improve and innovate Promote high quality professional practise Be visible, engaged and informed
Associated strategic risk(s)	1. We are unable to deliver our regulatory requirements effectively in a changing landscape, affecting our ability to protect the public 2. Our standards do not reflect current practice and/or they are not understood by registrants and our stakeholders 3.b We are unable to maximise our use of the data we hold to share insights to protect, promote and maintain the health, safety and wellbeing of the public
Risk appetite	Regulation - measured
Communication and engagement	External engagement with public inquiries and reviews in response to requests. This report has been discussed with the Executive Leadership Team.
Equality, diversity and inclusion (EDI) impact and Welsh language standards	Our engagement with public inquiries and reviews has had a positive impact on EDI work within HCPC as a driver for improvements in data collection and analysis and the content of our standards requirements for registrants. We have not identified any effects on or opportunities for use of the Welsh language.
Other impact assessments	No impact assessments applicable.
Reason for consideration in the private session of the meeting (if applicable)	Not applicable

Public inquiries report 2021 - 2025

1. Introduction: public inquiries and reviews

1.1. Public inquiries are independent investigations into matters of public concern about a particular event or set of events and are usually established by the UK or devolved governments. Inquiries can operate on a statutory or non-statutory basis.

1.2. Statutory inquiries are established under the Inquiries Act 2005, which confers special powers on these inquiries to compel bodies to submit evidence, give testimony and undertake a range of activities surrounding this, for example acting in line with certain confidentiality requirements or data sharing rules.

1.3. Public inquiries are intended to provide answers where there is public concern that things have gone wrong and the impact has been serious. They usually address three key questions: what happened, why did it happen and who is to blame and what can be done to prevent this happening again? The scope and focus of their approach is set out in terms of reference documents, which are published early in the process of an inquiry.

1.4. Public inquiries are therefore of considerable interest to those directly or indirectly affected or harmed by failures in policy, service delivery, or regulation. As a result, findings also have direct relevance to government and other influential stakeholders and carry political and reputational risk for all stakeholders who are involved or have a role to play.

1.5. Public inquiries typically take several years to carry out their work, averaging around 1,500 days to complete, report and make recommendations, and are chaired independently of political or public sector bodies. In high profile cases both statutory and non-statutory inquiries may be led by someone with the appropriate credibility and reputation (such as a judge or King's Counsel) to give public confidence.

1.6. However, there are some examples which sit between these concepts, for example reviews held undertaken by oversight bodies such as the Professional Standards Authority (PSA), the Health Services Safety Investigations Body or local health service providers. In the spirit of transparency and public protection, we monitor these (and share information where appropriate) alongside "full" public inquiries.

1.7. At present, we are monitoring 26 inquiries and reviews, where proceedings or recommendations are directly relevant to our work or that of our registrants. The HCPC is not the direct focus of any inquiries or reviews.

1.8. Of the 26, 18 have concluded and published their recommendations. Seven are in progress. A draft update to the Council summarising key themes arising from recent inquiries and reviews is attached at Annex A.

2. Current context and external environment

2.1. The number of inquiries convened has risen over recent years, alongside a longer-term shift away from other forms of investigation such as royal commissions. Since 1997 there have never been fewer than five public inquiries running at any one time and as at February 2025 there are 20 inquiries ongoing or announced – the most ever at one time. The rising number and cost of public inquiries (£130m last year) has led to questions being asked about how to improve their effectiveness and introduce greater accountability.

2.2. The final report of the Infected Blood Inquiry in July 2024 called for a greater role for the Commons Public Administration and Constitutional Affairs Committee in deciding if there should be a public inquiry and in monitoring the government's response to recommendations made by statutory inquiries. The Thirlwall inquiry (Lucy Letby) also took a detailed retrospective look at the extent to which recommendations from previous inquiries and reviews have been implemented.

2.3. The House of Lords Statutory Inquiries Committee published an 'Enhancing Public Trust' report in September 2024 to address concerns about the cost, effectiveness and duration of public inquiries. It also noted that most recommendations, even where accepted by government, are never implemented. The general effect of the Committee recommendations is intended to be more agile and responsive to those affected by events and introduce more centralised governance and greater accountability.

2.4. The government responded to the report on 10 February 2025 and accepted the main recommendations, with the following commitments:

- a sponsoring minister should set an indicative deadline for publication;
- the creation of a new Public Inquiries Committee, as a Parliamentary select committee to monitor and report on the steps being taken to implement inquiry recommendations;
- to introduce a "community of practice" to support Chairs with expert advice, and potentially a group for collaboration between Chairs;
- to increase the use of interim reports; and
- to publish guidance on how Chairs should involve victims and survivors, including during the drafting of terms of reference.

2.5. The government has also committed to 'examine how best to ensure more effective transparency and accountability around the response to inquiry recommendations and the implementation of those which are accepted' and 'enable lessons to be learnt more swiftly and at lower cost.' This may include the introduction of a publicly accessible online tracker showing how and when inquiry recommendations have been put in place and greater use of non-statutory and expert panel-led inquiries.

3. Recent engagement with public inquiries and reviews

3.1. We aim to foster positive, transparent relationships to support inquiry teams in their aims and help to shape recommendations that reflect an accurate understanding of our role and the context in which we work.

3.2. We are actively engaging with the Health Services Safety Investigations Body (HSSIB) in relation to their investigation into the pre-hospital interpretation of electrocardiograms (ECG) in ambulance services. We are engaging with the review to help shape thinking on how best to ensure quality assurance of paramedics' training in ECG interpretation. This has concluded its investigation and publication is expected in April 2025.

3.3. We are liaising with the Lampard inquiry into inpatient mental health deaths in Essex. This was convened as a statutory inquiry in October 2023 following a lack of cooperation with the former non-statutory Essex Mental Health Independent Inquiry established in 2021.

3.4. Our Chief Executive Bernie O'Reilly is supporting the David Fuller review and engaged with a regulatory seminar in November 2024 and completed an oral interview in January 2025. This explored the role of regulation in managing risk alongside appropriate measures from employers and use of criminal checks.

4. Risk appetite

5.1. In the risk appetite review of September 2024 (see Appendix 2), the HCPC's Audit and Risk Committee (ARAC) outlined a measured approach to regulatory risk. The committee agreed that "it is essential that mitigations to ensure ongoing public protection are in place as a foundation of taking risks to delivering regulatory requirements".

5.2. Public inquiries highlight both risks and potential learning in the delivery of public protection by regulators. This can be direct, where we are the specific target of a recommendation or investigatory procedures, and indirect, where we or our professionals have a clear opportunity to learn from inquiry outcomes in the wider health and care environment.

5. Next steps and recommendations

5.1. The government response to the Enhancing Public Trust report signals that government wants greater scrutiny and transparency over recommendations arising from public inquiries and reviews in the future. This paper shows that while we have not been the subject of an inquiry in recent history, we take the role of inquiries seriously and look for learning from them for the benefit of our organisation. We will continue to refine our internal processes for how we monitor new and ongoing inquiries and how we engage and contribute to inquiries (where appropriate).

5.2. This update provides an opportunity to review how we have engaged with inquiries to date and themes arising which are relevant to the HCPC. It also supports our horizon scanning work and insights into the external context for the development of the new corporate strategy from 2026 onwards.

Annex A: Public inquiries and reviews - 2025 report to Council

1. Background

1.1. Public Inquiries and reviews offer valuable learning opportunities for the HCPC and serve as a critical source of information to inform improvements to public safety in the wider healthcare sector.

1.2. They can play a key role in driving strategic change and enhancing our performance by identifying areas for improvement and supporting the organisation's commitment to delivering high standards of regulation.

1.3. It is essential we monitor and respond to inquiries and reviews to address patient safety concerns and maintain our focus on continuous improvement.

1.4. To ensure a structured approach, the Policy and Standards team maintains a log to track recommendations arising from relevant public inquiries and reviews. This acts as an accountability tool to document and monitor the commitments we have made in response to recommendations which relate directly to the HCPC, to regulatory bodies in general, or broader issues such as patient safety and professional standards.

1.5. The HCPC is rarely a direct subject of inquiries and reviews and there have been no recent instances of this. However, we have identified themes from inquiries and reviews which provide a valuable source of learning and information and highlight points of reference for good practice across the health and care sector.

1.6. At the time of this report, the environment surrounding inquiries and reviews is changing. The government response to the Enhancing Public Trust report signals that government shares a desire for greater scrutiny, transparency and accountability to surround recommendations arising from public inquiries and reviews in the future.

1.7. While we have not been the central subject of most recent examples, we take the role of inquiries and reviews seriously and look for learning from them for the benefit of our organisation and our efforts to protect the public. We will continue to refine our internal processes for monitoring new and ongoing inquiries and how we engage and contribute to inquiries where this is appropriate.

2. Overview: recent public inquiries and reviews

2.1 There are currently 26 inquiries and reviews listed in the tracker, containing 86 recommendations from 2013 to 2025. None of these are directly for the HCPC. Of the 86 recommendations, 52 are historical with no further action required.

2.2 We have identified seven published reports since we last updated the Council in March 2021:

- Health Services Safety Investigations Body (HSSIB) – Mental health inpatient settings: Creating conditions for the delivery of safe and therapeutic care to adults (October 2024);
- UK Covid-19 inquiry module one: resilience and preparedness (July 2024);
- The Infected Blood Inquiry (May 2024);
- The Cass review - Independent review of gender identity services for children and young people (April 2024);

- Independent Review of Greater Manchester Mental Health NHS Foundation Trust (January 2024);
- Reading the signals – Maternity and neonatal services in East Kent: the Report of the Independent Investigation (October 2022); and
- The Report of the Independent Inquiry into Child Sexual Abuse for England and Wales (October 2022).

2.3 Eight further public inquiries and independent reviews relevant to our work or our registrants have commenced since our last update to the Council. These are as follows.

- UK Covid-19 inquiry – announced May 2021. This will examine the impact on healthcare systems across the UK including the impact on healthcare staff from diverse backgrounds, availability of staff, communication with patients and clinical decision making. The inquiry is ongoing with no date announced for publication of a final report.
- Scottish Covid-19 inquiry – announced August 2021. Next health and social care impact hearings are scheduled for May 2025. The inquiry is ongoing.
- The Independent inquiry into the issues raised by the David Fuller case – announced 8 November 2021. Phase one report published November 2023.
- The Lampard Inquiry into inpatient mental health deaths in Essex. This was convened as a statutory inquiry in October 2023 following a lack of cooperation with the non-statutory Essex Mental Health Independent Inquiry established in 2021 and is currently gathering evidence, including from the HCPC.
- The Thirlwall inquiry into events at the Countess of Chester hospital (Lucy Letby). Key issues have included whistleblowing and the regulation of NHS managers. This finished hearing evidence in February 2025. We are awaiting report publication.
- HSSIB Investigation into pre-hospital interpretation of electrocardiograms (ECG) in ambulance services and paramedic training, education and competence – announced July 2024. This investigation has concluded and a report will be published in April 2025. A further report on clinical advice available to ambulance crews to interpret ECGs for suspected StEMI across protected characteristics is due to be published in October 2025.
- The Leng review: an independent review of physician associate and anaesthesia associate professions– announced November 2024. Recommendations are expected to focus on how new roles should work in the future, their safety in the health team and how effectively they are deployed in the context of multi-profession working and regulatory reform. The conclusions are expected to be announced in spring 2025 to help inform the NHS long term workforce plan.
- The Ockenden review on Nottingham maternity services is due to publish its final report in June 2026. It is expected to make findings in relation to thematic experiences of patients from ethnic minority backgrounds, organisational culture and leadership, whistleblowing and consideration of local workforce race equality standards.

3. Key themes arising from recent inquiries and reviews

3.1 We have identified eight key themes arising from recent inquiries and reviews which align with strategic work we have undertaken to continuously improve how we deliver our functions as a regulator. These include:

- public interest, public protection and the role of regulation;
- governance and leadership;
- equality, diversity and inclusion;
- data sharing, record keeping and intelligence;
- education, training and Continuing Professional Development (CPD);
- engagement and support for service users;
- raising concerns, candour and whistleblowing; and
- reflective practice.

3.2 We have included a thematic summary of our progress against inquiry findings and recommendations below. We take a problem-solving approach to recommendations with consideration given to the most effective and proportionate means of achieving the intended aim. Findings and recommendations are sometimes directly addressed with targeted action but are more often dealt with as part of existing programmes of work.

Public interest, public protection, and the role of regulation

3.3 The Infected Blood inquiry (2024) made several recommendations which the HCPC is already in alignment with, for example by foregrounding public protection in our standards and making sure that they are clear and straightforward enough for professionals to understand and act in line with. We will also consider how a recommendation relating to self-reporting of near misses can be taken into account in future standards reviews.

3.4 We are monitoring developments arising from the Paterson inquiry (2020) on the development of legislation around clinical negligence reform and collaboration between regulators which we expect to be addressed as part of the Government's regulatory reform agenda.

Governance and leadership

3.5 Concerns about leadership and governance in the healthcare sector is a key theme of public inquiries and reviews in recent years. The Messenger review (2022) examined the state of leadership and management in the NHS and social care, and the Kark review (2019) assessed how effectively the fit and proper persons test prevents unsuitable staff from being redeployed or re-employed in health and social care settings. The Hyponatraemia inquiry (2018) called for leadership development to be prioritised at all levels of health service delivery.

3.6 We strengthened our expectations on leadership for registrants in updates to our standards of proficiency in 2023, as follows:

8.6: understand the qualities, behaviours and benefits of leadership
8.7: recognise that leadership is a skill all professionals can demonstrate
8.8: identify their own leadership qualities, behaviours and approaches, taking into account the importance of equality, diversity and inclusion
8.9: demonstrate leadership behaviours appropriate to their practice

3.7 We are currently supporting work to develop the NHS leadership framework and responded positively to the consultation on regulation for NHS managers. We have also worked with Health Education England to help develop leadership guidelines for educational providers.

Equality, Diversity, and Inclusion (EDI)

3.8 A key finding of the Williams review (2018) highlighted the need for greater fairness in regulatory processes. Among its recommendations was a call to ensure fairness in investigations and hearings.

3.9 In line with the review's recommendations, we recognise the importance of data to understand the impact of our regulatory functions. We have dramatically improved our collection and analysis of EDI data, so that registrants can record and update their EDI monitoring data as an integral part of the application and renewal processes, which means we now hold EDI data for more than 99% of our 352,593 registrants.

3.10 This means we can now share data about the demographic profile of our registrants on our online data hub, and we now publish analysis across a range of protected characteristics in both our Annual Fitness to Practise report, and a standalone analysis in November 2024. The report examined the EDI characteristics – such as age, sex, ethnicity, nationality and profession – of registrants involved in fitness to practise (FTP) proceedings.

3.11 We have also strengthened our EDI requirements in both the standards of proficiency (SOPs) and the standards of conduct, performance and ethics (SCPEs). Our standards have expanded on our expectations around EDI and reinforced our commitment to promoting inclusivity and equality in practice. To support registrants, we hosted webinars to discuss these changes, providing guidance on how to implement EDI principles effectively.

Data sharing, record keeping and intelligence

3.12 The need to optimise use of data sharing, record keeping and intelligence to ensure public safety is the focus of several inquiries and reviews.

3.13 The PSA's Morecambe Bay review (2018) made recommendations to work with others in the health and care system to address regulatory concerns, to make sure that appropriate information and intelligence is shared, and to make sure that our teams have appropriate resource and training to correctly analyse our intelligence. The Gosport Inquiry (2018) also recommended that oversight bodies should work closely together to share intelligence.

3.14 In response, we introduced new FTP thresholds in 2019, based on analysis of past cases and launched professional liaison and upstream regulation work. We are also working on implementation of emerging concerns protocols (ECPs) in England and Northern Ireland. We regularly attend intelligence sharing meetings with other professional regulators and system regulator and quality assurance bodies.

3.15 The Professional Standards Authority's (PSA's) review into sexual misconduct (2019) also highlighted the importance of using data to detect and sanction perpetrators. We worked with survivors to produce a sexual safety hub to provide a resource to support registrants and improve safety of service users and learners. Last year we published a report on Fitness to practise concerns related to sexual misconduct

2023-24. We are building on this learning with insights from other surveys such as the NHS Staff Survey and the National Teaching and Education Survey. We also influence the collection of similar data (e.g. NHS Staff Survey) in other UK countries (Scotland and Wales) to help us better understand the picture across the UK.

Education, training and CPD

3.16 Several inquiries and reviews have made specific recommendations in relation to education, training and CPD.

3.17 The PSA's review on telling patients the truth recommended the provision of training to registrants around candour and speaking up, with reference to context, and worked examples. In response, in August 2024 we published an online resource for duty of candour including a range of supporting materials such as guidance, blogs and webinars.

3.18 Reading the Signals (2022), an independent investigation into maternity and neonatal services in East Kent, recommended compassionate care is embedded in lifelong learning and CPD for all health professionals. Currently registrants can record this as part of their CPD requirements or audit when renewing their registration. We publish standards of CPD for registrants on our website, together with a range of additional supporting materials. We will launch a consultation on our standards for training and education later this year.

3.19 HSSIB is currently undertaking an investigation into the use of electrocardiograms (ECGs) by paramedics. We are liaising with the review to share our views on how to ensure appropriate quality assurance in the future.

Service user engagement and support

3.20 The importance of effectively engaging with service users and providing them with adequate support has been highlighted in several inquiries. The Infected Blood Inquiry (2024), Reading the Signals (2022) and Gosport report (2018) emphasised failures to address concerns raised by service users about patient care. This is also an emerging theme in the current Ockenden review and Lampard inquiry. The Williams review (2018) stressed the need for fairness, transparency, and appropriate support for patients and families involved in FTP proceedings.

3.21 In response to these findings and recommendations, the HCPC has taken steps to enhance its support for service users, witnesses, and family members throughout FTP processes.

3.22 The HCPC's new FTP case management system incorporates a stakeholder complexity rating system. This system identifies cases involving vulnerable parties, enabling the HCPC to tailor communication and provide additional support as required. By flagging these cases, we can ensure that service users and their families receive appropriate and timely updates through FTP proceedings.

3.23 We offer independent support through the advocacy charity POhWER. This service offers person-centred lay advocacy service for people with mental health needs, learning disabilities or those who due to life events require support to be involved with FTP hearings. We also work with Communicourt, an intermediary service available to witnesses and registrants to support those with communication needs at final hearing stage.

3.24 Finally, we operate a Registrant Support Service, which offers free, independent, confidential 24/7 advice and support for registrants involved in the FTP process.

Raising concerns, candour and whistleblowing

3.25 Listening to and addressing concerns raised by service users, registrants, and staff and the importance of candour is a recurring theme in recent inquiries and reviews, including the Infected Blood inquiry (2024), Greater Manchester Independent Inquiry into Mental Health (January 2024), Cumberlege inquiry (2020), Hooper inquiry (2019), Gosport inquiry (2018), Morecambe Bay review (2018). This is also an emerging theme in the Thirlwall inquiry into events at Countess for Chester (Lucy Letby). We are committed to continuous improvement to support culture change across the healthcare landscape.

3.26 We provide clear information and guidance on how to raise concerns about professionals on our register. This explains what we can and cannot investigate to help people understand our role. We recently launched a new online portal to enable people to make complaints more easily and enables us to monitor EDI characteristics of patients raising concerns to ensure we are accessible to everyone. This sits alongside existing email, postal and telephone channels to ensure everyone can raise concerns in the ways that suit them best.

3.27 In 2024 we updated our standards of conduct, performance and ethics to strengthen and clarify our expectations for registrants on candour and speaking up. We also published a range of supporting guidance and attended a series of workshops on speaking up held by NHS employers, targeting international registrants who have recently begun work in the UK and related stakeholder organisations.

3.28 In response to concerns raised by the Hyponatraemia inquiry (2018), in 2021 the Northern Ireland executive consulted on proposals to introduce a statutory duty of candour for individuals. Alongside other regulators we shared our concern that this may cause unintended negative consequences. A new consultation is now underway on organisational and contractual duties of candour, and a wider “being open framework” and we are currently developing our response.

3.29 In response to the recommendations from the Hooper review on whistleblowing, we improved reporting mechanisms to ensure disclosures are handled securely and efficiently. A whistleblowing module is also included in induction eLearning for all HCPC employees, emphasising the importance of whistleblowing and the procedures to follow when such a complaint is received. We have also recently introduced “speak up guardians” within the HCPC to ensure robust processes for sharing concerns are available to all staff.

3.30 We also updated our standards of conduct, performance and ethics in October 2023. Changes to standard 1.6 replaced the requirement for registrants to “challenge” colleagues who discriminate against service users or carers with a requirement to “raise concerns” with employers and as a formal process via Fitness to Practice. This shift in language clarified that registrants should follow appropriate procedures to report concerns while ensuring their own safety and that of others.

Reflective Practice

3.31 The Gosport Report (2018) and the Williams Report (2018) emphasise the value of reflective practice. In response, we have updated our online materials to highlight the

benefits of reflective practice for registrants and improve the resources available. These materials explain how reflective practice can be integrated into Continuing Professional Development (CPD) and clarify how it is considered in fitness to practice proceedings. We also developed new guidance on the use of reflective practice materials in fitness to practise matters.

4. Summary

4.1 The HCPC remains committed to listening and learning from the outcome of future public inquiries and reviews and continuous improvement of the way we work. We have made significant changes to our aims and procedures, including improved support for people who wish to make a complaint, improved use of data and intelligence, and providing leadership on culture change in the healthcare system. We will continue to monitor recommendations and findings relevant to our regulatory role and be accountable and transparent in our response.

Contact for further information:

Name: Tom Miller

Role: Policy Manager, Policy and Standards

Email: Thomas.Miller@hcpc-uk.org