AN HCSA REPORT

HCSA
The hospital doctors' union

ACTION NOT WORDS

TACKLING SEXUAL HARASSMENT IN MEDICINE

*The trade union for **all** hospital doctors, wherever you are in your career*

www.hcsa.com

About this report

Methodology

This report is based on testimony provided by 319 hospital doctors via online survey conducted in July 2023.

Respondents were asked a range of multiple choice questions and given the opportunity to give qualitative data in the form of longer open-ended answers.

All quotations included within this report are from survey participants, with specific permission for their anonymous use and publication.

An additional case study was provided by an HCSA member willing to share their own experiences of sexual harassment at work. This is clearly identified as such in this report.

Demographics

Just over half (55.0 percent) of respondents identified as male, 40.9 percent as female, and 1.5 percent as non-binary or other. A further 2.5 percent did not provide a gender.

Around three-quarters (75.5 percent) of respondents stated they were white, 12.0 percent were Asian or Asian British, with 2.5 percent Black, Black British, Caribbean or African and a further 3.5 percent in mixed or multiple ethnic groups.

Respondents were also asked to state their age, with the 18-24 age bracket accounting for 0.9 percent, 24-34 13.2 percent, 35-44 22.9 percent, 45-54 29.5 percent, 55-64 27.3 percent, and over-65s representing 6.3 percent of respondents.

In terms of grade, 73.5 percent stated they were a consultant, 13.7 percent were specialty trainees, 3.8 percent core trainees, 2.9 percent SAS grades, 1.9 percent foundation trainees, and 1.6 percent medical students. A further 2.6 percent were locally employed doctors.

Full-time hospital doctors accounted for 73.3 percent of respondents, with 26.7 percent working less than full time.

Structure

This report is composed of four parts. The first sets out the background which motivated HCSA's focus on this area. The second describes the findings of our research. The third explores the implications of our findings. The final part presents recommendations for change.

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Foreword

"Words are not enough"

Isslia Roberts
HCSA National Officer

HCSA is committed to helping members tackle sexual harassment within medicine and dedicated to creating positive, tangible change for the benefit of the medical profession more widely.

Sexual harassment is by no means a new topic. It has attracted renewed attention more recently with movements such as MeToo and a seeming increase in workers across different sectors feeling empowered to speak up.

Numerous reports have already been written on the matter. But words are not enough. Action and meaningful change are needed.

I commend the courage, bravery and strength of all those who have contributed to HCSA's research, those who have experienced and/or witnessed sexual harassment and those who have shared their stories.

Our voices and the stories shared are powerful and will help support the case for meaningful change. This report highlights there is still much work to be done.

HCSA is committed to helping to tackle sexual harassment in the workplace, taking tangible positive actions to educate and empower doctors, with the aim of eradicating sexual misconduct experiences for our members, for the profession and for the future.

Sensitivity warning

Please note this report contains wording on sexual misconduct/sexual harassment and sensitive information which some may find distressing. This report highlights sensitive issues and examines real life experiences shared by those impacted by sexual harassment.

Within this report the terms 'victim' and 'survivor' are both used. The use of 'victim' refers to the legal term and does not seek to reinforce any negative connotations.

Background

Sexual harassment in medicine

Once an exclusively male profession, medicine has undergone a drastic demographic change over past decades. The General Medical Council's 2023 Workforce Report detailed this change.

In 2022, 49 percent of licensed doctors were female and 51 percent male – down from over 56 percent in a decade. With 52 percent of doctors joining the workforce now women, and men making up over half of leavers, that demographic trend will only continue. Soon, medicine will be a majority female profession.

This seismic change to the landscape means medicine is required to be a safe and welcoming space for women.

However, women are still underrepresented in senior roles. Research on behalf of NHS England found that fewer than 25 percent of medical director posts were held by women.

Beneath the headline figures some specialities, most notably surgery, retain a significant gender imbalance. The GMC reports that in 2022 only 16 percent of registered surgeons were women. The high rates of sexual harassment within the specialism were exposed by the Working Party on Sexual Misconduct in Surgery, which revealed that two-thirds of women surgeons and almost a quarter of their male counterparts had been the target of sexual harassment. Yet only 16 percent of those impacted by sexual misconduct had made a formal report.

Sexual harassment is not gender specific, but the data and statistics show that more women than men experience it in the workplace, including within healthcare settings. It disproportionately impacts women.

Yet historically incidents are underreported and under-investigated. A BMJ/Guardian study of sexual harassment in the NHS revealed that 193 of 212 trusts in England had reported only 10 or fewer staff-on-staff incidents in the five years to 2022 despite a combined workforce numbering into hundreds of thousands.

While 4,000 NHS staff had been accused of rape, sexual assault, harassment, stalking or abusive remarks towards other staff or patients over the same period, the report authors found trusts had taken action against just 577.

The Health and Safety Executive's Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) fail to define sexual harassment as a health and safety matter despite it representing a clear form of workplace violence. This closes an obvious way to measure the impact of sexual harassment. Instead, the majority of incidents take place under the radar.

SEXUAL HARASSMENT – LEGISLATION

The law is clear. It states that everyone has the right to a safe and healthy working environment, without fear of inappropriate or uncomfortable behaviour or harassment of any kind. This is an absolute right enshrined in UK law.

The definition of sexual harassment is quite broad, deemed as "unwanted conduct of a sexual nature". Conduct can include jokes or "banter", sexual comments, sexually explicit photos or messages, gestures, being propositioned, unwanted touching, hugging and kissing.

Under the Worker Protection (Amendment of Equality Act 2010), in force from 26 October 2024, employers are legally responsible if an employee is sexually harassed at work by another employee and the employer has not taken "reasonable steps" to prevent it from happening.

However, provisions in the draft Bill to make employers legally liable for protecting their staff against third-party harassment were opposed in the Lords and removed from the legislation.

TACKLING SEXUAL HARASSMENT IN MEDICINE

In recent years there has been growing and welcome recognition of sexual harassment within medicine and healthcare settings more widely, acknowledging its significance and the impact on victims, who continue to be disproportionately women. Yet there

still appears to be little acceptance of the responsibility of employers to actively contribute to female employees' health and wellbeing at work by tackling sexual harassment.

NHS England launched its first ever sexual safety charter in September 2023, which commits whole organisations and their staff to a zero-tolerance approach – a welcome step to acknowledge the seriousness of the problem. But it remains to be seen what tangible change this will bring on the ground.

Similarly, new GMC professional standards in January 2024 introduced explicit rules on sexual harassment towards colleagues, stating that doctors "must not act in a sexual way towards colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress."

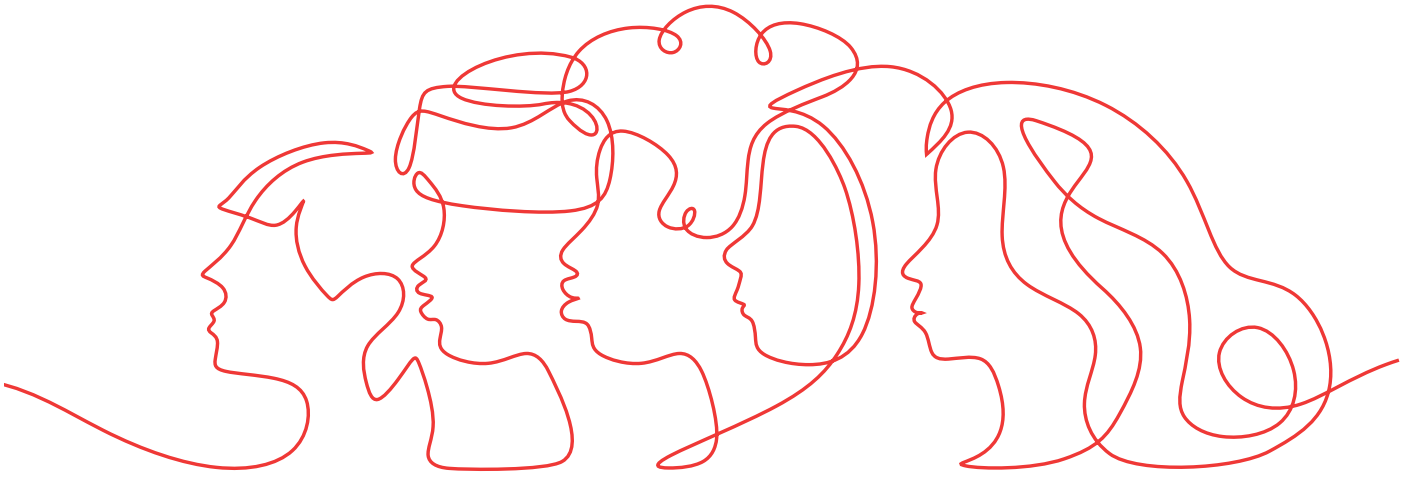
These developments are undoubtedly positive, but in order to be effective will require a sea change in the under-reporting and under-investigation of such incidents, as well as a far-reaching cultural shift.

HCSA is committed to tackling and eliminating sexual harassment in all its forms and to supporting victims. That means maintaining attention on this issue and empowering doctors to challenge misconduct.

Further, it means making employers understand the negative impact of their failure to address the issues, including failing to provide genuine support, trust and confidence to staff who report or seek to address such behaviour.

This research project is aimed at exploring the complex factors underpinning sexual harassment in medicine. It seeks to understand the factors which must be addressed by all stakeholders, and in particular employers, if the NHS is to move from recognising its significance to truly working to eliminate it.

There still appears to be little acceptance of the responsibility of employers to actively contribute to female employees' health and wellbeing at work by tackling sexual harassment.



Detailed findings

Experiences of sexual harassment at work

FREQUENCY OF SEXUAL HARASSMENT AT WORK

An overwhelming majority (70.5 percent) of respondents stated that they had witnessed or experienced sexual harassment in the workplace during their medical career. The figure rises to 78.4 percent when narrowed to responses from female doctors.

These range from inappropriate comments and verbal harassment to sexual assault, the latter being experienced by 3 percent of respondents. Eighteen percent of respondents said they had encountered conduct of a sexual nature which they found upsetting, offensive, humiliating, intimidating and/or degrading.

Among the most common negative behaviours experienced were:

- Telling sexual stories or jokes
- Unwelcome comments about your appearance, dress or body
- Explicit language, eg sexual swear words or suggestive language
- Personal questions about sex life, relationships or sexual preferences
- Unwanted physical touching.

Half of those who had experienced sexual harassment said it occurred at least once every few years, and 13 percent said it happened at least once a year. Around one in 10 experienced such behaviour a few times a year.

PERPETRATORS

Most commonly, the perpetrator was a colleague, experienced by 72 percent of hospital doctors responding.

One in 10 said they had experienced sexual harassment perpetrated by a manager, and 29 percent by a third party.

THE NHS AS A HIERARCHICAL WORKPLACE

The fact that 1 in 10 perpetrators were managers contributes to a feeling of powerlessness for victims.

In qualitative responses, several respondents highlighted power dynamics in the workplace and the impact that these have on their ability to speak up.

One doctor who did act to report the sexual harassment they had encountered at the hands of a more senior figure was warned of the potential consequences: *"I was advised to consider whether I should escalate the issue if I wanted a career in that speciality in that region.*

"I found it shocking that a person may have to choose between protecting their career prospects versus rightfully complaining about sexual harassment because the perpetrator was in a position of power or influence."

Power dynamics and sexual harassment

"A consultant once put his hand all the way down my knickers and touched me intimately. I was horrified, shocked and frozen. This was a serious sexual assault and I never dared say anything because I was ashamed and also pretty convinced no-one would believe me."

"On one occasion, I was touched in a crowded room and did not know the identity of the individual. That meant I spent the rest of the rotation feeling on edge."

"Junior doctors have absolutely no power within NHS hospitals and put up with abuse from colleagues from various healthcare professional groups in silence. I know a doctor who as a foundation doctor was pinned against a wall and threatened in a sexual manner by a physician associate. She is now avoiding a career in that particular specialty, specifically to avoid that person, despite me telling her to report it, as she feels that permanent members of staff have far more power than a junior doctor, no matter what their role."

"It felt like power dynamics were significant in terms of who could call things out … as a junior member of staff it felt like something more extreme would have to happen for me to be able to report it or bring it up."

The reporting challenge in workplaces

UNDER-REPORTING OF SEXUAL HARASSMENT

Of respondents who had experienced sexual harassment, only one in 10 had reported it to their employer.

Reasons for not reporting include not being sure if it was sexual harassment and concerns over impact on career.

IMPACT OF DOCTOR ROTATIONS

Resident doctor respondents highlighted the impact that rotating from one placement to another has on their likelihood of reporting issues. Some respondents explained that since their time at a workplace was short-term they did not feel raising concerns would be meaningful in achieving the deeper cultural change required.

The prospect of rotating out of a workplace where sexual harassment is present was cited as an opportunity for a "fresh start", also reducing the likelihood of reporting.

THE ROLE OF GENDER "NORMS" IN UNDER-REPORTING

Some respondents framed their response around how they felt "as a man" or "as a woman", demonstrating the interplay of gender norms with sexual harassment.

Several female respondents described a societal expectation that women will experience sexual harassment and should simply "put up with it".

One stated that they didn't feel impacted *"as unfortunately as a woman sexual harassment of various forms has always happened and so you just learn to let it go over your head".*

Another stated: *"I wasn't concerned by the behaviour, it's part of UK society. Often it was usually not directed at me but other staff (usually junior female)".*

Meanwhile, some male respondents described not feeling they were "taken seriously" because of assumptions that sexual harassment is exclusively perpetrated by men against women.

THE IMPACT ON CAREERS

A number of female respondents highlighted concerns that reporting sexual harassment would impact on their career progression, particularly where perpetrators were in more senior positions.

One locum consultant said they had not spoken up against harassment by their medical director who was due to interview them for a substantive contract.

Some respondents reported their career had indeed suffered after doing so, including being rejected without interview when applying for a training post.

One noted that a manager responsible for sustained sexual harassment had "disclosed that he is turned on by women in power". While the victim did report the issue, she explained that the experience has had a long-term impact and prevented her from taking any leadership role or saying anything in a "strong" manner to avoid giving the perpetrator a "sexual thrill".

She concluded: *"This inhibits my ability as a leader at work. I never thought this would be an outcome of sexual harassment."*

HANDLING BY EMPLOYERS

Of those who did report sexual harassment, 75 percent felt their employer could have done more.

Respondents reported the sense that their concerns had been "brushed under the carpet" by senior consultants or nurses within the trust, or being left with the impression that sexual harassment should be accepted as "one of those things".

When asked what NHS employers could do to improve their response, respondents repeatedly stated: "Take it seriously". This conveys a widespread perception that employers will not act on reports of sexual harassment.

LACK OF AWARENESS OF LOCAL POLICY

More than half of hospital doctors responding (52.5 percent) did not know whether their employer had a sexual harassment policy.

All NHS trusts should have a specific policy that is actively promoted in the workplace. All staff should understand what constitutes sexual harassment, the consequences of this behaviour, how to report it and where to access support.

This is not only needed for those directly involved but also to create a culture where bystanders feel empowered to speak up.

However, even where a policy exists, low awareness will limit its usefulness.

Detailed findings

The impact of sexual harassment on doctors

INDIVIDUAL IMPACT

Respondents provided qualitative data on the impact of sexual harassment within the NHS.

On a personal level this included day-to-day changes to how victims act in the workplace, such as opting to dress differently, avoiding certain meetings, a loss of confidence and being less likely to go to certain colleagues for help.

There were also more extreme impacts such as career detriment, mental health detriment and sickness absence.

WORKPLACE IMPACT

Hospital doctors also reported wider impacts on the department they are working in, such as issues retaining female staff and an increase in staff sickness absence.

For instance, one respondent reported that "all junior female clinical fellows left the department" as a result of harassment.

This highlights the importance of rigorous workplace standards on sexual harassment to promote a positive working environment and therefore the best patient care.

INTERACTION WITH OTHER PROTECTED CHARACTERISTICS

Some respondents described how the impact of sexual harassment was heightened as a result of other parts of their identity, compounding the harm caused.

For one, this had added "to the burden of feeling 'kept in my place' as a professional women of colour."

Doctors on how they have been affected

"I have had several prolonged periods of sickness absence, I am under the care of a psychiatrist and my physical health has suffered. It has placed a huge burden on my family."

"It has caused me to freeze in place a few times, out of proportion to the actual touch or action. Once I dropped to the ground when unexpectedly tickled from behind – very embarrassing. It has also caused me to feel internal stress and deep anxiety when encountering inappropriate words or actions from patients."

"I suffered huge anxiety, had difficulty sleeping and finally the impact on my physical health that meant I had to resign from my job. I still take medication eight years on."

"When it happened with a consultant colleague whom I trusted and respected it made me question my own conduct, my professional value and the underlying intentions of all senior male colleagues. It has taken a long time to shake off the impact of this sexual harassment."

"I have survived, but I am forever changed ."

I am a victim and a survivor of sexual assault in the workplace. It has been an unimaginably difficult few years and I hope that sharing my story will help others.

As I discovered, victims of sexual assault are often further victimised by the investigation and resolution processes that are meant to provide justice – and we suffer more and for longer than the perpetrators, who are most often men.

This discrimination has to end. This is especially important in the NHS, where I work as a doctor and where the majority of the workforce is made up of women.

Like so many, I suffered behind closed doors. There were no witnesses to the attacks on me. The law and the policy of my employer, the NHS trust, acted as a deterrent to speaking up rather than providing me with protection.

I feared the complaints process, police referral and how it would all impact on me. Instead, I repeatedly tried to shut down the behaviour myself. In the process, I became increasingly frightened at work. I felt so isolated and lonely and precious little support was offered, which had a huge adverse impact on my mental health. After months of unsuccessfully taking various measures to protect myself, I found myself locked in my office in tears. I realised I had no option but to report.

Placing responsibility with the victim to establish the necessary support had already incurred delays and exacerbated the harm I suffered. I then came to realise that many employers do not have the training or experience to investigate such sensitive cases.

They have a legal duty to both parties and financial and reputational risks to themselves to consider. I therefore lost confidence in their investigation and was advised to report to the police. Despite not looking for a criminal prosecution, this was the action I felt was necessary to protect myself and my career.

> *"My employer explored the possibility of us both returning to work in the same department and essentially asked me, the victim, to make changes to facilitate this"*

Yet even after I had reported the perpetrator to the police and the General Medical Council, my employer explored the possibility of us both returning to work in the same department and essentially asked me, the victim, to make changes to facilitate this.

I feel really let down by so many organisations that were supposed to support and protect me and, if nothing changes, cannot honestly say that I would advise others to report. In particular, I have found the GMC outcome hard to accept. In my case there were no sanctions or even a warning towards a male doctor who admitted to committing sexually motivated acts and making sexually offensive comments in the workplace.

While I now know of resources such as charities like Rights of Women and trade unions like my own, HCSA, there is still little in the way of specific practical support in the workplace. Some progress has thankfully been made to better protect doctors and other NHS staff from sexual assault and sexual violence at work. I value the updated GMC guidance and the NHS England charter on sexual safety. However, these will only be as effective as the processes around them, and we still need to see major change.

First, every organisation should have a behavioural charter that promotes a supportive work environment. We can't just rely on policies there to challenge behaviours that are sufficiently below a minimum acceptable standard. We need to raise the bar on what employees can expect at work. Second, we need to work towards zero tolerance, where everyone feels able to speak up against wrongdoing and be supported when they do. Early action will hopefully prevent the escalation of abusive behaviours and

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make processes less harmful to everyone.

Next, support should be readily available and tailored to the needs and wishes of the individual. This may include counselling, psychology, support from an independent sexual violence adviser, occupational health or other medical support, or legal advice where applicable. Lastly, investigations should be impartial and conducted by those with sufficient training. The option of reporting to the police should be discussed and the employee supported in whatever decision they make. Processes must be impartial regardless of the gender or seniority of the perpetrator.

It has been over four years since the assaults started. I am still on medication and have been receiving psychological treatment. But I cannot help thinking about the effects of the perpetrator's actions on the wider NHS. I have had several periods of sickness absence when not only have I not been working as a doctor but I have been a patient using scarce NHS resources. The perpetrator was off work for months during the investigation and many, many hours of staff resources and costs have been incurred by lengthy investigations.

I have survived and I am still in my job, but I am forever changed personally and professionally. Like other victims, predominantly women, I may yet decide I can no longer work in a profession where I do not feel physically or psychologically safe. We all have a responsibility to ensure there is zero tolerance of sexual assault in the workplace – not just for the impact on NHS staff, but on our patients.

■ The author is a doctor working in the NHS in England. This contribution was written to contextualise the HCSA research project.

Analysis

That only one in 10 respondents affected by sexual harassment actually reported the incident is a shocking indictment of the culture within our health service. It is clear from the findings of this research project that the NHS faces deep systemic challenges.

Under-reporting appears to be driven by the dire responses of many employers to those individuals who do speak out, a lack of clear information on how to raise concerns, power dynamics within a hierarchical NHS which empowers abusers and creates the fear of – and leads directly to – career repercussions, and a cultural tolerance of sexual harassment "as just something that happens" in common with long-standing and discredited wider societal attitudes.

There are stark echoes in these findings of the wider culture of silence within the NHS that HCSA has identified in separate qualitative research among safety whistleblowers. This found that employers and the wider system for which they are responsible often focus on silencing complainants rather than supporting them and addressing their concerns.

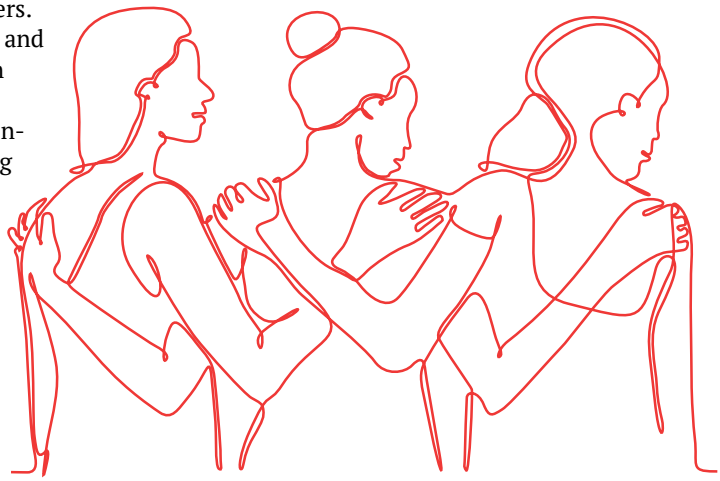
Many victims do not report sexual harassment for fear of being disbelieved or damaging their working relationships and career prospects.

There are also practical considerations and individuals face microaggressions such as potentially being shunned or excluded for reporting a colleague.

In HCSA's experience of supporting members, doctors are reluctant to report incidents formally because they fear the lack of concrete proof will be held against them – sexual harassment does not always entail documentary evidence. Victims often state they do not want to deal with the stress of intrusive and often insensitive policies and formal processes. Members have expressed fears of being excluded or becoming vulnerable to mental ill health if they were to take action that could add even more stress.

Yet the impact of sexual harassment on individuals can be devastating physically and psychologically, and the impact on wider teams can be destabilising and toxic.

HCSA's medical leaders, members and staff have witnessed first-hand its impact – the toll on a doctor's mental health, confidence, work and career



Empowerment and culture are key

prospects, workplace and personal relationships, and the psychological trauma and long-term health implications.

Those who experience sexual harassment report feelings of mistrust, anger and confusion. Members have also stated their desire to leave the medical profession altogether.

The impact of sexual harassment for employers includes increased sickness absence, low morale, reduced productivity, recruitment and retention issues, loss of talented employees, costly grievances and tribunal action, reputational damage, as well as potential scrutiny and unwelcome investigations from external bodies and agencies.

The NHS England sexual safety charter goes some way to acknowledging these challenges, committing signatories to pledges including to "eradicate sexual harassment and abuse in the workplace", provide appropriate support, maintain clear policies which are acted on, offer training and establish reporting mechanisms.

However, in a health system awash with policies and initiatives there is a clear risk that these pledges will remain just that. In order to be effective doctors will need to have trust and confidence that reports will be taken forward. Cases will need to be thoroughly investigated and perpetrators sanctioned appropriately.

In HCSA's view, based on the findings of this report and our many years of experience supporting hospital doctors, the aspirations enshrined in the NHS England charter are welcome – indeed, some of them reflect our own conclusions in this report – but they fall short of detailing the action needed to bring real change. To dislodge such a deeply embedded negative culture will require more tangible, practical steps.

> *There still appears to be little acceptance of the responsibility of employers to actively contribute to female employees' health and wellbeing at work by tackling sexual harassment.*

Unlike other forms of misconduct issues within the workplace, when it comes to sexual harassment the individual is often questioned in a manner that has connotations of "victim blaming" and/or "secondary victimisation" – not dissimilar to sexual harassment or sexual assault cases within the criminal domain.

Inappropriate lines of questioning appear, such as:

- "Did A do anything to lead on B?"
- "Why did A respond to B if they were feeling uncomfortable?"
- "Why didn't A report it sooner?"
- "Why did A not tell B to stop?"

Sexual harassment is a truly subjective experience, and no two cases are ever the same no matter the similarities. This requires policies and procedures which recognise this.

We must create a culture of intolerance of sexual harassment, with unequivocal leadership that repeatedly and loudly addresses abuse with prompt and appropriate sanctions against perpetrators, regardless of their status or seniority, and changes the perception of those who report sexual harassment.

The empowerment of those who report or challenge sexual harassment, as well as education and awareness, can provide tangible opportunities to stamp out a toxic or seemingly accepted culture. This, in turn, can build greater confidence for others to challenge or call out such behaviour and increase awareness and understanding of what should not be tolerated or accepted within the workplace.

NHS employers have a responsibility to build and restore confidence in policies, procedures and in reporting mechanisms. They need to recognise that those who report sexual harassment help deliver on their obligations to uphold equality and safety for everyone.

Twelve steps to bring the change doctors need

1. Lifelong training

Everyone in the NHS must understand their role as an ally in the fight to combat sexual harassment. People need to be accountable for their actions – and this is far more likely if the medical profession keeps talking about sexual harassment and sexism.

All medical schools should provide equality and sexual harassment training as part of students' entry into medicine to enshrine the required behaviour.

Training should ensure that those who witness incidents are clear on their responsibilities to colleagues, and those who may face sexual harassment are clear on their rights.

Regular training reviews should continue throughout a doctor's medical career. Doctors in leadership roles must undergo training as a pre-requisite for holding such a post.

2. Distinct grievance processes and policies specifically for sexual harassment cases

Dedicated grievance processes and sexual harassment policies are needed to reflect the complexities and sensitive nature of such complaints. This would build trust and confidence among doctors and wider staff that their complaints will be taken seriously and dealt with appropriately.

A pool of staff within each employer should be adequately and thoroughly trained on handling sexual harassment cases, not only on these specific policies and processes but on the complex impact on individuals.

Such policies should also be promoted within induction processes.

3. Extend the three-month limit on bringing a sexual harassment claim via tribunal

The current three-month limit for pursuing a sexual harassment claim at Employment Tribunal is wholly inappropriate given the complex and traumatic nature of many cases.

The difficulty for individual victims is often exacerbated by stressful formal policies and investigatory processes.

The three-month limit creates an artificial barrier to justice, and fails to recognise the practical and human considerations arising from cases of this nature.

The three-month limit should be raised to six months to take these factors into account.

4. A mentor support system within workplaces for those who report sexual harassment

NHS employers should be mandated to identify a pool of individuals willing to provide support and/or mentorship to individuals who report sexual harassment.

A support system signposted to by but isolated from formal policies and processes would further help empower, and build the trust and confidence of, victims. A strong, supportive network of mentors could also help to advocate meaningfully for a zero-tolerance approach to sexual harassment.

5. Employer sexual harassment policies must be clearly and widely promoted

Not only should sexual harassment policies exist but staff must be aware of their existence and contents.

Policies should be clearly displayed and promoted publicly in the workplace, including informational campaigns explaining what to do if someone faces harassment, promoting early intervention, and advertising reporting options.

The definition of sexual harassment itself should be clearly promoted, as should values and behavioural standards. These should be visible to staff and regularly reinforced.

6. Safe reporting pathways

Employers must establish and promote reporting pathways to show that issues can be raised without negative consequences for the person reporting them.

Employers must emphasise that they are grateful to those who raise concerns and that no matter a staff member's contractual status they will be believed and taken seriously.

If offered multiple reporting routes, including via mentors, it is more likely that victims will find someone to whom they are comfortable speaking.

7. Regular climate surveys to measure sexual harassment

Employers must use regular surveys to capture problems that are not formally reported.

Capturing a record of the mood and environment employers will identify problems that can be addressed earlier, preventing escalation of the issues and/or more serious consequences.

Such snapshots can be a reliable indicator of the prevalence of sexual harassment in a workplace.

8. Accurate record-keeping

Data retention and systems should be designed to identify any repeat offenders or repeat reports involving the same individuals.

To encourage reporting, systems should allow victims to record their harasser's name and the times and dates of abuse, and to turn this into a formal report if another note is made against the same person.

This will help mitigate the fact that often there is a lack of physical evidence of an incident or incidents occurring, which hampers an individual's ability to progress a complaint.

9. A culture where all inappropriate behaviour is challenged

Senior management must vocally and visibly challenge inappropriate behaviour. Leadership at all levels must be expected to speak out and act on any issues.

A culture where sexist, misogynistic or harassing behaviour is addressed and tackled at source will have a cascading positive impact on wider values and principles.

Performance management should also encompass an individual's approach to sexual harassment.

10. Tailored risk assessments for more vulnerable staff

Lone workers, younger workers/interns and those on placements are often at higher risk of sexual harassment. Risk assessments should acknowledge this risk.

Sexual harassment should be risk-assessed against other related policies, such as lone working policies and/or acceptable use of IT policies.

11. RIDDOR recording of sexual harassment incidents

Sexual harassment is a health and safety issue. The fact that it is not treated as such downplays its seriousness for individuals and workplaces and means the majority of incidents remain invisible.

The Health and Safety Executive's RIDDOR reporting system should be opened up to include sexual harassment.

This will assist in challenging toxic workplace cultures and help hold employers and perpetrators to account.

12. Implement in full an employers' duty to safeguard staff against sexual harassment

Changes under the Worker Protection (Amendment of Equality Act 2010) apply as of 26th October 2024 and place a new preventative duty on employers.

However, the Lords blocked provisions to introduce employer liability for third-party harassment and watered down wording elsewhere stating employers must take "reasonable steps" as opposed to "all reasonable steps" to safeguard employees against sexual harassment.

NHS staff, like other public-facing workers, rightly expect that their employer should protect them against sexual harassment by third parties, and the law should be amended to place a mandatory legal obligation on employers to do so.

HCSA: Supporting women doctors

HCSA – the hospital doctors' union is dedicated to bringing meaningful change to the benefit of our members and the wider medical profession.

We will continue to provide specialist support and education on sexual harassment, and work with allies to press for the tangible steps needed to bring meaningful change. Talking is not enough.

As a trade union, HCSA wants to strengthen and help our members to reinforce a positive and diverse culture within medicine which will aim to achieve true equality. This is the thinking behind HCSA's Women Focused Support service – the first of its kind by a UK trade union.

Its establishment was motivated by our deep understanding of how inadequate policies or legal rights can have a disproportionate impact on women. It is shocking in 2024 that there remains no legal right to breastfeed at work. On flexible working, all too often managers employ statutory reasons for refusing applications.

Rarely do workplace policies exist around miscarriage or still birth. Many women face issues trying to secure time off for IVF treatment as this falls outside pregnancy discrimination law.

The WFS service is an offer of enhanced support from a female national officer on issues which predominantly affect women in medicine. Its goal is to remove or minimise the stigma and barriers which often exist.

In doing so, we aim to improve and increase positive experiences of women doctors. We aim to build confidence and empower individuals and provide enhanced support to challenge discrimination, sexual harassment and breaches of policy.

Women Focused Support covers issues that take place at, or impact on, hospital doctors' work such as:

- Sexual harassment or sexual assault
- Sexism/sex-related harassment and bullying
- Pregnancy/maternity discrimination or issues
- Breastfeeding
- Flexible working
- Miscarriage or still birth experiences
- Domestic abuse
- Menopause/menstruation issues
- IVF
- Terminations
- FGM or other cultural-related issues.

Our goal is also to help prevent women leaving medicine for avoidable reasons, often at the peak of their knowledge and experience.

Through the service HCSA is seeking to develop an enhanced understanding of the issues that negatively impact women and their careers in medicine, and use this to bring about real change.

SUPPORT AND HELPLINES

Members can seek specialist advice and support from HCSA if they have experienced and/or witnessed sexual harassment in the workplace.

Hospital doctors can also seek support and advice from the below organisations:

Acas
https://www.acas.org.uk/contact

Citizens Advice
https://www.citizensadvice.org.uk/

Galop: LGBT+ sexual violence support
https://galop.org.uk/

Police
https://www.police.uk/

Rape Crisis England and Wales
https://rapecrisis.org.uk/

Rights of Women
https://www.rightsofwomen.org.uk/

The Survivors Trust
https://www.thesurvivorstrust.org/

SurvivorsUK: male rape and sexual abuse support
https://www.survivorsuk.org/

Samaritans
https://www.samaritans.org/

Victim Support
https://www.victimsupport.org.uk/

HCSA
The hospital doctors' union

www.hcsa.com

*The trade union for **all** hospital doctors, wherever you are in your career*

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