General Medical Council

Decisions at the initial assessment stage

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Introduction

1. The initial assessment stage allows the Regulator to carry out an initial assessment of a concern to decide whether there is a reasonable likelihood that regulatory action is required to protect the public[*]. This is known as the test for onward referral[†].

2. Regulatory action will be required where a Physician Associate (PA) or Anaesthesia Associate (AA):

a. poses any current and ongoing risk to one or more of the three parts of public protection, meaning their fitness to practise is impaired and restrictive action - conditions, suspension or removal - is required in response, or

b. does not pose any current and ongoing risk to one or more of the three parts of public protection meaning their fitness to practise is not impaired, but the behaviour or poor performance giving rise to the concern amounts to a significant departure from the professional standards and the PA or AA needs to be warned that the behaviour or poor performance should not be repeated.

3. The Regulator may defer reaching a decision on whether the test for onward referral is met until after the conclusion of any investigation into the concern by another body and our consideration of its outcome[‡].

4. Where the Regulator proceeds with evidence collection and at any stage:

- considers that the test for onward referral is not met, the concern should be closed[§]
- considers that the test for onward referral is met, the concern must be referred on to the Case Examiners to consider[**]

5. At all stages of the fitness to practise process, including the initial assessment stage, consideration will need to be given to whether an interim measure may be needed to protect the public. The Regulator should apply the guidance *Decisions on interim measures* to reach a view on this.

[*] Our legal role to protect the public is explained in more detail in *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates).*

[†] Rule 4(1) of the General Medical Council (Fitness to Practise) (Anaesthesia Associates and Physician Associate) Rules 2024 with then ('FTP Rules 2024')

[‡] Rule 4(4) of the FTP Rules 2024

[§] Rule 4(3) of the FTP Rules 2024

[**] Rule 4(2) of the FTP Rules 2024

6. The purpose of this *Decisions at the initial assessment stage* guidance is to support the Regulator to reach fair and consistent decisions on how to approach evidence collection at the initial assessment stage and on whether the test for onward referral is met.

Should a decision on the onward referral test be deferred?

7. Sometimes the information giving rise to a concern is already being considered by another body ('third-party investigation'), such as:

- the police or courts
- a coroner
- NHS or other health authorities
- other regulators
- employers

8. Where this is the case, the Regulator may decide, at any stage during an assessment, to defer reaching a decision on whether the test for onward referral is met until after the conclusion of the third-party investigation and our consideration of its outcome[*].

9. To decide whether it is appropriate to defer, the Regulator should consider the following:

a. whether the outcome of the third-party investigation would assist with the progression of evidence collection

b. whether the outcome of the third-party investigation is needed to inform a decision on whether the test for onward referral is met;

c. the likelihood of duplication, and the consequential impact on the PA or AA and others, such as witnesses, as well as lack of efficiency, from progressing our own evidence collection pending the outcome of the third-party investigation; and / or

d. any request for us not to take steps which could compromise the third-party investigation.

10. The presence of one or more of these factors is likely to indicate that deferral is proportionate.

[*] Rule 4(4) of the FTP Rules 2024

11. Consideration will always need to be given as to whether an interim measure may be needed to protect the public while a third-party investigation is ongoing. The Regulator should apply the guidance *Decisions on interim measures* to reach a view on this.

Evidence Collection

12. To assess whether a PA or AA poses any current and ongoing risk to public protection or needs to be warned that specific behaviour or poor performance should not be repeated, the following needs to be considered:

- **a.** Where on the spectrum of seriousness the concern lies;
- **b.** The impact of any relevant context; and
- **c.** How the PA or AA has responded to the concern[*].

13. The purpose of evidence collection at the initial assessment stage is to gather information to confirm whether the concern is capable of being proven and where it is, support consideration of each of these matters. This is to support a decision at the initial assessment stage about whether the test for onward referral is met and where it is, to ensure that Case Examiners and MPTS tribunals have sufficient evidence to support their decision making. Evidence collection will be carried out by GMC staff on behalf of the Regulator.

Being proportionate, transparent and fair when collecting evidence

14. The Regulator must be proportionate[†] when carrying out evidence collection, collecting what is required and no more than necessary to sufficiently evidence a concern to inform a decision on whether the test for onward referral is met, and where it is, inform Case Examiners' or MPTS tribunal decision on whether the PA or AA poses any current and ongoing risk to public protection, meaning their fitness to practise is impaired. To assess what is proportionate at the initial assessment stage, GMC staff should be clear about the options for collecting evidence that are available to them.

[*] Our publication *What we mean by fitness to practise (Physician Associates and Anaesthesia Associates)* explains these concepts in more detail.

[†] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.

15. Before directing that a PA or AA undertakes an assessment of their performance, health or knowledge of English language, the Regulator should first consider what alternative objective evidence is available to understand the concern. An assessment should only be directed where it is the most proportionate way of effectively evidencing the concern being assessed.

16. When requesting information from any source, including the PA or AA themselves, the request made should be targeted so that the Regulator is only seeking to obtain information that is relevant to the concern being assessed. Unspecific requests made for information about a particular PA or AA, or event, are unlikely to be proportionate.

17. To ensure the Regulator's approach to evidence collection can be transparent[*], GMC staff who are exercising our powers under the legal framework and rules should share the evidence gathered with the PA or AA, and relevant third parties, where appropriate. This supports us to be open and clear about the steps we are taking to assess the concern raised. It also gives relevant parties a proper opportunity to engage in the fitness to practise process and provide relevant information.

18. To ensure fairness[†] in the Regulator's approach to evidence collection, GMC staff are expected to demonstrate professional curiosity to recognise, explore and better understand a concern. GMC staff should evaluate information, ask questions, challenge assumptions and be open to new evidence or changing circumstances that might inform next steps. This approach supports us to gather relevant evidence to help decision makers reach fair decisions.

19. To support fair decision making, GMC staff should explain what we expect from individuals involved in the fitness to practise process and treat them with compassion and respect. Communication and engagement with individuals should be tailored, taking their needs and preferences into account.

Is the concern capable of being sufficiently evidenced?

20. In all instances, the Regulator will need to consider the information received and reach a view on whether it's possible to obtain sufficient evidence to inform a decision on whether the PA or AA poses any current and ongoing risk to public protection.

[*] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.
[†] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.

Historic concerns

21. The time passed since the circumstances giving rise to the concern may be relevant to the Regulator's assessment of whether the concern is capable of being sufficiently evidenced. Where the length of time that has passed since the circumstances giving rise to the concern means it is not possible to sufficiently evidence the concern, it will not be proportionate to progress the initial assessment.

22. However, before deciding to close a concern on the basis it cannot be sufficiently evidenced, the Regulator must consider whether the nature of the concern justifies a decision to proceed with an initial assessment despite the impact the length of time passed may have on the quality of evidence. The following factors should be considered when making this decision:

a. The starting point for assessing the seriousness of the concern

The *Decision on whether regulatory action is required* guidance details types of behaviour or poor performance that indicate a low to high level of seriousness as a starting point. Where the concern has a mid-range to high level of seriousness as a starting point, such as sexual misconduct, then evidence collection should usually proceed.

b. The presence of any factors that increase the seriousness of the concern

The *Decision on whether regulatory action is required* guidance also sets out the factors which increase the seriousness of the concern. In particular, where the concern may be persistent or repeated or the PA or AA has fitness to practise history, then evidence collection should usually proceed.

c. The reason for the length of time it has taken for the concern to be raised with us.

The Regulator should take into account the reasons given by the complainant or referrer for why the concern was not raised with us sooner. The Regulator may need to consider the effect that the nature of the concern may have had on a person's ability to bring a complaint forward, such as concerns about sexual misconduct or concerns involving traumatic events. The Regulator should also consider any protected characteristics*, particular vulnerabilities, language barriers or cultural issues and the impact these may have had on the timing of raising the concern. For example, if a complainant has a

* The nine protected characteristics under the Equality Act 2010 are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

disability or was a child at the time that the circumstances giving rise to the concern are said to have taken place.

Anonymous and confidential complaints

23. In some circumstances, an individual who raises a concern can feel that doing so will cause them harm and so they may raise the concern anonymously or confidentially. While a concern that has been raised anonymously or confidentially can be harder to evidence, it should still be progressed at the initial assessment stage unless it is clear that there is no prospect of establishing evidentially that the test for onward referral is met.

24. Seeking further information from the complainant or referrer should be possible where the concern has been raised confidentially. However, where the complainant or referrer is anonymous, it will not usually be possible to go back to them to clarify any matters about the concern.

25. In circumstances where further information cannot be obtained from the complainant or referrer, thought should be given as to whether the relevant employer or contractor may have knowledge that could help build the evidential picture and inform the decision on whether the test for onward referral is met. This will require a limited disclosure to be made to the relevant employer or contractor for the purpose of obtaining further information which will enable a decision to be made as to whether the assessment should continue.

26. The nature of anonymous information means we need to treat it as if the complainant or referrer has raised concerns about our use of the personal information, in particular disclosure of such information. Where information is confidential, it is reasonable to assume that the complainant or referrer does not want to disclose their personal information and has raised concerns about our doing so. Before making a limited disclosure, please consider the below section on *disclosure of personal information.*

Disclosure of personal information

27. Where further information is required from a third-party as part of evidence collection, and a concern has been raised or a request made about our use of personal information, issues relevant to disclosure of personal information will need to be considered.

28. When considering issues relevant to the disclosure of personal information, the Regulator should seek objections from the data subject, or complainant or referrer (if not the data subject) first, where possible. It may be appropriate to have further dialogue with the data subject, or complainant or referrer (if not the data subject) about the proposed use of their information and explain the safeguards that will be taken (such as redaction) to protect them from identification. Where there are objections, the Regulator will need to consider if the potential seriousness of the information received justifies the disclosure being made.

29. When making decisions regarding our use and the disclosure of personal information received about a PA or AA's behaviour, performance or impact of a health condition, where a concern has been raised or a request made about such use (or we are treating it as though there has been), the decision maker should refer to *Using personal information in the fitness to practise process for Physician Associates and Anaesthesia Associates*.

30. Information shared anonymously is less likely to contain personal information and generally can be disclosed. If personal information that could identify the data subject, or complainant or referrer (if not the data subject) is redacted, confidential information i.e. shared in confidence, is also usually likely to be capable of being disclosed. However, in every case, consideration should be given to whether the nature of the information received is such that disclosing it will risk identifying the data subject, complainant or referrer (if not the data subject), or a third party.

What type of information should be sought from the PA or AA during evidence collection?

31. To be transparent and fair[*], the Regulator should disclose the concern to the PA or AA and offer opportunities for them to comment on the concern and provide their own evidence. Exceptionally, we may not disclose the concern to the PA or AA, which is likely to occur in the following circumstances:

i. where the complainant or referrer has raised a concern or made a request about our use of their personal information, or information has been shared anonymously or confidentially, and there is a risk of identification of the complainant or referrer, or other third parties, if disclosed to the PA or AA; or

ii. if disclosing the information to the PA or AA could impact their welfare; or

iii. if disclosing the information could impact an ongoing third-party investigation.

32. There may be information that only the PA or AA holds that could be critical to our assessment of risk. As part of initial disclosure we should encourage PAs and AAs to share

[*] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.

information about relevant context that might decrease risk or demonstrate they have insight as early as possible, subject to legal advice, as this can help us to resolve matters more swiftly. This is particularly the case where the nature of the concern indicates a low level of seriousness as a starting point, and so evidence from the PA or AA demonstrating that they have insight and have remediated will carry more weight in the Regulator's assessment of whether the PA or AA poses any current and ongoing risk to public protection and can significantly reduce such risk.

33. Whilst we cannot require that a PA or AA provides us with copies of material produced for the purpose of professional development or produced while reflecting on their professional practice to improve it[*] (reflective notes), we can invite them to provide evidence of insight and remediation as part of their response to the concern. But whether they do this and the form it takes is for them to decide.

What type of evidence should be sought from third parties, including the complainant and / or patients?

34. The Regulator should consider the information already available to them and reach a view on what type(s) of evidence should be sought to inform an assessment of the concern in a fair and proportionate way.

35. When deciding what types of evidence to seek from a third party, the Regulator should start by asking themselves which are likely to be the most informative and relevant to assessing whether the PA or AA poses any current and ongoing risk to public protection.

36. Evidence that can be sought from third parties includes:

- further information from the complainant
- information from the PA or AA's employer
- information from the incident location
- medical records
- a local investigation report
- a coroner's report
- police / CPS file
- witness statements and supporting documents
- expert opinion (expert report or documented discussion)

[*] Paragraph 7(5) of Schedule 3 to the Anaesthesia Associates and Physician Associate Order 2024 ('the Order')

37. Where the concern relates to the care a patient has received, we should normally seek to obtain their account. Where patients experience barriers to engaging with us, reasonable steps should be taken to provide tailored support to help them engage with us. Where a patient has died or is unable to engage with us directly, it may be appropriate to support the person closest to their care to engage with us on their behalf. This will usually be a next of kin or someone with legal authority to act on the patient's behalf.

38. Where a third-party report or police / prosecution file can be requested, it will usually be proportionate to seek to obtain this prior to taking witness statements.

Evidence about relevant context and how the PA or AA has responded to the concern

39. Where possible, consideration should be given as to what steps are needed to check any statements made by a PA or AA, for example, evidence about the steps they have taken to remediate or information the PA or AA has provided about the context of the concerns. The guidance on *What we mean by fitness to practise (Physician Associates and Anaesthesia Associates)* provides an explanation of the key concepts of relevant context, insight and remediation.

40. It is likely that further information around local relevant context will need to be specifically sought from the relevant healthcare provider.

Public interest concerns

41. In some circumstances, a PA or AA who is subject to a concern about their fitness to practise will have raised a public interest concern about their employers. A public interest concern (or whistleblowing) is a concern which has been raised by a PA or AA in the wider public interest. This may include concerns that patient safety or care is being compromised by the practice of colleagues or by the systems, policies and procedures in the organisation where the PA or AA works.

42. Where we become aware that a PA or AA has raised public interest concerns, we will apply our safeguards for PAs or AAs with a history of raising public interest concerns who have been referred to us by the organisation involved. These safeguards include, where appropriate, carrying out provisional enquiries and seeking legal input in drafting an assessment plan to focus on corroborating the concerns raised by the organisation and ensuring that any history of raising public interest concerns is visible to case examiners if the case is onward referred so they can appropriately weigh any evidence from an organisation about which a PA or AA has previously raised public interest concerns.

Should an expert opinion be obtained?

43. As part of evidence collection, the Regulator may ask for an independent professional opinion from an expert on the standard of care provided by the PA or AA and whether that PA or AA:

a. met the standard expected of a reasonably competent practitioner in the relevant field; or

b. fell below the standard expected; or

c. fell seriously below the standard expected.

44. *Good medical practice* and its associated guidance sets out the standards of competence, care and conduct expected of PAs and AAs.

45. We will usually obtain an expert opinion where we are investigating clinical concerns about the treatment provided by the PA or AA.

46. We may also obtain an expert opinion on whether a PA or AA's actions and decisions were clinically indicated and / or carried out in accordance with the professional standards and any other relevant guidance and standard practice. We may do this where it is alleged that a PA or AA's actions when providing treatment were sexually motivated on the basis that they carried out an intimate examination which was not required.

47. We can also obtain expert opinions from non-medical experts, for example digital forensics, accounting or handwriting experts.

48. An expert opinion may be obtained through a documented discussion with an expert or through obtaining a written expert report. A documented discussion will often be more proportionate in the first instance where the concern has a starting point of a low level of seriousness.

Should an assessment of performance, health or knowledge of English language be directed?

49. As part of evidence collection, a PA or AA may be directed to undertake an assessment of their performance, health or knowledge of English*.

* Rule 6(4) of the FTP Rules 2024

Performance assessment

50. Where concerns relate to clinical failings, evidence to assess whether those failings pose any current and ongoing risk to public protection, meaning their fitness to practise is impaired, will vary but may include:

- expert reports
- multi-source positive feedback
- medical records audits
- the existence or lifting of local or voluntary conditions
- information from the PA or AA's annual appraisal

51. Where the nature of the concerns are such that a performance assessment is the only way to effectively assess any current and ongoing risk and the impact on the PA or AA's fitness to practise, the Regulator should consider directing a performance assessment.

52. In deciding on the appropriateness of directing a performance assessment, the Regulator should consider information about the PA or AA's current working position or recent posts, the areas of concern, and whether the PA or AA is currently in the UK or not.

53. The following factors would indicate that directing a performance assessment would not be appropriate:

a. the clinical concern amounts to a single act or omission, or a small number of acts or omissions which, while not amounting to a pattern of poor or unacceptably low standards of professional performance, are sufficiently serious to suggest the PA or AA poses a current and ongoing risk to public protection; and / or

b. the PA or AA has provided evidence of appropriate and effective remediation; and / or

c. the risk to public protection can be effectively assessed in an alternative way.

Health assessment

54. Where a PA or AA's health is likely to be relevant to the consideration of a concern, the Regulator may decide that a health assessment is necessary.

55. Before directing an assessment, the Regulator should first assess the availability of alternative objective evidence. The type of alternative objective evidence available will vary, but may include:

- reports from their treating healthcare professional or from Occupational Health

56. The presence of one or more of the factors below may suggest that a health assessment is not appropriate:

a. the type and severity of the health condition is unlikely to affect the PA or AA's fitness to practise or pose any risk to patients either now or in the future;

b. there is no evidence that the PA or AA's health has had a significant effect on their behaviour or performance to date;

c. there is evidence that the PA or AA has insight into the impact of their health condition and is seeking or receiving appropriate treatment or support;

d. independent medical opinion is available to demonstrate insight into the impact of their health condition and that the PA or AA is complying with treatment;

e. the PA or AA's employer and Occupational Health are aware of the PA or AA's health condition and are providing suitable support;

f. the PA or AA is in stable, long-term employment or training and is subject to an effective locally managed action plan;

g. the PA or AA is restricting their practice appropriately, according to a locally managed action plan.

57. The presence of one or more of the factors below may indicate that a health assessment may be appropriate where no alternative objective evidence is available:

a. the type and severity of the health condition is likely to affect the PA or AA's fitness to practise either now or in the future - this could be because the condition is known to have high rates of relapse or is likely to result in a lack of insight or cooperation on the part of the PA or AA;

b. the type and severity of the health condition poses a clear risk to patients or is likely to pose a risk to patients in the future;

c. there are existing concerns about the PA or AA's behaviour or performance which seem likely to be related to the impact of the PA or AA's health condition;

d. independent medical opinion raises concern in relation to the PA or AA's level of insight into the impact of their health condition or compliance with treatment and / or support mechanisms;

e. the PA or AA lacks insight into the impact of their health condition or has failed to seek appropriate treatment;

f. the PA or AA has failed to follow the advice of treating healthcare professionals and / or occupational health departments or has ceased to engage with support;

g. the impact of the PA or AA's health condition appears to have led to their involvement in dishonest or criminal activity - a health assessment is indicated whenever use of alcohol or drugs has resulted in a criminal conviction, such as driving while under the influence of alcohol.

58. In considering the above factors, the Regulator may also wish to consider whether:

a. the PA or AA has any relevant fitness to practise history which would increase the seriousness of the concern;

b. a health assessment is appropriate at the present time if the PA or AA is currently seriously ill;

c. a health assessment is appropriate at the present time where the PA or AA is currently an in-patient or is receiving community care.

English language assessment

59. Where there are concerns about a PA or AA's knowledge of English language, the Regulator may decide that an English language assessment is necessary.

60. Before directing an assessment, the Regulator should first assess the availability of alternative objective evidence. The type of alternative objective evidence available will vary, but may include:

- a PA or AA's previous IELTS test results or OET results
- primary qualifications
- applications to other medical authorities
- experience working in an English-speaking environment

61. In evaluating the relevance of any alternative evidence of a PA or AA's knowledge of English, the Regulator should also consider how recent and how robust the evidence is, and balance this against the seriousness and timing of the concern.

62. Where a PA or AA has completed an IELTS test or OET within the last two years*, and achieved the minimum scores we require, careful consideration should be given to whether it is necessary to direct them to complete a language assessment. In addition, where a PA or AA has recently completed a relevant qualification that has been taught and examined in English, depending on the circumstances, this may be a strong indication that a language assessment is unnecessary.

63. The Regulator should also weigh up the relevance of any language assessments the PA or AA may have undertaken as part of the registration process for another regulatory authority in a country where the first and native language is English. Consideration should be given to which language assessment was used and the requirements for satisfactory completion applied by the medical authority.

64. One or more of the following factors, in the absence of sufficient alternative objective evidence, is likely to indicate that directing an English language assessment may be required:

a. a decision or finding by another regulatory authority that a PA or AA does not have sufficient knowledge of English to safely treat patients in an English-speaking context;

b. concerns about the PA or AA's performance which appear to be linked to the PA or AA's difficulty communicating in English;

c. a serious instance or a persistent pattern of poor record keeping linked to a lack of knowledge of English giving rise to patient safety concerns as other healthcare professionals are unable to understand medical notes or treatment plans.

65. There may be situations where concerns about a PA or AA's knowledge of English arise during our interaction with them. Matters which may give cause for concern about knowledge of English include requesting or using an interpreter during a meeting or telephone conversation with us, a self-declaration that suggests their knowledge may be limited, or where there is other good reason to believe they have serious difficulty in communicating with, or understanding, others. The Regulator may consider these matters when deciding if it is necessary to direct a language assessment but to be fair in their approach should be mindful of the impact that *Differences in culture, faith and communication* can have.

* The British Council advises that proficiency in English deteriorates after two years if it is not used on a regular basis.

66. When assessing information which relates to concerns about a PA or AA's knowledge of English, the Regulator should consider whether there is any evidence to suggest an underlying health condition. Health conditions which may impact on a PA or AA's communication skills include neurodegenerative disorders and acquired brain injuries from either a traumatic or non-traumatic event.

67. Where the Regulator has good reason, based on specific evidence, to indicate that the impact of a health condition may be underlying a concern about a PA or AA's knowledge of English they should consider whether there may be alternative, objective evidence available about the impact of the health condition or whether a health assessment may be appropriate. Evidence obtained about the impact of a PA or AA's health condition should provide specific information about whether the health condition is likely to impact on communication skills. In these circumstances, the Regulator should consider delaying a decision on whether it is necessary to direct a language assessment until further information is available about the impact of the PA or AA's health condition.

Should a third party or PA or AA be required to supply information or produce a document?

68. As part of evidence collection, a third party or PA or AA may be required to supply information or produce a relevant document[*].

69. Any requirement to supply information or produce documentation must be made lawfully in accordance with our powers under the AAPA Order and Fitness to Practise Rules 2024 and be reasonable. To be reasonable:

a. the Regulator must reasonably believe the third party or PA or AA is in possession of the information or documentation required;

b. the requirement must be proportionate to the concern that is being considered -this means targeted and necessary to fulfil our legal role to protect the public [†].

70. The Regulator cannot, for the purpose of fitness to practise proceedings, require a PA or AA to provide material produced for the purpose of professional development or produced while reflecting on their professional practice to improve it[‡].

[*] Paragraph 7(4) of Schedule 3 to the Order 2024
[†] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.
[‡] Paragraph 7(5) of Schedule 3 of the Order 2024

71. Where a PA or AA fails to comply with a requirement to supply information or produce a document, the Regulator may draw an adverse inference or follow the procedure for removal of an entry from the register[*] provided the correspondence containing the requirement outlined the potential consequences for failing to comply.

72. Where a third party fails to comply with a requirement to supply information or produce a document, the Regulator may seek an order[*] requiring the information to be supplied or the document to be produced.[†]

Should evidence collection be paused because a PA or AA is unwell?

73. Where we receive information that suggests a PA or AA is extremely unwell, it may be appropriate to pause evidence collection, or certain activities within evidence collection, for a defined period to enable the PA or AA to obtain treatment or to reduce the immediate impact of the fitness to practise process on their health. Whilst an assessment is paused, consideration may need to be given as to whether an interim measure may be needed to protect the public or is otherwise in the interests of the public or the PA or AA. The Regulator should apply the guidance *Decisions on interim measures* to reach a view on this.

74. When deciding whether to pause evidence collection in full or part, the Regulator will need to consider the information received about the PA or AA's health. It may be appropriate and proportionate to pause evidence collection where the PA or AA is:

a. an inpatient as a result of a serious medical condition, such as where they have suffered a road traffic accident and been hospitalised or been detained under the Mental Health Act;

b. seriously unwell due to a mental health condition and they are undergoing treatment, such as where a PA or AA with a severe addiction has entered a detox programme;

c. seriously unwell due to a physical health condition and undergoing treatment, such as chemotherapy;

[*] Rule 6(7) of the FTP Rules 2024
[*] an order of the county court or, in Scotland, the sheriff in whose Sheriffdom is situated the address which—(a)is shown in the register as the address of the person concerned, or (b)the last known address of the person concerned
[†] Paragraph 7(6) of Schedule 3 of the Order 2024

d. seriously unwell and life stressors or significant events have further impacted on their mental or physical well-being, such as the death of a close relation; and / or

e. is identified as being at risk of suicide.

75. While evidence collection is paused, GMC staff should stop any part of evidence collection that requires input from the PA or AA. However, it may still be possible to continue gathering evidence that does not require immediate input from the PA or AA, such as obtaining witness statements, medical records, or expert reports.

76. In all concerns where a pause is put in place, the PA or AA's health should be monitored by liaising with their advocate, treating healthcare professional or general practitioner. Evidence collection should be resumed once the PA or AA's health has improved or where the pause is no longer proportionate because protection of the public necessitates us taking action in a timely way and outweighs the interests of the individual PA or AA.

Is there more than one concern that should be considered at the same time?

77. During evidence collection, the Regulator may receive new information that was not originally considered at the pre-initial assessment stage.

78. If that new information is received from a different source but falls within the same scope of the ongoing initial assessment, the information can be taken into account when deciding if the test for onward referral is met.

79. If the information received is similar, or connected to, the concern that is the subject of the ongoing initial assessment, but is not the same, the Regulator will need to decide whether the information received meets the pre-initial assessment stage threshold i.e. raises a question of impaired fitness to practise. When making this decision, the Regulator should refer to the guidance *Decisions at the pre-initial assessment stage*. If the decision is that the information received does raise a question of impaired fitness to practise, it should be added to and considered as part of the ongoing initial assessment. If the decision is that the information received does not raise a question of impaired fitness to practise, it will not be considered further.

80. If the information received is clearly not connected to the current concern that is the subject of the ongoing initial assessment, but may meet the threshold for an initial assessment, it should be considered separately at the pre-initial assessment stage. This is usually when the information is very different to the original matter such as where the ongoing initial assessment relates to clinical concerns and the information relates to a criminal conviction that is unrelated to the PA or AA's practice.

Decision on whether the test for onward referral is met

81. The onward referral test will be met if there is a reasonable likelihood that regulatory action is required to protect the public.

82. Where the Regulator considers that the test for onward referral is not met, the concern must be closed. A concern can be closed at any point during an initial assessment, if it is clear the onward referral test cannot be met. Where several concerns have been raised about a PA or AA, the Regulator may determine that some do not meet the onward referral test and that some do.

83. Where the Regulator considers that the test for onward referral is likely to be met, the Regulator must notify the PA or AA and provide them with an opportunity to make representations, which should be taken into account in deciding if the onward referral test is met. Where it is met, the concern must be referred on to the Case Examiners to consider.

Has the concern been sufficiently evidenced?

84. To decide if the onward referral test if met, the Regulator will first need to consider all the evidence that has been collected and reach a view on whether the concern has been sufficiently evidenced. If the concern has been sufficiently evidenced, the Regulator should go on to apply the *Decision on whether regulatory action is required* guidance to assess whether the PA or AA may pose any current and ongoing risk to public protection meaning their fitness to practise is impaired, or where no impairment is found whether we may need to issue a warning.

85. A decision to make an onward referral must be based on an assessment that there is sufficient evidence of the concerns that pose a risk to public protection. It is not proportionate to proceed with concerns where the evidence is not capable of supporting the need for regulatory action. This is because when considering whether regulatory action is needed, Case Examiners or MPTS tribunals will need to decide that the allegations about the PA or AA are more likely than not to be true. They will also need to be able to make an informed decision on impairment and regulatory action. To be in a position to do this, they must have access to sufficient evidence.

86. Where proportionate options for evidence collection have been tried and it has not been possible to sufficiently evidence the concern, the concern should be closed at the initial assessment stage.

87. In situations where the evidence gathered is conflicting and there is no further evidence that can be obtained to support either position, the concern should be referred to the Case Examiners for them to consider provided the test for onward referral is met.

Being proportionate, transparent and fair when applying the test for onward referral

88. The Regulator must be proportionate[*] in their approach to deciding if the onward referral test is met, asking themselves what is required and no more than necessary to achieve public protection in a timely way.

89. To ensure decisions made about the onward referral test are transparent[†] , the Regulator must give reasons for their decisions and record them clearly. This means using straightforward language and explaining technical terms wherever possible. This is important as it will help the PA or AA understand the Regulator's decision, to enable them to make meaningful representations in cases where the Regulator is minded to refer the concern to the Case Examiners for an accepted outcome.

90. To ensure fairness[‡], the Regulator should act reasonably, be consistent, be impartial and be aware of the risk of bias and take steps to mitigate it.

91. Differences in communication and culture can be difficult to identify from written information alone. However, where the Regulator is considering evidence, they should be mindful that cultural, faith or other characteristics such as those related to disability, can impact on how an individual engages with the fitness to practise process and communicates with us. Where supported by the information available, and where appropriate to do so, the Regulator should have regard to differences in communication, culture or other characteristics (if they have this information) when considering written evidence.

Minded to Refer Decision

92. Before making an onward referral decision the Regulator will need to notify the registrant of whether the Regulator is minded to make an onward referral, prior to the registrant making representations. In order to do so, the Regulator will need to form a provisional view on whether the test for onward referral is likely to be met by considering the *Decision on whether regulatory action is required* guidance. This sets out the categories of concern that indicate a high, mid-range or low level of seriousness as a starting point.

[*] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.
[†] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.
[‡] Our publication *Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)* explains these principles in more detail.

93. Where the evidence collected about the PA or AA's behaviour, performance or impact of a health condition indicates a mid-range to high level of seriousness as a starting point, it is likely that the onward referral test will be met. This is the case even where there is information available about relevant context and / or insight and remediation that decreases risk, given this evidence will carry less weight when assessing the overall current and ongoing risk to public protection posed by the PA or AA.

94. Where the evidence collected indicates a low level of seriousness as a starting point, the Regulator should consider if there are any additional factors which increase the level of seriousness or if there is relevant context and / or information relating to the PA or AA's response to the concern that increase risk.

95. The onward referral test is likely to be met where, in the Regulator's view, there is a reasonable likelihood that regulatory action will be required to protect the public. The onward referral test is not likely to be met in cases that indicate a low level of seriousness as a starting point where there are no additional factors that increase seriousness, no relevant context and / or no information relating to the PA or AA's response to the concern that increases risk, and in the Regulator's view, there is not a reasonable likelihood that regulatory action will be required to protect the public.

96. Where the Regulator considers that the test for onward referral is likely to be met, the PA or AA must be notified that the Regulator is minded to refer the concern to be considered by the Case Examiners. This notification must include[*]:

- the basis on which the Regulator considers the test for onward referral may be met and any relevant evidence
- that the PA or AA may make written representations within 28 calendar days beginning with the day on which the notification is served
- that the PA or AA has a right to be represented

Should the timeframe for representations be extended where the Regulator is minded to onward refer?

97. The Regulator has discretion to extend the period for representations.[†] This may be at the request of a PA or AA (or a representative on their behalf) to extend the timeframe for representations, or on the Regulator's own initiative.

[*] Rule 5(2) of the FTP Rules 2024
[†] Rule 5(4) of the FTP Rules 2024

98. When deciding whether it's fair and proportionate to extend the timeframe for a PA or AA to make written representations, the Regulator should be mindful that all PA and AAs have a duty to cooperate with their regulator. However, the individual circumstances of the concerns should be taken into account.

99. In making the decision, the Regulator should have regard to:

a) whether there is a good reason why the PA or AA needs additional time to make representations;

b) the potential impact a longer timeframe will have on the PA or AA and others affected by the ongoing fitness to practise process;

c) the length of extension required and the likelihood of the PA or AA making written representations within that time;

d) the seriousness of the concern(s) which have raised a question of whether the PA or AA's fitness to practise is impaired; and

e) the need to protect the public, which is more important than the interests of any individual.

Is the test for onward referral met?

100. Where the Regulator has reached a provisional view on current and ongoing risk to public protection and notified the PA or AA that it is minded to refer the concern on to the Case Examiners to consider, the Regulator must take into account any representations received from the PA or AA and consider how this affects the assessment of any current and ongoing risk and therefore whether the test for onward referral is met.

101. Where the Regulator considers that the test for onward referral is not met, the concern must be closed.[*] A concern can be closed at any point during an initial assessment, if it is clear the onward referral test cannot be met. Where several concerns have been raised about a PA or AA, the Regulator may determine that some do not meet the onward referral test and that some do.

102. Where the Regulator considers that the test for onward referral is met for one or more concerns, those concerns must be referred on to the Case Examiners to consider.[†]

[*] Rule 4(3) of the FTP Rules 2024
[†] Rule 4(2) of the FTP Rules 2024

103. As the onward referral test involves a consideration of whether there is a reasonable likelihood of regulatory action being required, this includes consideration of both a warning and restrictive action. Where the Regulator is of the view that the concern falls just short of posing any current and ongoing risk to public protection and could be concluded with a warning, this will meet the onward referral test and should be referred to the Case Examiners for consideration.

104. The onward referral test is not about deciding whether regulatory action is required, only whether there is a reasonable likelihood that it may be. Where there is any doubt that cannot be resolved by gathering further evidence, the Regulator should refer the concern to the Case Examiners to consider.

105. The Regulator should be cautious where a decision about whether the test for onward referral is met may be considered inconsistent with a decision made by another public body in relation to the same or substantially similar facts. This may include an NHS investigative body, a Coroner, or an Ombudsman. However, as our remit and functions differ from other organisations there may be good justification for taking a different approach. The Regulator should explain the reasons for taking a different approach in their decision. The Regulator must notify the PA or AA of their decision on the test for onward referral, together with reasons, within 5 business days beginning with the day on which the decision is made.[*]

106. It is important that complainants and referrers are kept updated about the progress of their concern. The Regulator should also notify the complainant or referrer of their decision on the test for onward referral.

[*] Rule 5(5) of the FTP Rules 2024