professional standards authority

Learning Points Bulletin

Issue 1 | July 2024

Welcome to the first edition of the new, twice-yearly learning points bulletin – the first in a series. This bulletin covers the period from April 2023 to March 2024.

We share learning points with the aim of helping regulators to improve decision-making. By sharing learning from our scrutiny of decisions, we aim to improve the quality of the fitness to practise panel outcomes and to drive up standards in decision-making. They are also taken into account by our Performance Review team in their regular assessments of a regulator's performance.

We are in a unique position to see every relevant decision made by the 10 health and social care regulators, and so we're able to more easily highlight issues and identify themes. We understand that regulators may not agree with all of the learning points that we share but we hope that, in the majority of cases, you find them helpful and informative. We hope our regular bulletin will provide you with a valuable overview of the volume of learning points we send and regular issues we are identifying.

We have noticed a rise in final decisions involving sexual misconduct and inappropriate behaviour. We have chosen to focus on this as an area of interest in this bulletin.

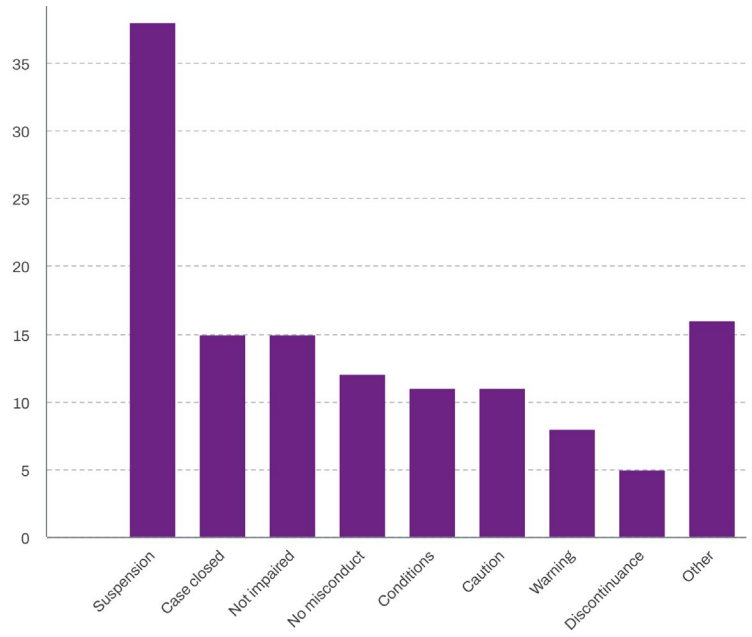
Key statistics April 2023 to March 2024

Determinations received	2,385
Learning points sent during period	131
Cases appealed	30

Suspension was the sanction that we fed back on the most

38

Most common sanctions fed back on



Our key concerns

1 Sexual misconduct

Of the 30 appeals we have brought against panel decisions over the last financial year, nine of these related to cases involving sexual misconduct. Common concerns we have are:

Number of PSA appeals involving sexual misconduct

9	April-2023-March 2024
3	April-2022-March 2023

- failures to consider the full gravamen of the misconduct and whether the misconduct revealed a deep-seated attitudinal problem;
- failures to find or charge sexual motivation where there is compelling evidence of such;
- failures to properly investigate and/or charge incidents relevant to a number of issues in the case including, but not limited to: sexual motivation, the credibility of any defence, pattern of behaviour, insight and future risk of repetition;
- failures to properly explore and test the credibility of the registrant's evidence before the hearing and/or at the hearing;
- failures to take into account material considerations which aggravate the seriousness of the conduct, and/or excessive weight is placed on mitigating factors which the panel do not sufficiently explain its relevance to the misconduct;
- insufficient weight is given to maintaining public confidence in the profession, and to maintaining proper professional standards and conduct for members of the profession. We see failures to give adequate reasoning as to why, despite the seriousness of the conduct, the public interest does not require a finding of impairment;
- there is a failure to give adequate reasons as to the sufficiency of sanction, (especially where the seriousness of the conduct found proved indicates that a more severe sanction should be imposed) and/or properly consider and refer to the relevant guidance.

2 Sexual motivation

We became a party to a GMC appeal under Section 40B of the Medical Act in which we raised additional grounds of appeal about the regulator's decision to bring charges in relation to sexual harassment and use of the wording from the Equality Act but where a separate charge of sexual motivation had not been brought. In this case, the panel did not make a finding of impairment. We were concerned that the way in which the charges were drafted contributed to the panel's failure to adequately consider the registrant's motivation for his behaviour towards six female colleagues.

We have also seen other cases where a separate charge of the 'conduct is sexual' has been brought but where sexual motivation has not been separately charged when, in the circumstances of the case and, in our opinion, it should have been.

See: (1)GMC (2)PSA v Dugboyele [reasons reserved]

Our key concerns (cont)

3 Witness vulnerability

We appealed a case where we were concerned that the charges before the panel did not reflect the true circumstances of the misconduct including the patient's particular vulnerability, which we were concerned had not been properly taken into consideration by the panel. The Judge agreed and added:

"*Second …where a MPT is considering the seriousness of a practitioner's misconduct it should examine the evidence as to the culpability of the practitioner and the harm which their actions have caused. Evidence about vulnerability goes to both questions. What the doctor knew or ought to have known, or believed, about the degree of vulnerability of the patient at the relevant time will be directly relevant to the degree of culpability … Third, in a sexual misconduct case evidence about vulnerability may impact on other considerations such as whether there was predatory behaviour by the doctor, the likelihood of repetition, and consent…[and the question of harm]"* [92-93]

The Judge was also of the view that an amendment to the charges to reflect the patient's vulnerability could and should have been made "*without injustice*" at the hearing "*bearing in mind the primacy of the public interest*". [112-113]

See: PSA v (1) GMC & (2) Onyekpe [2023] EWHC 2391 (Admin)

4 Sanction stage

A recurring concern we have which regularly features in our appeals and learning points relates to failures at the sanction stage. Common failings by panels include:

- did not correctly assess whether the registrant demonstrated insight and would realistically remediate their conduct, and the impact of this on appropriateness of sanction;
- did not adequately demonstrate application of the sanctions guidance or did not properly apply it;
- did not consider all relevant parts of the sanctions guidance;
- did not sufficiently explain why a more serious sanction was not required;
- identification and/or assessment of mitigating factors was wrong;
- did not adequately identify relevant aggravating factors;
- did not adequately take into account relevant features of the case in considering sanction;
- the sanction imposed did not flow on from the previous findings at misconduct and impairment;
- poor and/or brief drafting of reasons;
- did not consider whether the attitudinal concerns were deep seated;
- did not explain the reason for the length of the order imposed.

Our key concerns (cont)

5 Disclosure and barring

We have brought appeals and highlighted a number of learning points on decisions across regulators where we have concerns that the regulator and/or panel have not properly taken into consideration a Disclosure and Barring Service ('DBS') decision to bar a registrant from working with children and vulnerable adults. We have been particularly concerned where there are:

- failings by the regulator to bring separate misconduct charges to reflect the underlying conduct, but where the fact of being placed on a barring list had been charged;
- failings by the regulator to obtain any evidence as to the reasons which led to the DBS decision;
- failings by the regulator to explore whether the conduct which led to the DBS decision were the same concerns which were subject to regulatory proceedings, or whether there were wider concerns;
- failings by the panel to adjourn for further enquiries to be made where this was unknown;
- failings by the panel to not sufficiently address and consider the fact that the registrant was barred from working with vulnerable adults and children;
- failings by the panel in not considering whether the registrant could remediate their fitness to practise given that they had been and remained barred by the DBS, especially where the registrant did not intend to apply to the DBS to reconsider their barring decision;
- failings by the panel to make it clear that a future reviewing panel may require further information about the status of the DBS barring decision, and whether the registrant [or regulator] had taken steps to inform the DBS of the panel's decision and request reconsideration of their barring decision;
- Failings by the panel to consider these factors at the review hearing and where the registrant remained barred.

Making care safer for all

In March, we published ***Making care safer for all - a manifesto for change***. It outlined our recommendations to the next UK Government to help tackle some of the big challenges within health and social care. It also highlighted what professional regulation is doing to make care safer. Recommendation 3 focused on improving workplace culture and includes some stark statistics on sexism and sexual misconduct in health and social care. You can find out more in this **short animation**.

Relevant publications

- Alexis Hearden from 39 Essex Chambers recently visited our offices to discuss sexual misconduct in the workplace. Alexis agreed to produce an article for us covering the issues in this area. See Annex A.
- Hill Dickinson, one of our legal providers, published an article on 15 March 2024 on changes to sexual harassment legislation and they discuss the new positive duty on employers.

Sexual safety in the NHS

- On 12 April 2024, NHS England published ***Sexual safety in the NHS: survey results and update on charter implementation***. We were particularly interested to note their findings – revealing that 58,000 staff reported unwarranted sexual approaches from patients or other members of the public last year – that's 1 in every 12 NHS workers. One in 26 reported experiencing similar harassment from work colleagues. We were pleased to note that at the date of publication, more than 270 organisations had already signed up to the Sexual Safety in Healthcare Charter launched by NHS England in September 2023. The Charter commits to 10 key actions, including taking a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours within the workplace. We were also pleased to see the other work being done to ensure the healthcare system is a place in which sexual misconduct, violence, harassment and abuse are not tolerated.

1 in 26

NHS workers reported experiencing unwanted sexual approaches from work colleagues.

- The PSA's Research Conference was held on 14 November 2023, and we heard from Surviving in Scrubs. You can find their published report here.

- We are holding a research conference on 17 October which will feature the NIHR-funded Witness to Harm project, and other themes including sexual misconduct. More details can be found on our website.

- The PSA is also arranging a series of presentations and discussions on different aspects of sexual misconduct from September 2024-September 2025. If you are interested in finding out more, please contact Douglas Bilton by emailing douglas.bilton@professionalstandards.org.uk

Find out more

- sign up to receive the PSA's e-newsletter
- outcomes in our recent appeals
- our power to check and appeal final fitness to practise decisions
- the value our power to appeal adds to public protection
- read our previous research and reports on crossing professional boundaries/sexual misconduct

Get in touch

We would welcome any feedback on this publication. If you would like more information, please get in touch with Georgina by email.

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Annex A

Sexual misconduct towards colleagues

Alexis Hearnden | 39 Essex Chambers

Sexual misconduct cases are a now not infrequent part of the fitness to practise landscape and PSA research (Professor Searle, 2019) suggests that around 40% of sexual misconduct cases before healthcare tribunals involve sexual misconduct with colleagues (rather than patients).

Whilst the fitness to practise implications of sexual misconduct with patients are clear – and panels generally appear able to effectively judge – conduct which occurs between colleagues gives rise to slightly different and perhaps more difficult considerations.

This note briefly considers those issues and the lessons which can be taken from recent cases.

What do we mean by sexual harassment?

Sexual harassment is defined by the Equality Act 2010 as when a person engages in unwanted behaviour of a sexual nature, whether verbal, non-verbal or physical, that creates an intimidating, hostile, degrading, humiliating or offensive working environment. Examples include:

- unwelcome sexual advances, propositions and demands for sexual favours
- unwanted or derogatory comments or nicknames about clothing or appearance
- leering and suggestive gestures and remarks or jokes
- intrusive questioning or suggestions about your sex life or a colleague's sex life, and discussing their own sex life
- sexual posts or contact on social media
- spreading sexual rumours about a person
- sending sexually explicit emails or text messages
- predatory behaviour
- physical contact such as the invasion of personal space and unnecessary touching, hugging or kissing through to sexual assault, indecent exposure, stalking and rape (although rape is defined as a separate criminal offence).

UNISON conducted a study of around 8,500 members working in health in 2019 ('It's Never Ok: a report on sexual harassment against healthcare staff'), which found that nearly one in ten (8%) respondents had been sexually harassed in the last year. Of these, nearly a third (31%) said the harassment was frequent/ regular, and more than one in ten (12%) said it occurred daily/weekly.

The vast majority (81%) of those harassed identified as female. Most (61%) said the harasser was older than them, nearly two in five (37%) said they were in a more powerful position, with under a third (32%) experiencing harassment from a colleague with the same level of responsibility.

Unsurprisingly, the harms caused by sexual harassment can include adverse mental health, avoiding colleagues or seeking alternative employment, all of which can have consequences for patient safety.

Research was commissioned by the PSA in 2018 (Sexual behaviours between health and care practitioners: where does the boundary lie? -Simon Christmas, Fiona Fylan) because of a growing sense that fitness to practise panels seemed to treat sexual behaviour with colleagues as different (and less serious) than sexual misconduct with patients. The research revealed that practitioners were particularly concerned by conduct which took place in front of colleagues or patients, or where there was a suggestion that it distracted from patient care. Registrants also characterized

sexual misconduct with a colleague as an example of poor judgement – which may reveal a lack of empathy or ability to assess what is appropriate – with associated implications for fitness to practise. That said, there was an appetite for rehabilitation amongst registrants – especially if the person had made a mistake rather than demonstrated broad attitudinal issues (which would justify a more serious sanction if there was serious and persistent harassment). Concerns were expressed about losing competent practitioners from the profession for ill-judged overtures or relationships.

Regulator Guidance

Many healthcare regulators have published guidance about sexual misconduct which explains that it can be verbal or written, may including displaying or sharing images, as well as physical contact. However, the picture varies across regulators as to the extent to which the guidance expressly addresses sexual misconduct between colleagues. For example, the GMC has guidance directed at ensuring that personal and professional boundaries between colleagues are upheld, including the warning that any consensual relationship (including its end) should not have an adverse impact on clinical practice or team environments. Situations involving power dynamics or where training or career progression could be impacted are flagged as potential high-risk. In contrast, guidance issued by some other regulators is sometimes very patient-focused and may benefit from being widened to addressing workplace sexual harassment or misconduct.

Fitness to practise proceedings

Regulators assessing misconduct are well advised to consider whether they are dealing with sexual harassment (by reference to the Equality Act), or sexually motivated conduct, i.e. an act done in pursuit of sexual gratification or a sexual relationship (see Basson). Sexual harassment will usually (but not always) be sexually motivated but sexually motivated conduct may not be sexual harassment (since the Equality Act definition depends on the environment which the conduct creates). It is important to accurately reflect the character of the misconduct – and to think about terminology - when charging allegations and in presenting the case. There will also be a category of sexual misconduct cases where sexual advances may have been initially welcomed, but where the attention or action becomes inappropriate, which should be clearly reflected in the charge and case theory.

GMC, PSA v Dugboyele

This combined section 40A appeal and PSA challenge falls into the category of “one to watch”. Judgment is awaiting (hearing took place on 24 April 2024 before Mr Justice Murray. The case concerned a Specialty Grade Obstetrics and Gynaecology doctor who sexually harassed seven colleagues (touching, stroking, kissing and hugging). The MPT heard powerful evidence about the type of working environment that his conduct had created, but was persuaded by remediation evidence. The Medical Practitioners Tribunal (MPT) found misconduct but said that his fitness to practise was not impaired. The GMC challenged the decision on the basis that the MPT had been wrong to prioritise remediation over other factors and had failed to consider public confidence and standards when determining impairment. The PSA shared those concerns adding two further grounds - that the GMC should have alleged sexual motivation, and the MPT should have given adequate reasons.

The judgment will be an opportunity to understand the High Court’s view on charging – the GMC had charged inappropriate behaviour and unlawful sexual harassment (which was admitted) but not sexual motivation. The PSA argued that the failure to charge sexual motivation meant that the panel did not properly calibrate the seriousness of the misconduct, with consequences for its assessment of insight and sanction. It is hoped that the judgment will grapple with the issues of sexual harassment, sexual motivation and how best to capture misconduct in charging and case preparation so that panels are best placed to judge what is required to uphold patient safety, public confidence and maintain standards.