professional standards authority
for Health and Social Care

Professional Standards Authority response to General Dental Council consultation on fitness to practise guidance for decision makers

1. About us

1.1. The Professional Standards Authority for Health and Social Care (PSA) is the UK's oversight body for the regulation of people working in health and social care. Our statutory remit, independence and expertise underpin our commitment to the safety of patients and service-users, and to the protection of the public.

1.2. There are 10 organisations that regulate health professionals in the UK and social workers in England by law. We audit their performance and review their decisions on practitioners' fitness to practise. We also accredit and set standards for organisations holding registers of health and care practitioners not regulated by law.

1.3. We collaborate with all of these organisations to improve standards. We share good practice, knowledge and our right-touch regulation expertise. We also conduct and promote research on regulation. We monitor policy developments in the UK and internationally, providing guidance to governments and stakeholders. Through our UK and international consultancy, we share our expertise and broaden our regulatory insights.

1.4. Our core values of integrity, transparency, respect, fairness, and teamwork, guide our work. We are accountable to the UK Parliament. More information about our activities and approach is available at **www.professionalstandards.org.uk**

2. Answers to questions

Please tell us if our objectives have been met in the development of the Guidance for decision makers at the Initial Assessment stage, and the Guidance for decision makers at the Assessment stage

5. We have aimed to draft guidance which is correct, in that it accurately reflects the law and current practice. Please tell us if you agree that we have achieved this objective and, if not, provide reasons and any suggestions for where and how the guidance documents should be improved.

2.1. We broadly agree with the approach taken, but consider that some areas may require revision or clarification to ensure that the guidance accurately reflects the

law.

2.2. In particular, we recommend that the section on dishonesty in the Assessment guidance is revised to reflect more accurately the test in Ivey v Genting Casinos. Paragraph A41 currently states that dishonesty "does not have any subjective element". However, the test requires the decision maker first to ascertain the individual's actual state of knowledge or belief as to the facts before determining objectively whether the conduct was dishonest by the standards of ordinary decent people. The guidance presently captures the objective stage but risks missing the preceding consideration.

2.3. We also recommend further consideration of the case law cited in relation to discrimination and freedom of expression in the Assessment guidance. In particular, the guidance could usefully reflect the following:

- Adil v GMC [2023] EWCA Civ 1261 in providing a clearer explanation that where Article 10 rights are engaged, decision makers should consider proportionality and why regulatory intervention is justified
- Lambert-Simpson v HCPC [2023] EWHC 481 (Admin) in relation to the potential relevance of intention where discriminatory motivation is alleged. The guidance currently states that discriminatory language is assessed objectively which is broadly correct. However, Lambert Simpson highlights that where discriminatory motivation itself is alleged, intention can become relevant
- Husain v SRA [2025] EWHC 1170 (Admin) in distinguishing between conduct which merely causes offence and conduct warranting regulatory intervention. Given the inclusion of freedom of speech within the guidance, it could explain more clearly that lawful but controversial speech will not necessarily engage regulatory concerns, more is required than merely causing offence.

2.4. A reference to CHRE v NMC & Grant [2011] EWHC 927 (Admin) may also help explain the importance of public confidence and professional standards when considering whether concerns may amount to impaired fitness to practise.

2.5. There are some further areas where the legal framework could be more comprehensively reflected. For example, the Assessment guidance addresses restrictions applying to evidence from Family Court proceedings, but consideration should be given to whether analogous restrictions applying to material from the Court of Protection and Mental Health Tribunal should also be addressed.

6. We have aimed to draft guidance which supports consistent decision making. Please tell us if you agree that we have achieved this objective and, if not, provide reasons and any suggestions for where and how the guidance documents should be improved to better-support consistent decision making.

2.6. We broadly agree, and welcome the attempt to bring the considerations relevant to these decisions together into published guidance. However, we consider that further clarification of several concepts and thresholds would better support consistency. The GDC itself identifies consistency as a central objective of both documents and this is an important aspect of ensuring robust public protection and maintenance of public confidence in the process.

2.7. The Initial Assessment guidance could assist further decision makers in applying public confidence consistently. The Initial Assessment test identifies "dishonesty

which is more than minor in nature" as an example of conduct with public confidence implications (paragraph 24), but does not explain what might constitute minor dishonesty. An example could help distinguish matters requiring referral to investigation from those that are considered minor and do not.

2.8. There is also scope for greater clarity around discrimination, harassment and victimisation. We strongly welcome the prominence given to these issues which reflect the impact of discriminatory behaviours on public confidence which has been a theme of a number of recent inquiries and reviews including the Lord Mann Review into antisemitism in healthcare. However, paragraph A33 of the Initial Assessment guidance states that where information "suggests" such conduct, the Initial Assessment Test will be met. This appears to create a strong presumption in favour of referral. Although we agree that such serious matters are very likely to satisfy the relevant threshold, given that the guidance elsewhere acknowledges that information at Initial Assessment may be incomplete, untested and one-sided, there may be value in clarifying the role of credibility, context and evidential sufficiency. The guidance could explain more clearly the threshold for determining when allegations of discrimination meet the Initial Assessment Test to ensure consistency of application.

2.9. Similarly, at Assessment, paragraph A55 indicates that where evidence supports an allegation of discrimination, harassment or victimisation it is likely to result in an allegation of impaired fitness to practise. We support the clear recognition of the seriousness of this conduct, but recommend further explanation of how decision makers should assess evidential sufficiency, context and seriousness so that the provision is not interpreted as an automatic referral rule and to ensure robust and consistent decision-making.

2.10. It would be helpful to clarify further the sections covering social media (paragraph A23, page 15) and advertising (paragraphs A50-A51, pages 19-20). Both sections suggest that a subsequent concern received about a breach of the guidance following previous advice is likely to justify referral to Assessment. While repetition is clearly relevant, the guidance may benefit from clarifying that the seriousness and circumstances of the later concern should also be considered. As drafted, there is a risk that decision-makers may interpret these provisions as creating automatic escalation rules.

7. We have aimed to draft guidance which supports proportionate decision making. Although the legal framework provides less scope for decision makers at these stages to exercise proportionality in their considerations than at later stages of the process, certain aspects of their role still require consideration of proportionality. For example, in relation to the Assessment stage, in some cases the consideration of seriousness under Part C of the Assessment Test (paragraph 36, and 42 - 49), consideration of the appropriate extent of an investigation (paragraph 50), and consideration of whether a case should proceed where the informant has requested anonymity or they are not engaging or cooperating with the investigation (paragraphs 51 – 60).

Please tell us if you agree that we have achieved this objective and, if not, provide reasons and any suggestions for where and how the guidance documents should be improved to better-support proportionate decision making.

2.11. We support the emphasis on proportionality, but consider that several changes

would strengthen its practical application.

2.12. It is helpful that the guidance recognises a broad range of potential harms, including physical, psychological and financial harm, however the current wording potentially captures relatively minor matters that would not ordinarily raise fitness to practise concerns (such as a matter arising from a clinical negligence claim). At Initial Assessment, harm is defined as "any negative impact" resulting from a registrant's actions or omissions (paragraphs 20-23), and the Assessment guidance uses a similarly broad definition (paragraphs 37-39). We suggest clarifying that the relevant harm should be capable of engaging a fitness to practise concern and/or defining what is meant by 'any negative impact'. This is particularly important at Initial Assessment because the guidance expressly states that the threshold is deliberately low.

2.13. Proportionality would be further strengthened by greater detail around the progression thresholds on areas such as discrimination, social media and advertising as set out in our answer to question 6 above.

2.14. We also recommend strengthening the discussion of proportionality in the sections on freedom of expression in both pieces of guidance (Initial Assessment Guidance paragraphs A34-A47 and Assessment guidance paragraphs A58-A70). Both pieces of guidance correctly recognise both the importance of Article 10 and the possibility of lawful restriction where necessary and proportionate for regulatory objectives and acknowledges that there can be a tension.

2.15. However, further practical guidance would help decision makers distinguish between lawful protected expression, expression which may cause offence, discriminatory or harassing conduct, and conduct sufficiently serious to undermine public confidence. For example, in the Initial Assessment Guidance the discrimination section suggests that allegations of discrimination will meet the Initial Assessment Test, whereas the freedom of expression section recognises that not all offensive or controversial expression will do so. The guidance includes an example involving gender-critical views (paragraph A41) but provides limited practical support for decision-makers in assessing whether particular expression is likely to require regulatory action.

2.16. Currently the guidance places limited emphasis on intent. While intent may not determine whether language is objectively offensive, it may be relevant when assessing seriousness, risk and public confidence implications. As noted, Adil v GMC would be a useful reference on this topic, particularly in reinforcing the need to consider why regulatory intervention is justified where Article 10 is engaged.

2.17. We also welcome the approach taken to health cases in the Initial Assessment Guidance (paragraphs A17-A19), which appropriately focuses on risk, management of the condition and impact on practice rather than the existence of a health condition itself. However, where decision makers are directed to consider whether a condition may worsen, recur or be unpredictable, the guidance should state explicitly that these assessments must be based on the best available evidence and clinical opinion and to avoid assumptions being made about a particular physical or mental health condition. The same clarification should be made in the Assessment guidance (paragraphs A17-A23).

2.18. Finally, the provisions in the Assessment Guidance concerning informants who

disengage (paragraphs 51-57), or request anonymity (paragraphs 58-61) represent a sensible attempt to balance evidential sufficiency and the need to protect informants. However, there may be scope for clearer articulation of the circumstances in which the public interest should outweigh a request for anonymity. This may be particularly important in cases involving allegations of discrimination, bullying, harassment or sexual misconduct, where concerns about retaliation may be significant. The guidance could provide greater clarity regarding the factors that should be considered when balancing public protection, evidential requirements and requests for anonymity.

8. We have aimed to draft guidance which is transparent. In doing so, we have aimed to use clear and commonly understood language, which is free of technical terminology, wherever possible. We have also aimed to provide a clear picture of the basis on which decisions will be made. Please tell us if you agree that we have achieved this objective and, if not, provide reasons and any suggestions for where and how the guidance documents should be improved to better support transparency.

2.19. We broadly welcome the GDC's intention to make decision making at these early stages more transparent. Publishing the relevant considerations is in itself a positive step. However, some terminology and aspects of the process could be made clearer for readers outside the GDC.

2.20. The distinction between the different thresholds at Initial Assessment and Assessment is generally explained, but greater clarity around concepts such as "harm", "public confidence", "serious enough" and "evidential sufficiency" and "impairment" would make it easier for registrants, informants and other readers to understand why apparently similar cases might have different outcomes. The Assessment Test, for example, combines harm and public-confidence considerations with whether the issues are sufficiently serious that, if proven, fitness to practise might be impaired.

2.21. There are also some specific process points that would benefit from clarification. In the Initial Assessment Guidance, "refer to NHS" is identified as an outcome, even though many dental professionals work outside NHS settings (paragraph 40). The guidance would be clearer if it explained whether an equivalent route exists for concerns arising in private practice or, if not, what other local resolution options should be considered.

2.22. The ability to adjourn an Initial Assessment to gather additional information is also helpful, but the guidance does not set out parameters around how long such enquiries should remain open. Further clarity would help ensure that this route does not result in open-ended initial enquiries.

2.23. More broadly, accessibility remains an issue. The GDC's EIA itself identifies the guidance's readability as "very difficult" and recognises a potentially negative impact on people with learning disabilities, for whom advocacy may be required. Its proposed mitigation is principally to support secondary audiences on a case-by-case basis. Given that registrants and informants are expressly identified as intended secondary audiences of the guidance, we encourage the GDC to consider whether more accessible accompanying material or summaries could be provided as standard rather than relying primarily on case-by-case enquiries.

Equalities Impact Analysis

9. We want to understand whether, and if so how, our proposals might advantage or disadvantage people. Please consider the above protected characteristics and indicate for each whether you think these guidance documents may advantage or disadvantage people in these groups. Please provide the reasons for your response (including any suggestions for how the guidance could or should be improved).

2.24. We welcome the explicit consideration given to equality and the recognition within the EIA that clearer guidance may improve consistency and reduce the potential for unconscious bias. The EIA identifies potential positive impacts across protected characteristics and highlights the dedicated sections on discrimination, harassment and victimisation.

2.25. We particularly welcome the substantive treatment of discrimination, harassment and victimisation in both guidance documents, including specific reference to definitions of antisemitism and anti-Muslim hostility.

2.26. There are, however, areas where the equality analysis and guidance could be strengthened. First, as the EIA itself acknowledges, the "very difficult" readability of the documents may create a disadvantage for some people with learning disabilities. As noted in our answer to question 8, we would encourage the GDC to consider more proactive accessibility measures, including accessible summaries of the key tests and decision-making process. This may benefit all members of the public with an interest in understanding the relevant processes.

2.27. Second, as outlined in our response to question 7 the approach to health concerns and disability should ensure that decisions about prognosis, recurrence or unpredictability are not based on assumptions about particular conditions. The guidance would benefit from an express statement that future-risk assessments should rest on the evidence available in the individual case and, where relevant, appropriate clinical evidence. This could also be referenced in the EIA.

2.28. Finally, there is an important equality dimension to the relationship between discrimination and freedom of expression which we have commented on in our answer to question 7. Given the potential for cases to engage both protected beliefs and the rights of people protected from discrimination or harassment, the guidance should provide clearer practical assistance on how those considerations interact. The present guidance acknowledges the tension and the need for individual consideration, but further explanation would support proportionate exercise of regulatory powers and fair and consistent outcomes.

Any other comments

10. Are there any other comments you would like to make on the proposed Guidance for decision makers at the Initial Assessment stage and/or the Guidance for decision makers at the Assessment stage that are not covered by your answers to questions 5 to 9?

2.29. **Initial information gathering:** Paragraphs 9-10 of the Initial Assessment guidance provide that information which is insufficiently detailed to be assessed against the Initial Assessment Test will result in a case not being created. We suggest considering whether the guidance should expressly provide for limited, targeted follow-up where the matter described appears potentially serious but the information initially supplied is insufficient. This would help guard against potentially serious concerns being closed because of the form or completeness of

the initial report rather than the underlying risk.

2.30. **Interim orders:** We welcome the requirement to consider interim referral where a high level of risk is indicated and the specific factors dealing with seriousness, credibility and the likelihood of repetition. We suggest considering whether serious discriminatory behaviour should feature more expressly among the examples of concerns potentially requiring an interim order assessment, depending on the nature of the allegation and the immediate risk or wider public-interest considerations. The current examples expressly identify sexual misconduct, physical violence and serious dishonesty, among other matters.

2.31. **Health cases:** In the Initial Assessment Guidance (A19), the guidance lists a range of considerations for decisions makers when deciding whether the test has been met. These may be more helpfully framed as concerns and mitigations to concerns as currently they are a mix.

2.32. **Insufficient command of the English language:** The Assessment guidance highlights that cases involving English language proficiency would be considered as impairment on the grounds of misconduct but suggests that such cases would only arise in 'rare instances'. As there isn't any definition provided of 'rare instances' the basis for this assertion is unclear.

2.33. **Assessment guidance – adverse physical or mental health:** Paragraph 19 and 20 refer to consideration of health concerns as a ground of impairment but unlike the other grounds of impairment in this section this section does not outline what would constitute impairment in this context and simply refers to the need to obtain a health assessment report or a report from the registrant's General Practitioner or commission one. Whilst this will clearly be an important element of considering whether this ground of impairment is likely to be met, it would also be helpful to include an overview of what impairment due to adverse physical or mental health is likely to include. This is covered in more detail part at paragraphs A17-19 of the Assessment Guidance, however it would be useful to reference in brief here for consistency.