HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Sexual assault and harassment within the NHS workforce, HC 1903

Wednesday 25 October 2023

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Watch the meeting

Members present: Caroline Nokes (Chair); Elliot Colburn; Jackie Doyle-Price; Carolyn Harris; Lia Nici; Kate Osborne; Kirsten Oswald.

Questions 1 - 48

Witnesses

I: Tamzin Cuming, Chair, Women in Surgery Forum, Royal College of Surgeons of England; Professor Nicola Ranger, Chief Nurse, Royal College of Nursing; and Dr Chelcie Jewitt, Co-founder, Surviving in Scrubs, Emergency Medicine Registrar, NHS.

Examination of witnesses

Witnesses: Tamzin Cuming, Professor Nicola Ranger and Dr Chelcie Jewitt.

Q1 **Chair:** Welcome to this one-off evidence session about sexual assault and harassment in the NHS workforce. Can I thank our three witnesses for coming along this afternoon? We have Dr Chelcie Jewitt, the co-founder of Surviving in Scrubs; Ms Tamzin Cuming, chair of the Women in Surgery Forum; and Professor Nicola Ranger, chief nurse at the Royal College of Nursing. As is usually the case, Members will ask you questions in turn. They will make it clear which of you they are addressing, but if at any point any of you wish to come in on a question, please indicate and we will bring you in.

We read the newspaper coverage with a mixture of horror and extreme disappointment that these horrific assaults were happening in our national health service. Can each of you in turn—starting with you, Chelcie—set out what you see is the scale of the problem, as somebody who works in the sector?

Dr Jewitt: In short, it is massive. We know from the BMA's "Sexism in medicine" survey published a couple of years ago that 91% of female doctors have experienced some form of sexism while at work. That is then subdivided into 56% of them having experienced unwanted verbal conduct and 31% having experienced physical misconduct in the workplace.

We know that this is not just a doctor problem; it is a whole of healthcare problem. A survey by Unison, published in 2019 and with almost 8,500 respondents, showed that about 8% of allied health professionals—non-doctors—have experienced sexual harassment. That is in the years 2017-19. Putting that into numbers, about 680 were reported in that survey. We know that 33% of that cohort, about 224, have experienced frequent or regular sexual harassment. We also know that 12% have experienced it daily or weekly. Of that 680 figure, 150, or 22%, have been assaulted at work as well.

I am sure you are aware that we at Surviving in Scrubs are an online campaign, where anyone who works in healthcare can submit their stories anonymously. We have been going for about 16 months, and we have 187 submissions on a range of incidents, going from inappropriate comments all the way up to sexual harassment and sexual assault. This is huge, and it affects every aspect of healthcare.

Ms Cuming: Thank you for having this session. I have been involved in writing the paper and the report that you have seen. Our survey was directed at people working in the surgical profession. Most of the people who answered it were consultants and trainees, but there was a scattering of other respondents, including 10% of anaesthetists.

As you know, it is very similar to what Chelcie said: we showed that, among the respondents, this is widely prevalent. Nearly 90% of people

have witnessed sexual harassment working in the surgical sphere, and 64% of women have experienced sexual harassment. Fifty per cent of the people answering were men, which was really helpful, because it meant that we could look at this gender divide. Thirty per cent of the women answering had been sexually assaulted themselves, compared with 7% of men. Of that figure, only 16% have reported. That might be one of the reasons why we have not seen as much of this; it has not been consistently reported.

One of the things that has happened since the report is that a lot of women have come up to me and said, "I am so pleased you published that. I am so pleased that you got that out there. This is what is happening." A lot of the men have come up to me and said, "We had no idea". The subtitle we have in our paper is that men and women are "living different realities". You can really see that that has been normalised; we have put up with comments and things that have happened.

The question we asked was: how much has happened in the last five years? We knew that we might get people saying, "This used to happen, but it is not happening now", whereas the evidence we have is that it is happening now.

Personally, because I have been a consultant for 10 years, I thought that it had stopped happening, but it turns out that it just does not happen in my theatre; it turns out that it is happening elsewhere. When we have tried to address it and heard anecdotal reports in the past, people have said, "You need the data". Now that we have at least some data—obviously, people are reluctant to answer, and this is probably under-reported in surveys where people are not sure they can be anonymous—we now have to think how we are going to change things to stop this.

Q2 **Chair:** Can I ask you a follow-up question? The Committee was having a general discussion about this before you came in. You just used the phrase that men had said that they had "no idea"—really?—and that it "does not happen in my theatre". Does it not happen in your theatre, or you don't see it and you thought it had got better, because you are more senior, you don't tolerate it and therefore nobody dreams of behaving like that around you? And—I'm sorry, this is probably somebody else's question—how can we tackle the culture so that every theatre is like your theatre?

Ms Cuming: It is probably a little bit facile to say that, if every theatre had a woman surgeon, it would not happen. I don't think it is as easy as that, but it is true that only 15% of surgical consultants are women and that, if we could work to have more equality at the top of the profession, we may see some of this improving. The WHO had a vicious triad of sexual harassment in their report, and lots of places across society are trying to look at how to address that. One of them was a power imbalance; one was an organisation where, if you report something, it gets covered up or is not taken seriously; and one was a sense of impunity.

Because I, along with the consultant anaesthetist, am the most senior person in my theatre, this sort of comment—of course, we are all

susceptible to unconscious bias, and maybe I am not seeing things—and those kinds of conversations are not happening. When I was junior and training, I think I normalised it. I was used to the fact that these sorts of comments were just normal in theatre. The only time I noticed a difference was when, for the first time, I was working for a woman consultant surgeon, and I suddenly felt relaxed in theatre and we could just talk. I could say whatever came into my head and didn't have to put it through a filter first to see whether I was going to get laughed at or have personal questions asked of me.

Professor Ranger: As Tamzin said, I am delighted to be able to be here. Prior to doing this job at the Royal College of Nursing, I have been a chief nurse in three very acute, busy hospitals. I think there is a huge amount of under-reporting. If you look at nursing, it is a 90% female profession, yet one third of the most senior roles in nursing are with men. There is something about that relationship of power and potential influence over your career which I don't think should be underestimated. The NHS is built of teams, and breaking that team culture can go from team to collusion quite quickly. How do we keep an eye on that?

For nursing particularly, there is that colleague-to-colleague issue, but our biggest challenge is patient to nurse. We would be shocked at the number of incidents—sexual, violent, inappropriate behaviour and language—in nursing. I think it is massively under-reported.

In the past year, we have seen a 21% increase in incidents reported to the RCN. Reports like this highlight that, but the scale is significant and very challenging. I have been a frontline nurse and a senior leader in hospitals for many years: I never thought I would come to the day when, as chief nurse at King's, prior to this job, in south London, I had to put in a matron's post as a specialist in violence and aggression reduction. The scale of it was such that it was our No. 1 clinical incident. I had nurses who were bitten, who were sexually assaulted and whose arms were broken. The scale is extraordinary.

Q3 **Chair:** Thank you. Can I come back to you, Chelcie, and talk about the 2021 report "Sexism in Medicine"? Why has it taken so long to come out?

Dr Jewitt: That is a great question. Healthcare, as a profession—whether that is medicine, nursing or any of the other allied health professions—is an old institution, and there comes with that a culture that has been there for a really long time.

Anyone that goes into healthcare wants to help their patients. There is a culture within healthcare that patients come first and your own wellbeing, as a staff member, comes second. There have been stereotypes of who is in charge, and that is often a senior male colleague, whether that is a consultant or a line manager. The culture of speaking up just isn't there yet. If you do speak up and put your head above the parapet, you are "making a fuss", and there aren't any systems in place to support you. The reporting systems, if there are any at all, just aren't fit for purpose. There is no cohesive structure for who to report to.

We have examples, on our website, of people who have been sexually assaulted at work by a colleague, have tried to raise it with their line manager and been told, "No, this isn't a Trust issue; this is a GMC issue" and who have then gone to the GMC, and the GMC have said, "This isn't a GMC issue; this is a Trust issue". There is no ownership over who has the power to make perpetrators accountable at an individual level, a Trust level or an organisational level. All of the different organisations that are somehow involved do not communicate with each other—they do not talk to each other.

There are just so many different barriers, institutionally and culturally. But also, on an individual level, you are scared—you are scared to speak up, because, often, the person you are speaking up against is your boss. That boss is your educational supervisor who will or won't sign you off. They are the person you are scrubbing in with in theatre; they are the person you are going to if you need advice about a critically unwell patient. I am an A&E doctor. If I have somebody right in front of me who is about to die, I need to go and talk to my boss, but, if I have raised a complaint against them, that is so hard. That is damaging to the morale of the staff and is concerning when it comes to patient care as well. It is something on which so much work needs to be done.

Q4 **Chair:** Thank you. I do not know whether either of the other witnesses wants to add to that. Why has it taken until 2023 for this to have any sort of public scrutiny? Is it, as Chelcie indicated, that this is cultural and structural and that it is about people being afraid for their employment prospects, career prospects and ability to have their studies signed off?

Ms Cuming: Yes, it is all of those. We found that about 11% of people who responded to our report had been coerced into sexual activity in return for being signed off for the progression of their career.

The question of why it has taken so long is interesting and is probably outside the evidence we have in this report. But it is almost like, when you look back, there has been report after report. There is your survey, Chelcie, and there is the Unison report; there are reports across that. It feels like you kind of get to this tipping point. It may be that this data is what has tipped it to the point of having to have a discussion about changing something, but work has clearly been done in this field for at least a decade, and there have been reports about this happening in surgery in the UK for over two years. It feels like things take time and that there is then a sort of crystallising moment, and maybe we are there.

Professor Ranger: I think many organisations have reached that tipping point, where they absolutely know things have to change and be different. Our own organisation, the Royal College of Nursing, had an appalling review. That was undertaken by Bruce Carr KC. It looked into the culture of the college. With regard to people going to conferences, there was the appalling behaviour of senior male nurses preying on young student nurses, to the point where we had to cancel our conference after this review, because we were so worried about the safeguarding. We have

really taken the opportunity to clean up this kind of behaviour. There is no alcohol at conferences. We are really vetting who goes in with students.

I think every organisation is having to really think, listen, take account and make changes. At the moment, with the pressures that everybody is under, with the real challenges for many of our brilliant healthcare staff, this can be the last straw; it's the tipping point. People have had enough, and I think it is the time to structurally look at how we do things and make that reporting safe.

I have thought about this with particular regard to junior doctors. You have to nip these things in the bud, because if you don't do it right from the beginning, the culture begins. Some of our most eminent, powerful people are the strongest clinically. A power base builds up and, sadly, then becomes a sense of being untouchable. Whatever the culture and whatever the organisation where someone uses their power to be untouchable, that is incredibly frightening, particularly for women. I think it is absolutely right that we look at those structures, but also nip things in the bud. It doesn't take much to get a heat map.

The thing that I think is frustrating is that when people really ask themselves, they know where they are and they often have an idea of who and how. The question is how this culture develops. It goes from an incident to becoming the culture: "Oh, that's just the way they are. You have to be more resilient. They are a brilliant clinician." This is the culture we have to nip in the bud.

Q5 **Chair:** Thank you for that. I think you are bang on. This is not necessarily about sex, is it? It's about power—it's always about power. Are we lagging behind other countries? Can you point to anywhere in the world and say that the culture in medicine in X, Y, Z country is better and that they have led the way in researching this and tackling it?

Professor Ranger: I don't know, but I did think it was interesting that some of the Nordic countries like Iceland are very strong on gender equality. I don't know whether that translates into medicine.

Ms Cuming: Certainly we know, from a surgical point of view, that the Royal Australasian College of Surgeons started working on this five years ahead of us—2015 was when they started. They have been implementing the Operating with Respect programme, and they have done a follow-up study—a report—which has shown that the numbers of incidents have increased. That is counterintuitive, but it means that maybe people are more willing to report. Trying to change a culture is a long process, and I think we all need to recognise that and not think that we can turn things around quickly or simply. But that should not put us off starting that process and learning from other people. We have been in contact with that group at the Royal Australasian College to learn what we can from them.

Dr Jewitt: From our point of view, we know that there is limited data out there; there is some data, particularly within the surgical workspace, but this isn't just a surgical problem. Anecdotally, we had a stand at the AMEE

conference—the International Association for Health Professions Education—in Glasgow in August of this year, and people from all over the world came to us; so many countries came to us. We had people from Qatar, Sweden, Kuwait, Hungary, Poland, the States, Canada, Australia, New Zealand, Norway, Denmark, Portugal, Iran, Egypt, South Africa, Brazil and Argentina—those are the ones we can remember who came up to us and said, "It's great that Surviving in Scrubs exists. I wish something like this existed in our country." We know that this is an international problem and, if anything, that means we should definitely be looking at ourselves and trying to do more research and trying to pave the way for changing these issues.

Q6 **Carolyn Harris:** I want to go back to something you said, Professor Ranger, about nipping this in the bud. If we were to speak to a cohort of nurses, doctors, dentists who were going through the system 20, 10 or 15 years ago, would they have experienced the same kind of thing but not reported it? Look at, for example, the Met police. The kinds of things that have gone on there have been going on for many years, but it is only now that they have come to light. Do you think that would be the same?

Professor Ranger: For nursing, I think you are right, to a certain degree. We were just expected to be resilient about some of these things. It was just part of the job, and we had to find a way to manage it. I am old enough to have worked in that culture. But if I am honest, I genuinely think something has changed. Certainly, regarding patients, I have never seen as much abuse as now: physical, verbal, assault. The scale of it is increasing, especially since covid. Some of the behaviour that we see now would previously have been unacceptable and would not have been tolerated by the staff or other patients. I think something has shifted with regard to what is seen as acceptable behaviour. We see in A&E that the sense of violence and aggression and assault on staff is really staggering.

Q7 **Carolyn Harris:** Would that be linked to mental health or addiction problems?

Professor Ranger: It can be. I think this is why it is very difficult. You have heard from all three of us that this is such a complex thing: there is colleague on colleague, there is colleague to colleague, and there is power. It is even more complex in a healthcare setting because some of our patients are extremely unwell. Some may not have capacity at that moment, and they may not know how they are behaving. Trying to create zero tolerance, which is language that is used so much, is very challenging. If you have someone who is acutely psychotic, you are not going to not look after them. The people that we look after is something we do not always have control over. What we do have control over is how we look after those staff, how we behave as a team, and how we wrap ourselves around that individual. We have control over this, but in many instances that is still not at all good enough.

Q8 **Jackie Doyle-Price:** We have looked at the evidence on the Surviving in Scrubs website, which is obviously quite shocking. What is it, Chelcie, that you think makes these behaviours so prevalent within the NHS?

Dr Jewitt: In terms of inter-professional sexual misconduct, I definitely think power plays a part. There is a huge power play here. From the limited evidence that we have, we know that the most predominant perpetrator is someone in a consultant role or a more senior role. We know that these are the ones who are enacting these behaviours. There is definitely a power dynamic at play here, which has not been challenged. It has just been perpetuated and perpetuated. As I said before, there has been a long-standing culture of not being able to speak up or put your head above the parapet.

Q9 **Jackie Doyle-Price:** Is it because it is hierarchical?

Dr Jewitt: I think that plays a huge part. The thing is, we need the hierarchy because we need that clinical expertise. But just because you are a clinical expert does not mean you can assault your colleagues.

Q10 **Jackie Doyle-Price:** I put it that way because one of the ways that the NHS delivers its huge and complex array of services, in line with patient demand, is being managed through processes, which is actually quite de-humanising. It strikes me that the hierarchies within the healthcare delivery mechanisms are the same, where you are part of a process of care, as opposed to a person delivering care to a person, if you follow. I just wonder whether, if we had a more holistic approach to individual care pathways, as opposed to processes, that kind of behaviour could be teased out more easily?

Professor Ranger: We have to be clear about hierarchy and chain of command. We absolutely know that the safest thing is a chain of command. It keeps people safe. However, within that chain of command, anybody has to be able to raise a concern. We know that, with safety issues and when clinical issues go wrong, there is usually someone in the team that knew a mistake was happening. But if there is a culture where, because you are the scrub nurse or the porter, you cannot raise your concerns, that is where mistakes happen. We need to have that respect for chain of command and expertise, but it cannot be at the detriment of anybody raising a concern, the equality of opinions, and the equality of the right to be safe at work. I think that sometimes gets mixed up.

Q11 **Jackie Doyle-Price:** That reminds me—this is slightly tangential, but it does indicate the problems with culture—that the whole issues at Gosport were raised by nurses and dismissed because of where they sat in the chain of command. I think there is a cultural point here. Chelcie, would you expect to see the same in private medicine, or is that culturally different?

Dr Jewitt: Personally, I have never worked in private healthcare, but I know that most of private healthcare is staffed by people who also work in the NHS, so I suspect that these problems are going to be the same. I am not aware of any data, but I imagine that definitely needs to be looked into.

Q12 **Jackie Doyle-Price:** Do you have anything to add, Tamzin?

Ms Cuming: We sent our report to the Independent Healthcare Provider Network. I agree that clinicians are likely to work both in the NHS and privately. One important difference is that there are not usually trainees or students in the private sector, but at the same time you do not have that whole NHS structure, so people's jobs may be specifically related to one person, and the power may be even stronger in that sector. There is very little evidence out there. We did not specify NHS-working here, but there was a subset of people who were working in the NHS in England in our dataset. NHS England came out with a charter, which they have asked organisations to sign up to, and it might be advisable for networks of private healthcare providers to look into signing up to that charter.

Q13 **Jackie Doyle-Price:** I would like to ask a question about the whole array of organisations and different cultures within the NHS. Chelcie, did you find that there was more evidence in more remote areas, such as the ambulance service, than perhaps in a large general hospital, or was there not that kind of pattern?

Dr Jewitt: We do not have that data at the moment. We do know that there is definitely a culture of this within the ambulance sector as well. They have slightly different challenges because they are part of the blue light culture and overlap with the police services. Underneath our Surviving in Scrubs banner, we have Ambulance Voices, which is a campaign specifically related to the ambulance sector. We know that the ambulance sector is actually taking this really seriously. Last month, it published a dedicated body of work relating to sexual safety in the workplace, and they have a lot of ongoing working groups. I would argue that they are definitely further ahead than a lot of other areas in healthcare.

Q14 **Jackie Doyle-Price:** That is interesting—and, of course, they are probably the bit that is most public facing in an immediate sense. As you have all said, this behaviour ends up being normalised. Do you think that those perpetrators of bad behaviour do escalate? Is there evidence that certain individuals are just much more prevalent with their behaviour than others?

Dr Jewitt: Again, the data is limited. We have in papers that consultants are the most likely to be the perpetrators of harassment and assault, at the more violent end of the spectrum. On our website, we have multiple instances of harassment, and that does escalate. We have numerous case studies of this happening. Again, it is usually someone who is in a senior position. That is what we have as data and as evidence at the minute.

Ms Cuming: We also had reports of a similar thing where individuals would start with verbal. There is one quotation in the report about someone who started with being touched on the shoulder, then on the waist, and then, as that hadn't been repelled, the same person who had tried that out felt under her scrub top when she was changing. Then she felt guilty for not having done something about it at the earlier stages—so it all came back on her.

The work of the organisational psychologist we have been working with, Professor Ros Searle, for the report she published for the Professional Standards Authority, has shown that perpetrators sometimes test out the water by trying verbal, seeing how that goes down and, if that is tolerated, then progressing the behaviour. She wrote a report saying that it is not just bad apples, but bad barrels—maybe bad cellars. It isn't just a few bad apples—you might be encouraging people who otherwise would not act out this behaviour by having environments that are stressful, involve long hours and the power differential we have talked about, and are also tolerant of the early stages of this behaviour.

That is one reason that our report said that we maybe need to address this by looking at education and, as Nicola said, nipping it in the bud, getting in there at medical student level, getting in across the board, saying, "This is what sexual harassment is. You cannot say you didn't know, because you've had the education." It seems simple, but it's about having a policy saying, "Do not harass your colleagues. Do not harass your patients", and codes of conduct, so that at conferences there is a code of conduct and if you transgress it, there will be penalties—being ejected from the conference.

Q15 **Jackie Doyle-Price:** That is a really good point. One often neglected element of that kind of behaviour is that predators not only pick on vulnerable victims but pick on people to collude with and to cover that behaviour. That aspect of the behaviour is often neglected, but you can see how, in a culture like the NHS, that would be prevalent. We often refer to canteen culture, but it is where you effectively have a team, a brand, and it's us against the world that that kind of collusive behaviour becomes part of the tools. In terms of nipping it in the bud, it's really got to be zero tolerance and about empowering people to feel that they can speak out.

Professor Ranger: As Tamzin said, a lot of people are made to feel like they are the fly in the ointment, that they are not being resilient, and that they are a snowflake generation. There is a little bit of this, "Oh, it's all become very woke. In my day, there was a bit more banter." I think that is where it's got to stop from the beginning. The other thing I have certainly seen with nursing staff is people tracking people down on social media. That should not be underestimated. It's not just in the workplace; it's those unwanted advances that slip into, "I've tracked you down on WhatsApp, Facebook, Instagram." Before you know it, it goes outside the workplace as well.

Q16 **Jackie Doyle-Price:** Yes, of course it does. It's another tool of power.

I will start with you, Tamzin, for my final question. The surgical survey found that 10.9% of respondents experienced forced physical contact linked to their career opportunities. Did that number surprise you?

Ms Cuming: With all the results across here, we were not surprised, but at the same time we were shocked. I found that particular statistic the most upsetting, because that is the one that really illustrates the power differential. Ten per cent seems a high number, and that is all within the last five years for our respondents. This isn't something that has happened

in the past—this is happening now. What upsets us is the fact that you can't turn round and report that, because it gets shut down.

That is why we feel there ought to be recourse to report this to an external body—to say, "This happened to me. I just need a sign-off for this placement. I went to my consultant; I went to my educational supervisor." We have had reports where people have been all the way through that, up to the training programme director, and the whole thing has been shut down. There is nowhere else for them to go. There is a constant stream of people—there will be another one in six weeks' time—and this allows someone to do that continuously. That person is in position, exerting that power on a continual stream of people coming through as trainees.

That was the most upsetting thing. We heard a lot of stories that people had reported to us, that is why we embarked on this study in the first place. So we were, sadly, not surprised.

Professor Ranger: That is where royal colleges are extremely important because they are someone's professional body outside their reporting line. Those colleges are in a very strong position to be that safe place for nurses, doctors and clinicians. We have got to be stronger at being part of the solution within that.

Q17 **Jackie Doyle-Price:** Chelcie, anything to add?

Dr Jewitt: It is so difficult to find who to report these incidents to. I am a doctor in training, and I rotate every three, six months. Within the cohort of people I work with who are at my stage, we all know someone who you cannot be left alone with—we all know that person. But the culture is not there; we are not able to speak up and report them. When we have done so in the past, it gets shut down. That is at a trust level, but it is not a big enough issue for us to go to the GMC with, because the GMC does not think it is a GMC issue.

This is not just from my own personal experience; we are seeing this time and time again from the stories on our website. We know that these issues are long standing, that they are still going on, and that people do not have anywhere to turn. Currently, that unfortunately includes the royal colleges; we are not seeing them take ownership. No one is taking ownership of this problem.

Q18 **Jackie Doyle-Price:** Who would you like to see take ownership?

Dr Jewitt: I agree with Tamzin that it probably needs to be someone who is external. In healthcare, even though the NHS is a huge organisation, someone always knows someone else and there is only a certain degree of separation between people, so I think it should be some form of independent external body that people can go to. That body can then say, "This is a trust issue", "This is a GMC issue", or, "This is a college issue." That would be beneficial.

Jackie Doyle-Price: It is criminal behaviour. We are having this discussion here because you have criminal investigations, but if you are

going to nip this in the bud, we do not want it to get to criminal behaviour. We want to nip it earlier.

Dr Jewitt: Exactly. We have also been told that if something becomes a criminal investigation, the GMC does not want to know. Again, there is no ownership there.

Jackie Doyle-Price: I remember this with Paterson. This man mutilated his female patients on a regular basis, and nobody wanted to pick it up. In fact, the people who blew the whistle were the troublemakers. We will have to think about that. Thank you.

Q19 **Lia Nici:** Thank you to all three of you, and to your colleagues who are standing up on this. You have put your heads above the parapet, and we need you to because, as we have discussed, this is criminal behaviour; we have laws to supposedly stop this. It just shows that, in potential situations where the culture prevents that from happening, people end up in this terrible situation.

It has been reported that just one in ten hospital trusts have any policy or procedure to deal with sexual harassment or assault. Can I start with you first, Chelcie? Why do you think that is the case? Have you seen among your respondents any difference in the level of people saying they are having problems with those trusts that do not have policies and procedures compared to those that do, or do you think those that do have policies and procedures are still not doing anything anyway? Have you seen a spread of this situation across all hospital trusts?

Dr Jewitt: We are in the process of doing a preliminary analysis of the stories on our website, and at the moment there does not seem to be any difference in terms of where people are reporting from. We have not delved into whether those trusts have policies as such.

The other thing I would like to add is that this is very much talking about hospital trusts. We have to remember our general practice and primary care colleagues as well. That is a completely different ball game because they are smaller, company-based, business-based organisations where there may, in some places, be only a couple of GPs and a couple of practice nurses. There is no support out there for them at the moment either.

Q20 **Lia Nici:** Tamzin and Nicola, what are your thoughts on policies? How can this be a modern situation in an essential service? There are some trusts that have policies and procedures and do not seem to be taking any notice of them, and others that do not even have those policies and procedures when the acts that we are talking about are potentially criminal acts going on in the workplace?

Ms Cuming: I looked into my own trust. It is one little line. We have a bullying and harassment policy, and then it just says, "and sexual", at one point. I am thinking of the response when we first started trying to get backing for this research. People just felt it was too difficult and too hot to handle, and they did not want to engage with it. I think that probably

comes down to the same blinkered approach within trusts. I spoke to chief executive where I work. We have had meetings and we are going to try to lead the way and be a pilot in trying to introduce a policy and response to this. I do not think that has been the response everywhere, though. She was saying that, as a new person in the trust, she was not updated on previous incidents that have happened in our trusts and none of this ever gets up to board level. This is being suppressed at a low level. It is not being taken seriously.

Dr Jewitt: No one wants to admit that they have a problem.

Ms Cuming: That is the other thing: they do not want to be seen as an outlier.

Q21 **Lia Nici:** That is concerning in a profession where open discussion, learning from mistakes and highlighting where things have gone wrong is very important. I find it horrifying.

Ms Cuming: Again, that is in our report. It says that the data needs to be there and we need to be more transparent about it. We are now very transparent about patient safety incidents. We have a reporting system. We need something analogous for this that then comes up to board level and potentially is part of the CQC's assessment as to whether this is a good organisation or not. It must be taken seriously at every level, so that we can work out where the hotspots are. Where are the trusts that are managing this well and where are the trusts that are managing this badly? The data at that level is not there. Within trusts, where are the hotspots? I think you might need to consider an anonymous reporting system for that.

Q22 **Chair:** Surely we have to get to the point where it is such a hot potato that no trust wants to be seen not to be doing this. Rather than not wanting to admit it, we have to get them to the point where they go, "Yes, there is a problem here and we deal with it by doing A, B and C, as opposed to just pushing it under the carpet."

Professor Ranger: That is right, but enacting policies will be the key. There is a huge amount of under-reporting. As Tamzin said, we have improved safety through people reporting incidents and near misses. It may not have been something major, but it was a light bulb. People think they only have to report it if something serious happens. That is not true. It is the unwanted hand on your back or touching your bottom. It is all of that that makes people feel, "I don't want to make a fuss." Actually, if there is a way of reporting, you get the data. It takes leadership. It takes leadership because, particularly for medical staff, it is linked to power, and with that it becomes clinical services and everything else. Some CEOs will be very nervous about taking that on, and that is what has got to stop.

Q23 **Lia Nici:** Moving on from that, do you think that part of the issue here is that at board level there actually tend to be more clinicians who culturally are already invested in what is going on, rather than people coming from outside and saying, "Hang on. In my industry or profession we do it this way. Hello? Haven't you noticed that this is a gaping hole?" We always think, "We'll bring in clinicians, because they'll know how to run the

primary care trust,"—or the hospital trust or whatever—when actually you need some, if you like, new blood.

Professor Ranger: I think fresh eyes are always helpful. We know that anyone who works in the public sector, particularly in healthcare, has a higher potential of assault. That is there. So we have got to look at whether there are other professions or industries that are doing this better. But I think that healthcare is very complex in the fact that it is in teams and it is intimate. Saving someone's life is probably one of the most intimate things you can do as a team, and therefore it is far harder to step out and report, which is why we have got to break down that culture.

Q24 **Lia Nici:** This is for all of you: my background is in education, and if this kind of thing was going on in education, people would be horrified. I do not know if that is because generally they deal with children and therefore this is one of the biggest issues they have to deal with. At board level, when you come in as a new entrant or somebody moved to a new trust, you go through an induction. One of the things you talk about is appropriate behaviour, culture, what is and is not acceptable, and the chain of command of how you report that and how you are open. Is that not something that happens in any hospital trust?

Dr Jewitt: That absolutely does not happen. It has never happened in any of the inductions I have had at any of the trusts I have worked in.

Ms Cuming: It seems like such a basic thing, doesn't it? But we need to encourage that to be brought in.

Q25 **Lia Nici:** There has to be a difference between sexual assault and harassment, colleague to colleague—as you have already alluded to—and sexual assault and harassment, patient to professional, as well. They are two different things and they need to be treated differently, don't they?

Professor Ranger: I have worked at board level for 10 years in acute trusts. That reporting is very much starting to be there in more granular detail, patient to staff, but I am not sure it is at the same level, staff member to staff member. There are structures like Freedom to Speak Up Guardians, but I do not think people trust those. As Chelcie said, where that power over your career remains, that will always make things slightly more unsafe. It is about how we create that safety. Boards absolutely need to look at this. I think all of this is significantly under-reported, because there is still a massive fear factor in reporting. Chelcie, people would rather report to you than they would within their own organisation. That cannot be right.

Q26 **Lia Nici:** And their unions, clearly, as well. They do not feel safe to report to anybody. I can understand that. In large organisations, everybody would say as a way of undermining, "Nothing's really anonymous, because they'll be able to track you."

Interestingly, you talked before about how different it is in Iceland. I visited Iceland just a few weeks ago, and it is such a small population that everybody knows everybody. Do you think that anonymity, with people moving around the country and teams, can have a difference as well?

Everybody in smaller organisations—or countries, for that matter—knows each other, and your reputation goes along with you, whereas here perhaps you can hide your reputation a little bit.

Ms Cuming: People have said that in our research. Certainly, some people said, "This is the first time I've said this to anybody—that this happened." We work really hard to make this anonymous, in that you had to do it in one sitting, there were no cookies on your computer and there was no way of working out who had filled it in, because we just knew how hard it is to get the truth from people.

As you said, it's about being psychologically safe. You need a psychologically safe space in order to report this. But even with all those efforts we made to make this process anonymous, we still found that it was mainly the senior people who responded to it. You can only assume—and the GMC has changed good medical practice and there has been a new question for the trainees that came out this year. But half the trainees didn't answer it, because potentially you can be identified. If we're trying to uncover the scope of it and also have data to monitor any interventions we make, which is obviously quite important going forward, we need to have a psychologically safe way of monitoring.

Q27 **Lia Nici:** I suppose that if you ask in some research, "Which trust do you work at? What department? What job do you do?", you can identify that it will probably be one of six people, or whatever—or one person.

Ms Cuming: With some of the smaller specialties, you could, even in the region. That's why, with the results of this work, we have had to amalgamate some of the groups. Otherwise, they would have been too identifiable.

Q28 **Lia Nici:** Two last questions, because I don't want to monopolise time. First, last week we heard evidence from other witnesses about how women perhaps aren't listened to with regard to clinical conditions or issues. This is a question for all of you. Do you think there is a danger that women have been cancelled or not listened to for too long, and that now the worm is turning, because we are not willing to put up with this any longer? I know that's quite a controversial question. Chelcie?

Ms Cuming: I do not think it is a danger; I think it's high time that women were listened to. As the gender differences have shown with this research, there are things what we and the nursing structure have just taken as normal—we just take this in our stride—but a lot of the men working in this environment have no idea that this was happening.

There are a lot of male allies who are now able to listen because they just didn't know this was an issue. Maybe one of the reasons we've not been listened to is just a failure to appreciate the scope of the problem with some of the men who are in positions of power and just didn't understand what was happening. Yes, it's high time women were listened to.

Q29 **Lia Nici:** Following on from that—other colleagues? Chelcie or Nicola?

Professor Ranger: Nursing is a 90% female profession, as I said. I think that historically there has been a sense that it's part of the role—get on with it. It's absolutely key that we empower women to be able to report. I think that we as a college have looked and said, "We need more data, we need to actively make sure that we can be a safe space".

However, with regard to gender, I think it does have a significant part to play and, if I'm honest, not just about sexual assault and violence. I think nursing is in a very difficult place in this country—not being valued for the brain and the heart that you need to be a nurse, because we are 90% female. That has affected our pay, our terms and conditions, how we are treated, how we put up with it—absolutely wrong. I think it is absolutely time that nurses, as a profession, were respected for both their brains and their hearts, and this behaviour has got to stop, from patients as well as from colleagues.

It's time that we were respected for the absolutely vital role that we do. We are the closest to the patient, as the 24/7 presence. We're the ones who probably get the most physical and verbal abuse from patients. Where it makes a difference is when our colleagues work together with us to get this better.

Dr Jewitt: Women have been talking about this among themselves since they entered healthcare, full-stop. I think that now we're getting there in terms of the leadership—the female leadership—coming through. I think there is now some amplification of the female voice within healthcare. I think we've just got to the point where enough's enough and we want to change it. We want our voices heard, and that is definitely what all these pieces of work are starting to do.

We need more evidence, we need more research, and we need more time and finances put into this problem, because we know that most medical students now are female, nurses are 90% female and all the other allied health professions are predominantly female, so we need to look after the staff and we need to look after the wellbeing of the NHS.

Q30 **Lia Nici:** Do any of you know of any perpetrators of sexual assault or harassment, colleague-to-colleague, who have been disciplined or have lost their jobs because of their conduct?

Dr Jewitt: No. We have multiple case studies on our website where individuals have reported that they have been sexually harassed or sexually assaulted, and they as the victim have been either bullied to leave or have felt that they have had to leave for their own mental wellbeing, while the perpetrators have stayed in their role, and sometimes, have even been promoted.

Professor Ranger: It is a handful, but I have seen people lose their position and I have seen one very senior clinician sent to prison. There are some organisations where there are examples of good practice, but it takes courage and structure and it takes leadership, actually, to really sort this out. It is not easy, but I have seen it. It usually takes one or two

brave people and it just opens a floodgate. Then, absolutely, in a structured way, I have seen clinicians dismissed, both at medical consultant and managerial level.

Ms Cuming: I have also seen it. What was interesting was that we were told nothing about it. I only know why that person was dismissed by rumour. All we know is that he was there one day and the next minute we were saying, "Oh, where has he gone?" and then we were saying, "Oh, he has been sacked." But you have just heard it from rumour. There was no ability of the organisation to learn from it; it was all hushed up.

What Ros Searle has done is look at all the fitness to practise cases that came in front of the nursing regulator and the GMC. She has shown that yes, the sanctions were unequal between the regulators, but the sanctions are unequally applied and sometimes were unreasonable. People have been allowed to go back to work with a fairly minor slap on the wrist when, if anyone reasonable looked at what they have been reported as doing, you would be horrified.

There are many ways in which reform needs to be brought about. I know that the GMC has already been looking into reforming its own processes. But as you say, at the moment, even for people who are brave enough to report, quite a lot of times with some of the processes that have been recorded that they have been through, they have been retraumatised in that process. The people they report to have had no training on how to take that report and no training on how not to retraumatise someone.

They have had to go through multiple episodes, quite similar to some of the things we have heard from the police. Their integrity is brought into—the victim is questioned and sometimes the perpetrator is not questioned at all, or people have reported the perpetrator either not being questioned at all or being questioned in a very light-hearted manner. There is one in our report, quite upsettingly, where the perpetrator turned round to the victim after the hearing and said, "Why would they take the opinion of a silly little girl?" That is after the report; that was the outcome of her reporting.

Q31 **Lia Nici:** Thank you. I have a final question, Tamzin, Nicola and Chelcie. Hospital trusts, primary care and private clinics will all be listening to what you have to say. What is the most influential thing they need to do tomorrow to change that culture in those organisations to get this stopped?

Ms Cuming: People who do not have a sexual safety policy should have one. The process of looking at that, bringing it in and dealing with the results of reports will already start changing the way that reports are received. There are many other things that need to be done. Read our report and implement our recommendations, is the other thing I would say.

Professor Ranger: There has been significant improvement in things like child safeguarding, where the real onus is: report it. You don't have to

make a judgment about what the sanction is. Just report it to somebody. Somebody else will look at that information, and it will go through a very balanced overview.

I think sometimes people feel that they are scared to report, and so much would go on if someone were to just tell a colleague and then somebody escalates it. I know it is difficult with regard to whether the structures are there, but sometimes there are a lot of people suffering in silence, and we at least need to have a way of getting people to speak out, and with clear guidance around creating safety to report. We have to change the culture.

Dr Jewitt: I very much agree with regard to the reporting structures. They definitely need to be there. But in terms of what the most powerful thing could be, trusts need to admit that they have a problem and find it. That would be the most powerful thing. We know from the evidence out there that this is a healthcare-wide problem, and people are scared to speak up and speak out. There is a responsibility on trusts and organisations to go looking for this problem so that it does not continue. That is the most powerful thing that can be done.

Q32 **Chair:** Can I just pick up something you said, Nicola—that it is just a hand on the bottom? That is sexual assault. That is criminal.

Professor Ranger: It is.

Q33 **Chair:** I wonder whether there is a real challenge around the microaggressions being glossed over or ignored, where people think, "I'm just going to deal with it. I don't care. It didn't bother me so I don't need to report it", which then escalates. Should there be a duty on members of staff to report things like that that they have witnessed, rather than that happened to them?

Professor Ranger: I think you are absolutely right. This is why I worry that people do not see things for what they are, which is why things escalate. It is never just a hand on the bottom. I think there are a lot—talking for nursing staff—who literally think that sometimes it is just part of the job. That is not okay. When reporting and raising concerns, people tend to feel safer when they are not on their own.

You made the point about looking out for your colleagues and what you saw that was not appropriate. The way to create culture change is to be vigilant. As Chelcie said, look for it. It is not okay. I saw it as a chief nurse. Some people were just putting up with things that were totally unacceptable, actually. It is about really having the support of the local leadership to call it out and stand up for people—and in the moment. That is the other thing that really gets to me; people wait to fill out a Datix until the end of the day when they are sitting in the office. What did we do in the moment when that patient grabbed someone's breast and put their hands in between their legs? What did we do in the moment? I think it is about creating the culture of sorting it out and dealing with it in the moment. Reporting is sometimes in retrospect.

Q34 **Chair:** It is almost invariably in retrospect.

Dr Jewitt: I would just like to add to that. On the example you gave of direct physical sexual assault, absolutely in that instance something should be done at that moment. I do think that there should be a duty on colleagues in the healthcare industry to look after other colleagues.

When it comes to reporting on someone's behalf or reporting something that you witnessed, I think there needs to be a bit of caution there, because there is a tendency to come in as a bit of a saviour—"My colleague has been sexually assaulted," or "Dr Y did this to Dr Z"—and actually that victim might not have the psychological strength or capacity at that point to go through any form of investigation.

Again, going back to the reporting system, we would like to see something anonymous, so that, yes, you are naming the perpetrator, because they need to be held accountable, but you are protecting the victim if, at that point, they do not feel that they can take something forward. That would be the only thing I would want to say on that.

Q35 **Chair:** Finding a reporting mechanism that works is a real minefield. May I ask one question? I am about to be terribly political, and I apologise. Here, we have the Valuing Everyone training, and that applied from the Theresa May Government onwards: you had to go through it. The response from many colleagues was that this was woke nonsense and they were not going to subject themselves to it. Should there be something similar in the NHS, and what do you imagine the level of push-back to that would be?

Ms Cuming: I think there should be. I think we all go through mandatory training on a number of issues, and there should absolutely be something at least on the definitions of what constitutes sexual harassment and examples, so that those are known by people. There are ways of making this more effective. Having to click through an online training programme is likely to have very little influence, and again there is a lack of data at the moment as to what the most effective training is, but certainly you can do simulations and rehearsals, which empower people to speak out.

As you say, we have to be careful; some of these people do not feel empowered to speak out. Having some level of mandatory training would help, but we also have to be careful to make sure that we are not always focusing on the victim or the people who are targeted as the people who have to sort this out. From our evidence, more women witness sexual misconduct, and more women are victims of it and are targeted. It is not just up to us to try to solve this problem. That is the advantage of having universal education: you can try to get it to the people who most need it, who are the people least likely to come forward.

Q36 **Carolyn Harris:** Nicola, how much is this contributing to staff retention issues?

Professor Ranger: I really do think it has a huge effect on staff retention. I think we need to have more data. It is probably slightly different from what Tamzin and Chelcie have described, but I think the amount of abuse—physical assault—that nurses are enduring is at a scale that I have certainly never seen. When you put that into account with

being short- staffed, with regard to pay and with the pressure in the system, people are saying, "Why am I doing this? I can do something somewhere else, where I am safer, not being spat at and not being bitten." Genuinely, I think it is having a huge impact on retention.

I think it is a real tragedy. It is a wake-up call all round. We will not have a health service if we do not look after staff. The health service is made up of its staff, and of them a very large percentage are women—90% of nurses, as I keep saying. We need to start valuing them. There are 40,000 vacancies. That is not sustainable. As you saw, for the first time in the royal college's history, nurses went on strike. I never thought I would see that. If you listened to them, it was not just about pay: it was conditions, their concern about their patients and so on.

Q37 **Carolyn Harris:** Do you feel that there is a difference between the numbers of victims, if you like, among junior nurses and among sisters? Does the issue appear to be different among different roles and grades?

Professor Ranger: I think it is, because it is often those closest to the patient who tend to be the more junior in nursing. Given the power base, sometimes, in the medical profession, it is those who are the more junior. I am not saying that it does not happen to others, because it does, but I think that is where the challenge tends to be.

Q38 **Carolyn Harris:** Tamzin and Chelcie, is there anything you want to add to that?

Dr Jewitt: Just to go back to the attrition rates of staff in healthcare, when Unison published a survey in 2019 looking at allied health professions, including nursing, the data showed that 40% of allied health professions were thinking about leaving their job in relation to this kind of thing. I actually went looking for this for the medical profession the other day, but the data is not collected. There is the GMC leavers data, but it doesn't collect data regarding sexual harassment, assault, sexism and so on the workplace, and the BMA does not collect this data either. There is some work there that needs to be done.

But looking again at our website, we are seeing multiple people leaving their organisation, moving organisations, leaving their specialty, leaving their job, leaving their job role or leaving healthcare altogether. We do know that it is having an impact. Even if the data is just one nurse, that one nurse is such a valuable resource to healthcare. One leaving for these reasons is one too many.

Ms Cuming: In the same way, we also have the data from our research—I think we had 872 people give us details about their sexual harassment. One consultant surgeon said that she had resigned from her role because of the constant misogyny and comments; she said that sexual harassment is endemic. These are really damning things to hear. Think of how much time and effort it takes to train to be a consultant surgeon, and then to be driven out by this kind of behaviour.

When we look at trying to improve the working conditions, this is such an important part of it for women, and many others—our data wasn't able to look into the breakdown of non-binary gender, but we know that if you have other protected characteristics, such as ethnicity, the rate of abuse is higher. It is such an urgent problem to address, because improving the workplace conditions for people working in the NHS will both improve retention and probably have implications for patient safety as well.

Q39 **Carolyn Harris:** My next question is about data, which you mentioned. There isn't any data on the difference between women and men surgeons leaving the health service. Why is that not being gathered?

Ms Cuming: We are looking into that. The Royal College of Surgeons of England has just done a census, which is one of the first times we have actually started to get data looking at lots of things, such as how hard people are working, how often they are getting to theatre and how near they are to burnout. That is about to be published, and we have asked for that to be broken down by gender, so we are going to get some information. Hopefully that will then be repeated.

There are studies that have shown that it is about not just attrition, but people's depression and suicidal ideation, which happens in nursing and medicine. People who have been subjected to this kind of behaviour are more likely to leave, but also more likely to have that kind of serious depression and those thoughts. It is an urgent thing to address. It has been an urgent thing to address for years, but now we need to get to the point of doing something.

Q40 **Carolyn Harris:** I do not want this to sound like I think under any circumstances that nurses are not absolutely wonderful, because they are, and I don't believe they would allow whatever has happened to them to affect the service that they give to patients. But is there the danger that this kind of situation is going to affect patient care, with the amount of incidents you talk about?

Professor Ranger: I think we know at this moment in time that one of the biggest problems with morale and frustration is that sometimes people aren't able to give the care that they want to give, just generally. I think it's difficult for people, and nurses particularly. Sometimes they are in situations where they are concerned that the person is so difficult—how do we ensure that we give good care? I think, sadly, we have had examples where care has been appalling. We have seen that in some of the horrific inquiries and undercover. So to say that nurses don't sometimes give poor care is absolutely untrue—we know that.

With regard to violence and aggression or sexual assault affecting a patient's care, in hospitals particularly there is something about discussing and agreeing how we are going to manage that. I have seen areas of good practice where it is open. People are quite honest when a patient is very difficult to look after, and they put in very clear instructions about never going in on your own and always being in a group, and how to manage

that. I have seen areas of good practice, so it doesn't affect patient care, but that takes a good culture and good leadership.

Carolyn Harris: And management.

Professor Ranger: I can see that if you didn't have that structure, patients could be vulnerable.

Q41 **Carolyn Harris:** It takes dedication as well, doesn't it? It is a vocation.

Professor Ranger: Exactly.

Q42 **Carolyn Harris:** Can I come back to something you said earlier, Tamzin, about somebody maybe being there one day and not there the next, and nobody really knows why? Unfortunately, that is true in so many walks of life. So often, I will hear about people anecdotally, and nobody seems to know what happened to them. They disappear into the ether. That is not a good indictment on society, full stop, is it?

Ms Cuming: No, absolutely not. If that has happened, there should be an open discussion about it. As you were saying, it is part of trusts starting to own this and recognise that it happens. That is the beginning of trying to look into areas where they have a particular issue.

Coming back to patient impact, there is good evidence that a dysfunctional team will produce worse outcomes. You can imagine that if you have a surgical operation where one of the people is constantly moving away from somebody else because they are trying to invade their personal space or touch them, the outcome for the patient may not be as good as in a situation where that is not happening. Although our report didn't specifically look at the impact on patients, there is enough evidence to see that if this kind of behaviour is happening commonly, there is going to be a knock-on effect on how well that team is functioning.

Carolyn Harris: Thank you to the three of you. Thanks, Chair.

Q43 **Kate Osborne:** Before I move on to my questions, which are about the next steps, I want to pick up on something from what Carolyn said. She was asking you about retention, but I want to ask you about recruitment. In the NHS, I think there are over 120,000 vacancies. How widely do you think these issues with the culture and so on are known about outside the NHS, and do you think that might be a barrier to people joining the NHS in the first place?

Dr Jewitt: I think that this issue in healthcare has parallels in other industries—we have heard about the police, the film industry and education as well. I don't think that this is a purely healthcare issue; it is a societal issue. There are a lot of other issues that are impacting recruitment of staff in the NHS at the moment, in addition to this culture.

Ms Cuming: When we brought up this subject, people said to me, "You're going to put off women becoming surgeons." My concern is that if women become surgeons only to be sexually assaulted, maybe women shouldn't be surgeons until we have sorted it out. We discussed this at our women's

surgery conference in September, and we were pleased to hear that some of the younger women who were considering entering surgery were relieved that we were talking about it. They were not put off coming into surgery because they felt that we have at least begun to address it. All of this is a sort of double-edged sword. By bringing it out into the open, admitting that it happens and starting to take steps to improve the culture, we are hopefully going to make the NHS, and surgery in particular, a more attractive place to work.

Dr Jewitt: As a non-surgeon, I would like to reiterate that we have also heard that: the fact that surgery is owning its problem is making women feel that they will be safer in the future. Whereas, in other specialities, particularly acute specialities—such as my own in emergency medicine, acute medicine—this is not being talked about, and there is a lot of overlap in terms of the culture, the hierarchy, that kind of thing. I think talking about it is a positive step. It might have a negative impact initially, but long term it makes women feel they will be safer at work in the future.

Professor Ranger: Exactly what Tamzin and Chelcie have said. We need to talk about all the challenges, because that is the right thing to do. But I also think—without wanting to sound corny—we need to talk up at times what is great. It is still a privilege, I believe, to look after people at the most vulnerable times in their lives. We are absolutely right to raise legitimate concerns, but we have to structurally sort out the problems, and also think about our responsibility to recruit people. It is about recruiting them and talking up our professions, but also about being really honest about the challenges. Sadly, at the moment, everyone in healthcare needs to feel more valued with regard to the work they are doing.

Q44 **Kate Osborne:** Thank you all for that. We have to accept that the NHS is not immune from sexism and attitudes that are in our wider society, which I think we all have acknowledged. Reading the report was very upsetting, and I certainly send my solidarity to all the NHS staff who have been able to speak out on this. Nicola, you referred earlier to courage and leadership, so I thank the three of you for your courage and leadership on this issue.

NHS England has said that it will take a zero-tolerance approach when it comes to sexual harassment. What do you expect a zero-tolerance approach to look like?

Professor Ranger: I have to be really honest: I think it is very easy to make broad commitments like this. What we have shown is there is not enough data and evidence. People do not feel brave enough to speak up. To have a view of zero tolerance, while we support it, it needs far more work and data. I think these reports probably just scratch the surface, so it is very difficult. We cannot have slogans; we have to have action. That is about supporting people and really listening. My son jokingly said to me that his teacher told him, "You've got two ears and one mouth for a reason", and I think that is true. We do not do enough genuine listening. We are jumping to the solution and jumping to the slogan without taking the time to really listen to the genuine experiences of our staff in the

health service. That is absolutely key. People often know the solution themselves, so let's take the time to really listen, to collect the data and to find a solution that actually works.

These things are not going to be solved quickly. As you say, some of them are inherent structures that have gone on for a long time, but it has been a wake-up call. Certainly, at the college, I do not think our data has been strong enough. We have not been looking for it enough. This report, led by my two colleagues next to me, has been a wake-up call for the college. We have to have better data and overtly look and listen for those experiences.

Ms Cuming: I totally agree with Nicola there. Zero tolerance is a phrase that is reassuring to hear, but we now have to see it put into practice. What will that look like? If it is overly punitive— There are sexist comments and infractions where what could happen is someone needs to be taken to one side and told, "That's not appropriate", either in the moment or afterwards, whenever it is safe. That might be someone who has witnessed it, or they might have anonymously reported it. But everything does not need to go to a major response. If we can start to limit those more minor infractions, some people might say, "I don't know what to say," but it is about not having sexist jokes in a professional environment, Civility Saves Lives campaigns for civil working relationships. These things will themselves be changing the culture, and the NHS is so huge. The thing we can look out for is that we could potentially impact society if indeed we can bring about these changes within the NHS. I think it will be difficult. I admire the fact that that is what we are aiming for. We need to look at the granularity of how we bring it about.

Q45 **Kate Osborne:** Why do you think it took them up until two months ago to include it in their good medical practice professional standards?

Ms Cuming: I cannot say why, but I am very pleased that it has now been included. It is a long overdue change. Again, from what we have shown, if a lot of men are involved in creating standards— I have no idea who was involved in creating the standards, but some of the men may not have been aware of the extent of this. From the evidence we have, all the women knew it was happening but thought it was normal and did not think to bring it anyone's attention, and the men were not aware it was happening. That is why it can just have been, "Oh, it's a minor thing that happens in rare instances." Coming to the awareness that this is actually highly prevalent is very important. Then we start seeing it come into the thinking of NHS England, of GMC and of the other regulators. We just have to start to see that get through to the end point. At the moment, people who are currently reporting are still having an awful time. When are we going to see that change, and how are we going to get it from ambitions and things written down in policies to changes on the ground?

Dr Jewitt: The term "zero tolerance"—it is great to aim for it, but I don't think it is realistic. We need sanctions to be proportionate. Zero tolerance, to me, sounds as though someone who makes an off-colour joke is going to have their licence revoked, and that is not realistic. We need something that is proportionate to the offence. If someone is undertaking criminal

behaviour, they should undergo criminal proceedings. If someone says something a bit off-colour that is not quite right in keeping with codes of conduct and so forth, they should have education and training. There is real potential here to start doing so many things in tandem. We need further data. We need organisations to have a look at what is going on within them. We need the reporting structures to be, as we have said, anonymous, standardised and psychologically safe. We need them to support victims. We need to listen to victims, because we need to know what they want, what can help and what can be beneficial for them. We need to support them.

Education and training start in universities. This is professionalism at the end of day, and it should be intertwined into all curriculums—undergraduate and postgraduate. It should be coming into appraisals yearly. If you have a training portfolio, it should come into that. Induction—every time someone starts a new job, there is an opportunity to really start ingraining good culture into healthcare. There is just so much scope for what can be done here, and I think lots of potentially quite simple things can be implemented that can be highly effective.

Professor Ranger: Can I just add something that I think is really important, particularly for women? We hear the word "victim" and we sometimes think of someone who is vulnerable. It is the message that this happens to strong, articulate, brilliant women. There is something that is psychological: when you hear "victim", people sometimes automatically think of someone who is vulnerable. It is about getting the message out that this happens to extraordinary women who are very strong in many areas of their lives, which is why it is so difficult. I think it is important that we really get that message across; this can happen to anyone. We sometimes have an image of a victim, and I think it is important that we recognise that there isn't one type of victim. There is something really important in that.

Dr Jewitt: This is why our campaign is called Surviving in Scrubs, because the women who are experiencing these issues are surviving; they are continuing to work and continuing to provide patient care while dealing with trauma, in an environment where they should not be experiencing this. They are professional women.

Ms Cuming: That is also why we avoided using the term "victim" in our report. It was for exactly that reason. Lots of people do not identify as victims. They don't see themselves as victims; they are just angry.

Q46 **Kate Osborne:** Thank you. Does NHS England's new organisational charter on sexual safety go far enough? Do you think that it will be effective in making the NHS a safer place to work?

Professor Ranger: The Royal College of Nursing did sign up to that, which I think is right, but I personally agree with what Chelcie has said, in that sometimes, when we use language like "zero tolerance", it can give a very simplistic sense of what we are trying to achieve. The difficulty is that

it is far more complex than people sometimes fully understand, if I am honest.

Ms Cuming: I was really pleased to see it, and I think that the NHS England group behind it would accept that this is not the end of it. Just bringing out this charter was not expected to be the only answer, but it is a great first step and it has written down the ambitions. If all those ambitions can be brought to fruition, somehow, we really will have gone a long way to changing culture. So, it is ambitious, but now we have to look at the detail of getting those changes in place.

It is also interesting that there was then a call for people to sign up to it, so we can see the people who have or haven't and the speed in which, and interest that organisations have, in signing up to it. You have to look at yourself and decide whether you actually are willing to agree with it and sign up to up. I think that that will be helpful in the future—to look at those organisations that have stepped forward and said, "Yes, we are in the vanguard of working on this, and we are with you." In that way, I welcome it.

Dr Jewitt: It is a great first step. I would also mention that the BMA has brought a charter in as well, which has been signed by about 70 healthcare organisations—I can't remember the exact numbers. So there are two really good charters—two pieces of work—out there, but we need action now, not just words, and this is where time will tell, and we will see what an impact that makes. Hopefully, if all the ambitions that are in there are brought about, there will be a real, seismic change in culture.

Q47 **Kate Osborne:** What do you think trusts should be doing more, in terms of supporting colleagues who have been sexually assaulted or harassed?

Dr Jewitt: Trusts definitely need a policy on this. As we heard before, only 10% of trusts within England have a sexual misconduct policy. The policy needs to be implemented in collaboration with survivors of these behaviours, so that it is putting them into the focus, so that systems are streamlined and easy to navigate, and so that it minimises re-trauma for survivors. Organisations, trusts, need to bring in education and training. They need to own their problem. They need to publish reports that are happening, and their numbers. There needs to be some way of psychologically supporting survivors, whether that be psychologists in a trust specifically working on those issues or mentoring groups. There is so much.

Professor Ranger: As Chelcie said, we have to listen and act quicker. Sometimes we feel that trusts have to behave like a court of law and everything has to be beyond reasonable doubt, whereas we could be looking at something as a probability, a pattern, an act. Sometimes the bar is too high for action. As a result, as was said earlier, people get more confident and it becomes turning a blind eye before you know it. I don't think you always have to prove it; you have to go on probability, listen to what the person says and act.

Sometimes people say, "Put it in writing. Are you sure you didn't imagine it? Has anyone else noticed?" What that is doing is exactly putting the onus on the person to prove that something significant happened to them. No. We have to have organisations act far more quickly, whether it is a conversation or something more formal, but we do not have to build a massive body of evidence before we take action.

Ms Cuming: That is very important: believe the person reporting. That is the first thing. Give them their dignity by believing them. Have someone available—probably more than one, because with different people working in a hospital, some will want to report to a doctor and some will want not to report to a doctor. Have trained people who are able to take those reports and who are not terrified by hearing it. Some people are just the official line person you have to report to, but they might not have been trained in how to receive that kind of report.

Yes, if you have a policy in place, it will say what the response should be, so without that policy, we get a huge range of responses. If you are going to report something, having either witnessed or experienced it, you will know what happens next: that you will be supported and believed. That will make more people willing to come forward in a named way.

Also, have that option of reporting anonymously and keep that. If you say, "This happened to me. No, I don't want to take it any further," but then the next person also reports that same thing, we are building up a pattern of evidence. The organisation, whatever it is, needs a memory, so that it can come back and say, "We know there is a problem"—for example—"in this particular surgical department in this hospital. We have had a series of anonymous reports and now we have had someone who is prepared to report." We would then have more evidence than just, "It's my word against their word", which is often where this stops.

Q48 **Kate Osborne:** As with so many other areas, the Government have been accused of inaction in response to the surgical survey. What role do you think that the Government should play in tackling the issues highlighted? What action would you like to see?

Ms Cuming: We would like our recommendations to be implemented—much of that is what we have talked about here. As with the gender pay gap group, we would like an implementation group to make sure that this is not just a report that sits on a shelf and gathers dust, but that every single area is thought about and that we try to bring it in. We also want serious thought, ideally, to be brought to the idea of an external body to receive such reports and that can be a place for experts. If a trust, or healthcare or primary care person in that setting, cannot report through their local routes, they would have recourse to that body. Those are important.

Other things in the report as recommendations are education within trusts, which we have talked about a lot with other healthcare organisations, culture change and gathering data. It is about seeing that and boosting and supporting the response of NHS England and the NHS in the other

countries to this. That needs support and to bring in what we have asked for, which is that data is collected and then brought to the CQC. I think that Government might have some power to influence that and ensure this subject and occurrences of it in healthcare organisations are taken seriously and considered part of how good those organisations are and where they need to improve. Taking that blue sky thinking view of this, it is about both having recourse to experts so that the reporting system can be sorted out and having access to data in an ongoing way.

Professor Ranger: I agree with what has been said. I think we need a strategy that really is strong around sexual violence and aggression in the workplace with regard to structures and reporting. We need to really recognise that organisations need to invest in this, because actually there is no NHS without its workforce—there just isn't. At the moment, in so many ways we are just not seeing that full recognition, and women are a major part of that; they have to feel safe. The Government need to be strong with NHS England and every sector of healthcare in the UK to ensure that this is taken seriously and is not just another report. The real danger, sometimes, is that we get a report and then another one. You look back on some subjects and they have been reported on many times. This is highlighting that. As has been said, we want action that will make a difference so that we do not sit here, look back on this report and see that the same things are still happening.

Dr Jewitt: I would just repeat exactly what my colleagues here have said. I think the Government have the opportunity to have that real overview of what is going on—to have some form of independent piece of work to fully identify and define exactly what is going on, not just in surgery or nursing but in the whole of healthcare. We are doctors and nurses, but we have our other colleagues to think about as well—physios, occupational therapists etc. Such a huge number of people will be affected by this. Going back to what Tamzin said earlier, we can make a real dint in the misogynistic culture in the NHS. The NHS affects every single person in this country at one point or another in their life, whether it be on the day they are born, the day they die or somewhere in between, so there is a real possibility that we can make an impact on the whole of society. What is the phrase? "Shoot for the stars and you land on the moon", or something along those lines.

Chair: Can I thank all the witnesses for the evidence they have given? Is there anything else you would like to say that you feel we have omitted or that you have not been asked about? You are not obliged to do so.

Professor Ranger: Just thank you for the opportunity.

Chair: Thank you. I appreciate that what you have shared yourselves and on behalf of many colleagues will have been very difficult for many of us to hear—it was very difficult for me to hear—so it is hugely appreciated.