this week

MRCGP EXAMS page 297 • **LMC CONFERENCE** page 298 • **MYOCARDITIS CASES** page 300



From left: Daisy Cooper, Latifa Patel, and Maria Caulfield all welcomed the urgent NHS safety review

Abuse cost NHS £82m in five years

EXCLUSIVE The NHS is conducting an urgent review into physical and sexual abuse of staff on its premises, with recommendations expected in the autumn. It follows a *BMJ* and *Guardian* investigation that showed "shocking" levels of sexual abuse on NHS sites (p 306).

The investigation found 35 606 incidents of rape, sexual assault, harassment, stalking, and abusive remarks were reported over five years (2017 to 2022), with most (58%) being cases of patients abusing staff and 20% patients abusing other patients. Nearly three quarters occurred in mental health trusts.

Figures released to *The BMJ* under a freedom of information request show that the legal bill for physical and sexual abuse and violence on NHS premises in England between 2017 and 2022 was almost £83m.

Staff and patients were perpetrators and victims, with compensation of more than £45m paid out for 1648 cases. Claims from patients who were abused while under clinical care reached just under £18m for 233 cases, and 95 claims for sexual abuse amounted to more than £5m. Legal claims for staff or patients abused by members of the public totalled almost £65m, including £35m in damages, covering 1415 cases.

NHS Resolution, which provides a claims management service to the NHS, said it was conducting an in-depth analysis of all abuse against staff to assess what changes were needed to improve workplace safety. A spokesperson said, "This thematic review reflects our commitment to doing what we can to help ensure the NHS is a safe place."

Health unions have welcomed the move. Latifa Patel, workforce and equalities lead at the BMA, said, "If NHS trusts had appropriate and effective policies for reporting and dealing with cases of sexual harms and sexual assaults quickly and fairly, they would be less likely to incur such huge costs from long drawn out and painful legal cases."

Last week Maria Caulfield, health and social care minister, told a Westminster Hall debate that NHS staff rather than patients were the most common victims of sexual assault. She said that work was being done to support staff and to make their workplaces safer, although she did not specify how.

Daisy Cooper, the Liberal Democrat spokesperson for health and social care, who requested the debate, called on the government to create one complaints system for staff, patients, and visitors to capture all allegations within the health service.

Adele Waters, Ingrid Torjesen, *The BMJ*

Cite this as: *BMJ* 2023;381:p1185

CORRECTION

In the 20 May issue (p 253) the news story headlined "Consultants begin strike ballot" incorrectly stated that the BMA had launched a consultative ballot of consultants in England over industrial action that wasn't legally binding. The ballot is legally binding and is not consultative. The BMA previously held a consultative ballot on this issue, the results of which were released in March.

SEVEN DAYS IN

NICE: Take genetic variant test to ensure clopidogrel works for stroke prevention

ALISON THOMPSON / ALAMY

People who have had an ischaemic stroke or transient ischaemic attack should take a genetic test to see whether they can be treated with clopidogrel to reduce their risk of recurrence, NICE has said in draft guidance.

The institute currently recommends that clopidogrel can be used for treating people at risk of a secondary stroke, but it is not suitable for those with certain variations in the CYP2C19 gene because they cannot convert the drug to the active form. Offering the genotype test will help identify which patients need an alternative antiplatelet treatment.

An estimated 32% of people in the UK have at least one of the gene variants, which are more commonly but not exclusively found in people with an Asian family background. Evidence indicates that people with these variants have around a 46% increased risk of another stroke when taking clopidogrel when compared with those without.

Mark Chapman, NICE's interim director of medical technology and digital evaluation, said, "Until now doctors have not known who cannot be treated with clopidogrel until after they've had a second stroke or TIA, and that could be too late."

A consultation on the draft recommendations ends on 8 June.

Zosia Kmietowicz, *The BMJ* **Cite this as: *BMJ* 2023;381:p1146**

Pay

Junior doctors in Scotland are offered 14.5% rise

The Scottish government offered junior doctors a 14.5% pay rise in a two year deal that includes a 6.5% uplift for 2023-24 and an increase on its previous 4.5% offer to 7.5%, backdated for 2022-23. BMA Scotland will put the offer to members in a consultative vote. Chris Smith, chair of the Scottish Junior Doctors Committee, said the BMA had not agreed the deal or accepted any offer but that it was "without doubt an improvement on the 4.5% awarded last year, and the improved offer for 2022-23 would represent a slowdown in doctors' pay erosion."

Junior doctors in England to strike again

Junior doctors in England will go on strike for a third time for 72 hours from 14 June. This came after the failure of three weeks of talks with the government, with the BMA labelling the government's final 5% offer "in no way credible." The union has said that if the government does not improve its offer doctors will strike for a minimum of three days every month over the summer. It is calling for "pay restoration" to reverse an estimated 26% real terms cut in pay since 2008-09.

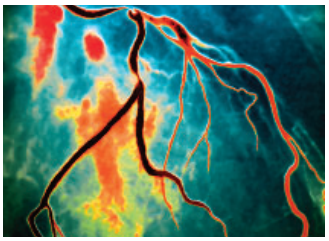
Public health

Views are invited on tackling major conditions

NHS England has called for evidence on how best to prevent, diagnose early, treat, and manage the six conditions that will inform the major conditions strategy announced in January, to help determine care policy for increasing numbers of people with complex and often multiple long term conditions. The strategy covers cancer, cardiovascular diseases, chronic respiratory diseases, dementia, mental ill health, and musculoskeletal disorders. Submissions are being accepted until 27 June.

Cardiovascular deaths rose 60% in 30 years

Deaths from cardiovascular disease jumped worldwide from 12.1 million in 1990 to 20.5 million in 2021, said the World Heart Federation. The highest CVD death rates occurred in central and eastern Europe and central Asia. The federation found that 64% of countries had implemented at least seven of eight recommended policies, including tobacco control programmes, access to CVD drugs, and

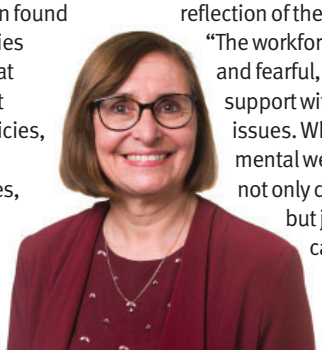


operational units in ministries of health. The lowest level of policy implementation was found in sub-Saharan Africa, where over half of countries lacked CVD drugs in primary care, CVD plans, and non-communicable disease units.

Staff shortages

Doctors' mental health is being affected

Most doctors (95%) fear that staff shortages threaten patient safety, and over half (54%) say the issue is affecting their mental health, found a Medical Protection Society survey of 5495 doctors, of whom 861 responded (15% response rate). Jane Dacre (left), MPS president, said that the survey findings were a sad reflection of the times. She said, "The workforce is exhausted and fearful, and many need support with mental health issues. When doctors' mental wellbeing is poor, it is not only damaging to them but jeopardises patient care."



LMC conference

GPs want to be "consultants in family medicine"

GPs have backed plans to rebrand themselves as "consultants in family medicine" and called for an immediate merger of the specialist and GP registers. Leaders gathering in London last week said they were sick of the negative reputation of primary care and of feeling like "lesser doctors" than hospital colleagues, despite being "expert medical generalists." Samantha Fenwick, an Aberdeen GP and medical director for the Grampian LMC, told the conference that GPs deserved a "fresh start."

Give us funding for private referrals, demand GPs

GPs must be funded for any follow-up work arising from requests from private providers, leaders urged. The LMC conference acknowledged that, with the NHS under severe strain, patients were increasingly seeking private care. But it passed a motion on 19 May instructing the BMA's GP committees across the UK to work with authorities to ensure "any involvement in a patient's care by an NHS GP as requested by a private healthcare or insurance provider should be remunerated appropriately." (For more on the LMC conference see p 298.)

MEDICINE

Artificial intelligence

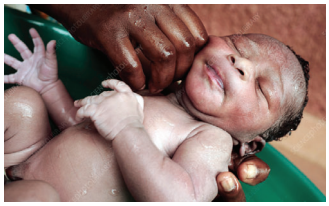
Students are warned about plagiarism

Medical students should not be tempted to "cut corners to meet deadlines" by using artificial intelligence tools such as ChatGPT in their written work, the Medical Defence Union warned. The defence body has raised concerns about the number of medical students using content generated by AI systems in their coursework, resulting in plagiarism allegations by their universities. As sophisticated AI technology becomes increasingly accessible, the defence organisation has emphasised the need for students to show that their work is "above suspicion."

Medical students have been warned not to use tools such as ChatGPT for coursework

Inequalities

Black Americans had 1.6m excess deaths in 20 years



The number of black people in the US who died in 1999-2020 was 1.63 million higher than if their mortality had matched that of white Americans, research published in *JAMA* found. The burden of excess deaths amounted to more than 80 million years of life lost, many due to premature death from heart disease and comparatively high infant mortality. A black infant born in the US is 2.3 times as likely as a white infant to die in the first year of life.

Dementia

Crisis looms as global targets are missed

At the World Health Assembly in Geneva the charity Alzheimer's Disease International issued an urgent call for the global action plan on dementia to be extended, after latest figures showed that targets had been missed. Only 39 of 194 World Health Organization member states have followed through on their 2017 promise to create a national dementia plan by 2025. The charity's chief executive officer, Paola Barbarino, said, "People living with dementia worldwide are the ones who pay the price when governments turn a blind eye to their situation."

Transgender care

US states ban or restrict access to doctors

Nineteen of the 50 US states have enacted bans or restrictions on transgender care, and many penalise doctors who provide puberty blockers, hormone therapy, or gender affirming surgery for children. Penalties include 10 years in prison in Idaho, fines as high as $25 000 (£20 000), and loss of medical licence. Restrictions are already in effect in 10 states, and doctors who provide transgender care face four direct penalties, said a study published in *JAMA*. Penalties include disciplinary action regarding a doctor's

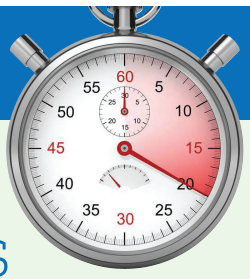
medical licence, private lawsuits, civil legal action by the state, and felony charges enabling criminal penalties.

Cite this as: *BMJ* 2023;381:p1176

ILLNESS IN WORK

Since the covid pandemic the percentage of 16-64 year olds reporting a work limiting health condition has risen from 16.4% (6.8 million people) in 2019 to 18.1% (7.5 million) in 2022

[Office for National Statistics]



SIXTY SECONDS ON . . . MRCGP EXAMS

YOU'VE GOT A PLACE?

Yes, for the applied knowledge test (AKT) but not the recorded consultation assessment (RCA) or the simulated consultation assessment. I missed the April RCA because it was oversubscribed, even though an extra sitting was added.

BUT I HEAR HELP IS AT HAND?

You're right. Doctors at the annual conference of local medical committees on 18 May called on the BMA's GP committee to work with the Royal College of General Practitioners to ensure no GP trainee is forced to extend their training because of a lack of available exam sittings.

WAS ENDING THE AKT ON THE CARDS?

"Big bang" examinations such as the AKT are outdated, according to Sarah Bodey, a GP trainer from north Wales who proposed the motion. She said these exams were little more than memory tests. "Rather than learning by rote, general practice needs to be testing the ability to utilise rather than memorise information. That's surely what we should be looking for in GPs of the future," she told the conference.

HURRAY, THE END OF AKT

Not so fast. That part of the motion was lost, with other speakers highly protective of the MRCGP exam. Rameez Rahman, from Bradford and Airedale Local Medical Committee, argued that the exams should not be "diluted" in any way. "We have spent a lot of time and energy on improving the prestige of our career and being on a par with hospital consultants. A cornerstone is the academic rigour of our training and assessment. Diluting this will undoubtedly bring this back into question," he said.

RC GP Royal College of General Practitioners

I'D BETTER GET OUT MY FLASH CARDS

On the upside, conference delegates also called for GPC UK to lobby the government to fund trainees' first MRCGP attempt. Bodey criticised the withdrawal of Welsh government funding, calling it "a kick in the teeth for those of us attempting to recruit the next generation of Welsh GPs." She said, "Providing financial support would be a powerful message for the future."

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2023;381:p1160

Let GPs offer services privately if not available on NHS, say delegates

GPs should be able to offer their patients private healthcare services that are not routinely offered or easily accessible on the NHS, voted representatives at the annual UK local medical committees conference in London on 19 May.

They noted that, unlike dentists and pharmacists, GPs cannot currently offer many private services to their NHS patients. The conference agreed that GP surgeries should at their discretion "be allowed to offer their NHS patients paid-for services if these services are not routinely offered by the NHS" or if they are routinely offered by the NHS but are "not accessible in a timeframe that the patient deems reasonable."

Two tier system

Stefan Kuetter, of Buckinghamshire LMC, who proposed the motion, said that, although he understood concerns about a two tier system, it already existed and GPs were "not the architects" of it.

"We can bury our heads in the sand, but our patients are already going elsewhere [for treatment], why not to us?" he said. "If you don't like that, you don't have to offer it, but don't stop others from offering it if it makes sense."

Kuetter also argued that patients who did pay for certain treatments could free up capacity in the NHS, which could in turn benefit patients who can't afford private treatment by lowering waiting times.

Naomi Rankin, from Liverpool LMC, spoke against the motion, arguing that the conference needed to reject the vote to "maintain the principles of the NHS."

"As an NHS GP I do not want this within my practice," she said. "If we follow this motion we are no longer providing that [care free at the point of delivery.]"

But speaking in favour, Timothy Owen, of Wessex LMC, said that general practice was "overworked and underfunded." He argued that "loosening" the contract to allow practices to top up their funding by charging for services like earwax removal or joint injection would allow them to increase salaries, increase retention, and employ more people.

SARAH TURTON/BMA NEWS

General practice is overworked and underfunded
Timothy Owen

In response to concerns that charging for some services was "the thin end of the wedge," Kuetter said: "We haven't got a plan B. We constantly clamour for more funding. It's not coming because the government can at any point call our bluff. We need to start thinking about what other income streams we can generate, because only then does the other side realise 'they have a plan B.'"

A separate strand of the motion, also passed, affirmed that GPs can be trusted to manage potential conflicts of interests arising from offering paid-for services to their NHS patients.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;381:p1166

Proposal to let SAS doctors work in general practice is rejected

When we look at SAS doctors we somehow miss the systematic discrimination
Amar Latif

We do not believe it is viable to create a separate role
Ujjwala Anand Mohite

GPs' leaders have overwhelmingly rejected the GMC's proposal to allow specialty and associate specialist doctors to work as primary care doctors in general practice.

The GMC had proposed the change as a partial solution to the workforce crisis in general practice, but both the BMA and RCGP expressed concern at the proposal.

Sarah Matthews, the GPC's policy lead for education, training, and workforce, said the GPC understood that a planned pilot of the proposals by NHS England that was due to start in 2023-24 had been shelved and said that the GMC should not go ahead with changes to regulations in the absence of pilots.

Numerous concerns

During an extended debate, speakers raised numerous concerns, including the level of supervision that would be required for SAS doctors to deal with undifferentiated care, capacity in general practice, and whether SAS doctors could be exploited under a "two tier system."

Speaking against the plan, Amar Latif, from Oxfordshire LMC, pointed out that a disproportionate number of SAS doctors were from ethnic minority groups or were international medical graduates and were women.

"The elephant in the room is that when we look at SAS doctors we somehow miss the systematic discrimination that happens within our NHS," he said.

Manu Agrawal, from South

“We too must consider industrial action to achieve full pay restoration”

GPs fully support junior doctors’ strike action and must consider taking a similar approach to achieve their own pay restoration, the conference heard.

Representatives applauded the “organisation and courage” of the BMA’s Junior Doctors Committee for taking industrial action in its fight for pay restoration. Junior doctors in England have carried out two rounds of strike action—a 72 hour walkout from 13 to 15 March and a 96 hour walkout from 11 to 14 April—in their fight for a 35.3% pay uplift. Last week they also announced a further three day strike next month.

GPs at the conference passed a three part motion in full that instructed the BMA’s GP committees of the four UK nations to take a similar approach to achieve full pay restoration for general practice, including considering industrial action.

Proposing the motion, Mark Green, chair of West Berkshire LMC, said, “To make the government take us seriously we need to stand and fight for our profession and for our patients. If the only way to achieve this is industrial action then so be it.”

He added, “You are voting on this motion to keep general practice alive and remove itself from the shackles it finds itself bound by.”

Gareth Olemann, chair of the Wales GPC, spoke against the motion, arguing that GPs needed an increase in resources rather than pay, because pay restoration was theoretically in the gift of GPs as independent contractors if they were willing to make cuts.

“Pay restoration is a legitimate ask for salaried doctors,” Olemann said. “Our demand should be for resource restoration.”

The BMA is currently preparing to re-ballot junior doctor members so that it can extend its mandate for strike action. Because of antistrike laws, the BMA said it can currently only legally strike until late August.

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2023;381:p1173

GPs call for urgent support to cope with soaring energy costs

General practices need an urgent package of support from UK governments to offset rising expenses and energy costs, the conference heard.

Delegates heard from GPs whose practices were struggling to stay afloat amid soaring costs of utility bills and other expenses. The meeting noted the “destabilising effect” of rapidly increasing expenses and energy costs that practices were absorbing.

Conor Moore, from Southern LMC in Northern Ireland, told the meeting his practice had seen costs rise by £6000 a year for gas and electricity alone. This, coupled with the rising cost of consumables and staffing, was making it difficult for practices to “keep the lights on,” he warned.

“Never before have we seen such a squeeze in our funding,” Moore said. “These increases in costs are unsustainable.” He added, “We may be small businesses, but we can’t simply pass some of our increased costs on to the consumer.”

Moore proposed a motion instructing the BMA’s UK GP Committee to negotiate an urgent package of support measures for all practices to ease the financial burden from rising costs.

The motion was carried as a reference after Moore agreed that negotiating support was best handled at a devolved level. This came after other speakers noted that the UK GP committee did not have a remit to negotiate but that each of the four national GP committees could seek to negotiate support with its own government.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;381:p1142

ONE PRACTICE had seen costs rise by **£6000** a year for gas and electricity alone

Staffordshire LMC, said, “We need to reject this idea that SAS doctors are less qualified; they are specialists in their own right and have earned that. This undermines us as GPs.

“This undermines the SAS doctors. SAS doctors are better off working in a hospital setting or even in a community setting, not as primary care doctors. This is exploitation. Why have a two tier system between SAS and consultants?”

Agrawal also raised concerns over supervision, adding, “Personally, I am fed up with supervising multiple roles on a daily basis and would love to have a workforce which can work independently and I can get on with my day job.”

HUGH HASTINGS/GETTY

The GMC had proposed the change as a partial solution to the workforce crisis in general practice, but both the BMA and RCGP expressed concern at the proposal

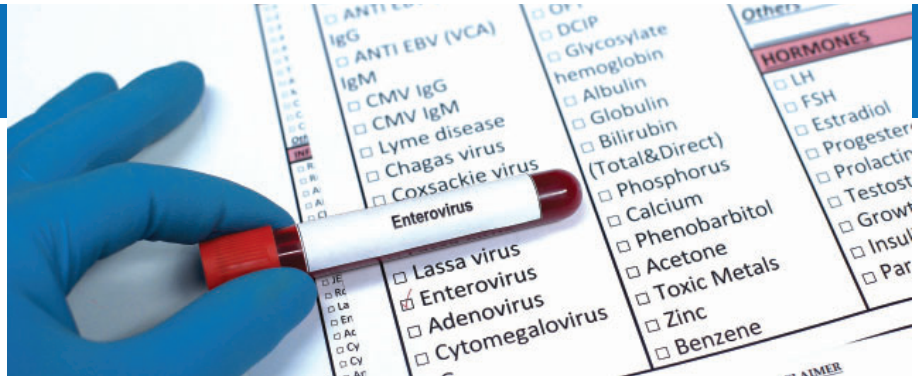
The conference also heard from Ujjwala Anand Mohite, chair of the BMA’s SAS Committee, who was also critical of the plans. “We do not believe that it is viable to create a separate role for SAS doctors in primary care, as it would lead to a category of ‘less GP’ and could lead to these doctors being exploited as a group,” she said.

Will Denby, from Hampshire and Isle of Wight LMC, also pointed out that the whole NHS—not just general practice—had a workforce crisis. “If we move doctors from one part of a sinking ship to another, we’re just rearranging the deck chairs,” he said.

HELEN SALISBURY, p 318

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;381:p1159



MYOCARDITIS **Unusual cluster of cases in babies is identified in Wales**

The World Health Organization has warned of an "unusual" increase in cases of severe myocarditis associated with enterovirus infection among very young babies in south Wales.

Between June 2022 and last month 10 babies under 28 days of age presented with symptoms of myocarditis at a tertiary hospital in south Wales and tested positive for enterovirus on PCR testing. Seven babies were treated in intensive care, and one died before transfer to tertiary care. One infant is still being treated in hospital.

The peak incidence was in November, with sporadic cases in other months. Seven of the 10 cases had further subtyping, which identified the enterovirus as either coxsackievirus B3 or coxsackievirus B4.

A further five babies have been identified with myocarditis and enterovirus infection over the same period in southwest England.

WHO said that the reported increase in myocarditis with severe outcomes associated with enterovirus infection was unusual. A review of data from the previous six years for the same tertiary hospital found only two similar cases before June 2022.

"The reported incident represents an increase in both the number and severity of enterovirus (coxsackievirus) infections in infants under the age of 1 month. There is increased morbidity and mortality associated with the current incident," WHO said.

Enteroviruses are a common cause of seasonal childhood infections and typically cause respiratory disease, hand, foot, and mouth disease, and viral meningitis. Most infections are mild and self-limiting. Neonates can, however, rarely develop severe enterovirus infection, which may present as a sepsis-like syndrome or viral meningitis. Enterovirus myocarditis is associated with high morbidity and mortality, especially in neonates, and can lead to severe complications, including heart failure, arrhythmias, and haemophagocytic lymphohistiocytosis.

Cause unknown

Public Health Wales emphasised that the reaction to the enterovirus infection remains extremely rare and that investigations were continuing to try to understand the reasons behind the cluster.

Christopher Williams, consultant epidemiologist for Public Health Wales, said that enteroviruses affect the heart only on very rare occasions. "This cluster is unusual due to the number of cases reported in a relatively short timeframe, and so investigations are now ongoing in collaboration with the paediatric team in the Children's Hospital for Wales to understand the reasons why and to investigate any further cases that may be reported in the coming weeks and months."

The UK Health Security Agency said it was investigating the cluster. It said the peak of the cluster was last September to December, in keeping with peak seasonal enterovirus activity, but that the underlying factors behind the increase were unclear.

Shamez Ladhani, a consultant paediatrician at UKHSA, said, "Given a higher than average number of cases in Wales in the autumn-winter months in very young babies, UKHSA is investigating the situation

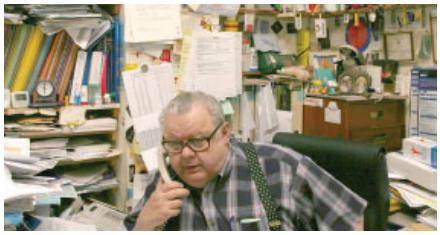
Space constraints, leaks, mould, and poor IT mean many practices are unable to deliver basic care, says RCGP

Two in five GPs in England have said their premises were not fit for delivering basic care, with too few consulting rooms or not enough space for multidisciplinary team meetings.

The findings came from a survey by the Royal College of General Practitioners, which was completed between December 2022 and January by 2649 general practice staff, including 1970 GP partners, salaried GPs, locums, and GP trainees.

Almost half (46%) of the respondents said that their PC or laptop software was not fit for purpose, with 38% reporting poor broadband connection, which led to problems exchanging information with other care providers such as pharmacy systems, out-of-hours care, and community teams.

GPs also reported poor access for disabled people, leaks, mould, and draughty windows. One respondent said their building had



"drafts in windows stopped by Sellotape" and there were "leaks in the building all the time."

The college said the survey showed the state of general practice "makes it difficult for practices to deliver a basic level of care, let alone achieve our vision for the future."

It said that there had been increased numbers of allied healthcare professionals, students, and trainees working as part of GP teams in recent years, without a parallel expansion of space for them to work in.

The college welcomed pledges in the Access Recovery Plan, published earlier this month, for one-off funding for digital telephony and care navigation training but described these as "positive steps" rather than the "silver bullet" that was needed to reduce the intense workload and workforce pressures GPs and their teams were working under.

It is now calling for urgent action to upgrade outdated IT systems and for all practices to have adequate space to treat patients and train GPs and other practice staff. It also wants to see further funding to

ALMOST HALF (46%) of the respondents said that their PC or laptop software was not fit for purpose

UKHSA is investigating the situation in England to see if similar cases have been observed
Shamez Ladhani

in England to see if any similar cases have been observed here and whether there are any factors driving the increase in cases."

The UKHSA said that clinicians should consider the possibility of an underlying myocarditis if they see a poorly feeding neonate presenting with respiratory distress, sepsis, shock, or meningitis. In such cases they should consider testing for enteroviruses in a respiratory sample, blood, stool, or cerebrospinal fluid. Myocardial dysfunction can be identified by measuring cardiac enzymes, electrocardiography, and echocardiography.

Enterovirus infection is not notifiable in the UK. Surveillance for enteroviruses is dependent on voluntary laboratory reporting of positive samples to the UKHSA. There is no specific antiviral therapy for enteroviruses. Treatment relies primarily on management of complications, including fluid management.

Parents and carers have been advised to practise good hand hygiene, including washing hands thoroughly before and after changing nappies, after using the toilet, and before preparing food.

Jacqui Wise, Kent
Cite this as: *BMJ* 2023;381:p1151

retrofit surgeries to improve energy efficiency. Investment allocated through integrated care systems to estates and IT was just 3% of the NHS capital budget per year, data show.

Kamila Hawthorne, RCGP chair, said that although the GP Access Recovery Plan had proposals to improve infrastructure, none would be quick or would tackle the structural issues. "It makes for troubling reading just how many practices, and in turn patients, are suffering, whether it's from a lack of sufficient space or an inability to coordinate with other care teams due to outdated IT systems," she said. "If we're to ensure the highest standard of care for patients, addressing these fundamental problems needs to be an immediate priority."

Zosia Kmietowicz, *The BMJ*
Cite this as: *BMJ* 2023;381:p1144

It makes troubling reading just how many practices, and in turn patients, are suffering
Kamila Hawthorne

Two cases of bird flu detected in poultry workers in England

How does the transmission of avian influenza to humans change the risks to the general population? **Jacqui Wise** reports

What do we know about the cases?
The UK Health Security Agency said that influenza A (H5) had been detected in two people who had recently worked on an infected poultry farm in England. Neither experienced any symptoms of avian influenza, and both have since tested negative on PCR swabs. The first person is likely to have had contamination of the nose from inhaling material on the farm. The second person is thought to be a more complicated case, and it is not yet clear whether they also inhaled the virus while at work. These aren't the first cases in humans in the UK. In January 2022 avian influenza was detected in a person in southwest England who kept a large number of birds in and around their home.

Is there a risk to the general population?
These latest positive test results do not change the level of risk to human health, which remains very low, said UKHSA. "These are people working in close contact with birds on infected farms," Susan Hopkins, the organisation's chief medical officer, told Radio 4's *Today* on 17 May. "There will be a lot of dust and potential virus fragments in the air, on the ground, and on clothing. They wear protective equipment, but there is still a risk it gets up the nose."

She added, "It remains uncertain whether it was a true infection—whether the virus was replicating in the nose and therefore a risk to others—or whether the virus was sitting in the back of the nose from contamination."

How were the cases detected?
UKHSA has been carrying out asymptomatic testing of people working on infected farms. Poultry workers are asked to take swabs of their nose and throat, which are then tested, during the 10 days after their exposure. In some cases they are also asked to have finger blood tests to check for antibodies against avian influenza.

Is there evidence of human-to-human transmission?
UKHSA has been offering testing to all contacts of the affected people. So far there is no evidence of human-to-human transmission, although some people are still being followed up.

Should the level of risk change?
A mandatory housing order for England and Wales was lifted on 18 April meaning poultry and captive birds can be kept outside again, following assessment that the risk had reduced. The avian flu outbreak is ongoing, however, with four million birds in the UK culled in the past year. But Hopkins said, "We are seeing much less detection in farms than we saw before winter and even last summer—and therefore the overall risk to poultry is less than it was." But she added, "Clearly, it's an ongoing risk, and we need to continue to monitor the situation closely."

What is the risk to people?
There have been a small number of deaths worldwide but none in the UK. In April this year a woman in China died from a different form of avian influenza, H3N8. In February Cambodian authorities reported two cases of H5N1 bird flu within the same family, raising concerns over potential human-to-human spread of the virus. Ian Brown, director of scientific services at the Animal and Plant Health Agency, said, "The virus is not changing its characteristics to something riskier to humans, but continued monitoring is important." He emphasised that farm biosecurity remained the most important defence. WHO assesses the risk to humans as low but warns that the situation must be monitored closely.

Writing in the *Guardian*, Devi Sridhar, professor of global public health at the University of Edinburgh, warned that bird flu could become the next human pandemic and that governments should be prepared. She said that the signals emerging across the world continued to be worrying, with reports of increasing cases of bird flu appearing in mammals. Sridhar wrote, "There are enough concerning signals that action should already be happening."

Jacqui Wise, Kent Cite this as: *BMJ* 2023;381:p1132

THE BIG PICTURE

Gardens created to enhance wellbeing

The Royal Horticultural Society's Chelsea flower show has long been an advocate of the health affirming properties of gardens.

This year's event was no different, with two show gardens designed to celebrate that message. A Life Worth Living Garden (right) was designed by Chris Beardshaw for the charity Myeloma UK. The garden, which won a gold medal, was created to "evoke a sense of calm reflection, hope, and resilience." It also marks the 25th anniversary of the charity, which assists patients and raises awareness of this incurable, but treatable, blood cancer.

A second show garden dedicated to health and wellbeing was the Centre for Mental Health's The Balance Garden (below), an urban community garden. Designed by Wild City Studio and supported by Project Giving Back, the silver medal winning garden is a space for an urban community to look after. Its landscaping was designed to create affordable ways of connecting with nature and growing food for everyone to enjoy.

Alison Shepherd, *The BMJ* Cite this as: *BMJ* 2023;381:p1186

Apology

In the Big Picture of the 13 May 2023 issue we inadvertently included an inappropriate image. We are sorry for any offence or harm caused. We have replaced the picture in the online version of the story (*BMJ* 2023;381:p1044) and in the online PDF version of the This Week section. We are reviewing how the image came to be included in the journal and how to prevent future occurrences.

GUY BELL/ALAMY

EDITORIAL

The primary care access plan for England

Proposed measures don't go nearly far enough

The government's long promised plan for recovering access to primary care in England, published on 9 May, is designed to "tackle the 8 am rush and make it easier and quicker for patients to get the help they need from primary care."[1] The focus is on general practice, supported by community pharmacy, with proposals to recover access to dentistry not due to be published until later this year.

General practices in England delivered more appointments than ever before in March 2023, 20% more than in the same month in 2019.[2] But despite this growth in activity, demand still outstrips capacity. Although satisfaction with the care received from general practice remains high, satisfaction with access has fallen to its lowest ever level.[3]

As ever with such plans, it brings together a series of initiatives, some of which have already been announced. There are no major surprises, and the plan can broadly be divided into four themes: investment in community pharmacy, investment in technology, reducing bureaucracy, and increasing workforce.

Community pharmacists

Community pharmacy sees the largest investment, with an additional £645m over two years. This is intended to support community pharmacies to manage a range of common conditions, including the ability to prescribe some medications and deliver clinical services such as blood pressure checks.

Moving community pharmacy towards delivery of clinical care has long been the direction of travel, and from 2026 all newly qualified pharmacists will be able to prescribe.[4] Similar schemes for managing common conditions in community pharmacy already exist in Scotland and Wales.

ALISTER FIRTH/ALAMY

The plan is lightest on workforce matters

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The sector has welcomed the investment,[5] but with contract negotiations over the deployment of the additional funds only now beginning, and existing concerns about whether existing services are adequately funded and sustainable,[6] any benefits will take a while to materialise. Many community pharmacies are facing substantial financial and workforce challenges and may not have the capacity to deliver the new services despite the funding.

Clear communication with the public will be important to avoid expectations being falsely raised.

On investment in technology, £240m has been "retargeted" in 2023-24 for new technologies to support improved access, including online tools, expansion of the NHS app, and digital telephony. Much of this is aimed at improving care navigation so that more patients can be diverted to self-care, community pharmacy, or other services. Importantly, the plan recognises that practices need the headspace and capacity to support effective implementation of new tools and processes,[7] and funding is available for backfill and staff training. The plan states the money is being retargeted, but it is not clear where from.

On reducing bureaucracy, the plan restates previous commitments to improve communication between general practice and secondary care and reiterates the requirement for integrated care boards to increase pathways for patients to self-refer for some services, such as community podiatry and physiotherapy.

However, with extremely long waiting times for these community services, many may still turn to general practice to try to expedite their referral.

Missing links

It is on workforce that the plan is lightest. Changes to visa rules will allow international medical graduates more time to find sponsorship when they qualify, a reiteration of the commitment to the additional roles reimbursement scheme (introduced in 2019 to support the recruitment of 26 000 additional staff into general practice) and to previous commitments to resolve pension tax problems. Signals that the wider NHS workforce plan is on the way are welcome, but without that funded long term workforce plan it is hard to see how, despite efforts at the margins, the gap between capacity and demand can be reduced significantly.

The plan is also absent on estate. Substantial investment is needed in the bricks and mortar of general practice because it is simply not extensive enough or sufficiently well maintained to house the diversity or scale of workforce that is required.[8]

Really improving access to primary care will take a sustained and substantial refocusing of NHS resources on primary care, supporting the expansion of the workforce, consistent and coherent engagements with patients and communities, and a continuing and relentless focus on shrinking the gap between demand and capacity.

Cite this as: *BMJ* 2023;381:p1103

Find the full version with references at http://dx.doi.org/10.1136/bmj.p1103

EDITORIAL

Covid-19 vaccination and vaginal bleeding

Postmenopausal bleeding must be investigated, even when it follows vaccination

In the spring of 2021, reports started accumulating of menstrual changes and unexpected vaginal bleeding after covid-19 vaccination.[1] Fortunately, a wealth of data from menstrual cycle tracking apps allowed researchers to quickly show that vaccination can temporarily increase cycle length and menstrual flow, with cycles returning to normal soon after.[2 3]

Although postmenopausal bleeding is generally no cause for concern, in approximately 9% of cases, bleeding is a sign of endometrial cancer.[4] For individuals who are accustomed to no longer having regular periods, both the bleeding itself and subsequent investigations to rule out cancer are a cause of substantial distress. As such, investigating whether covid-19 vaccination raises the risk of postmenopausal bleeding and, if so, why this occurs and what outcomes are expected, should be a priority.

A nationwide cohort study of the female population of Sweden, recently published in *The BMJ* (doi:10.1136/bmj-2023-074778), takes the first step in exploring this association.[5] Of almost three million participants included, 1.56 million were 45-74 years old and this subcohort was queried to identify instances in which individuals sought healthcare for postmenopausal bleeding.

The risk of seeking healthcare for postmenopausal bleeding was calculated before vaccination, within seven days of vaccination, and between 8 days and 90 days after vaccination, to determine whether the risk was increased by vaccination.

After adjusting for covariates, the authors found a small increase in the risk of seeking healthcare for postmenopausal bleeding 8-90 days after the second and third dose of covid-19 vaccine but no increased risk of seeking healthcare for menstrual changes in individuals who were premenopausal.

STUART WALKER/ALAMY

A sharper focus is needed on how menopause and perimenopause interact with other aspects of health

Angela Taylor, patient partner

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Covid-19 vaccines and boosters are no longer offered to most individuals younger than 50 years in the UK,[6] therefore, consideration of the implications of postmenopausal bleeding after vaccination is essential, because these will now affect more people than menstrual changes.

Support and advice

With this in mind, doctors and gynaecologists who are aware of the potential increased risk of postmenopausal bleeding after covid-19 vaccination will be better equipped to support and advise patients. Patients who take medications, such as hormone replacement therapy, that are known to cause postmenopausal bleeding as a side effect, are more likely to have a higher threshold for investigation of endometrial cancer.[7] We might, therefore, ask if the findings from this study warrant a similar approach to the management of postmenopausal bleeding after covid-19 vaccination.

However, the reported association with vaccination was weak and causality was not established, so anyone who has postmenopausal bleeding following vaccination should still be encouraged to seek medical attention, and investigated for endometrial cancer via recommended pathways.[1]

The Swedish study examined only healthcare contacts, not the result of any investigations, but future nationwide cohort studies could provide further insights into clinical outcomes. A more comprehensive understanding of the broader effects on quality of life will also require qualitative approaches focused on ensuring that patients feel comfortable sharing their experiences.

Defining the mechanisms by which postmenopausal bleeding associated with covid-19 vaccination might occur would allow us to better understand whether this side effect is a cause for concern. A subgroup analysis in the BMJ study by Ljung and colleagues indicated that all studied vaccines were associated with an increased risk of postmenopausal bleeding (although for the Moderna and AstraZeneca vaccines the estimates were imprecise), suggesting a mechanism mediated by immune response to vaccination, rather than by a specific vaccine component.[5]

This raises the possibility that postmenopausal bleeding may also occur following other vaccines, such as those for influenza and shingles—an area for further research.

A sharper focus is needed on menopause and perimenopause and how they interact with other aspects of health. The potential link between covid-19 vaccination and postmenopausal bleeding is only one example: a related observation is that some people living with long covid report symptoms that are exacerbated by, and overlap with, those of perimenopause and menopause.[9 10]

In the UK, the new Women's Health Strategy,[11] along with grassroots activism, is raising public awareness in this area. Let's ensure that research keeps pace with these efforts.

Cite this as: *BMJ* 2023;381:p1122

Find the full version with references at http://dx.doi.org/10.1136/bmj.p1122

BMJ INVESTIGATION

Medical colleges and unions call for inquiry over "shocking" levels of sexual assault in the NHS

More than 35 000 cases of rape, sexual assault, harassment, stalking, and abusive remarks were recorded between 2017 and 2022, but only one in 10 trusts has a dedicated policy to manage the problem. **Ingrid Torjesen** and **Adele Waters** report

ROWENA SHEEHAN

Medical colleges and healthcare unions have urged the government to take immediate action against sexual assault and harassment in the NHS after an investigation by *The BMJ* and the *Guardian* found that trusts are failing to protect staff and patients.

The BMJ and the *Guardian* sent freedom of information (FOI) requests to every single hospital trust and police force in the country for data on how many sexual safety incidents, a term which covers a spectrum of behaviours from abusive remarks to rape, they had recorded on NHS premises, as well as hospital trusts' policies on how to manage and prevent the problem.

The responses show that more than 35 000 sexual safety incidents were reported to 212 NHS trusts in England between 2017 and 2022 and that less than one in 10 trusts has a dedicated policy to deal with sexual assault and harassment. Despite staff being the group predominantly affected (in 62% of incidents), trusts are no longer obliged to report abuse of staff to a central database.

We doubt whether the NHS is capable of getting its own house in order
Naru Narayan

The BMA told *The BMJ* that it called on the government to "urgently produce a plan of action to protect our colleagues," with the Academy of Medical Royal Colleges and others going further and telling us that they are calling for a full independent inquiry into the epidemic of sexual assault in the NHS.

The Hospital Doctors Union (HCSA), GMB union, the Society of Radiographers, the British Dietetic Association, and the Liberal Democrats all told *The BMJ* that they are also calling for an urgent independent inquiry. HCSA said that employers have "no real grasp of this complex issue" and that their approach to dealing with it "only makes the situation worse, driving staff into ill health or out of the service."

"These revelations are truly sickening," says Liberal Democrat health spokesperson Daisy Cooper. "We need an independent public inquiry now, to uncover the full extent of this scandal and put an end to it." She continues: "Ministers must hold the NHS to account: every trust needs a dedicated policy in place to prevent sexual harm, a clear and effective process for those affected to report incidents and a single system to collect data so we can see the full extent of the problem."

"HCSA's experience to date makes us doubt whether the NHS, despite the best intentions of many, is capable of getting its own house in order," says HCSA president, Naru Narayanan. "We need a formal independent inquiry into the issue to uncover the truth and hold policy makers and employers to account. We need real cultural change."

Poor reporting systems

Responses to FOI requests from 212 NHS trusts in England show a total of 35 606 sexual safety incidents were recorded over a five year period (2017-2022) . At least 20% of incidents involved rape, sexual assault, or kissing or touching that a person did not consent to, although not all trusts provided a breakdown of the type of incidents recorded. The other cases included sexual harassment, stalking, and abusive or degrading remarks. The data show that patients are the main perpetrators of abuse in hospitals. Most incidents (58%) involved patients abusing staff, with patients abusing other patients the next most common type of incident (20%).

Yet experts say that these figures vastly underestimate the problem because systems for recording are so poor across the NHS. Trusts have wildly varying criteria for when a case is reported, says Deeba Syed, senior legal officer for Rights of Women, a helpline that provides support for women who have been sexually assaulted or harassed at work. Each trust has a different practice around whether they report cases before or after an investigation or disciplinary action, she says. "I don't think there is a robust reporting system," she told *The BMJ*. "There's no one doing it correctly. They're all doing it differently and on different understandings of when to report."

Both staff and patients might be unsafe

Sexual safety incidents involving patients are reported through the National Reporting and Learning System, a central database of patient safety incident reports, which is being replaced with a similar system this year. But abuse of staff is not reported through this system, and trusts are no longer obliged to disclose it to NHS England, *The BMJ* and *Guardian* have learnt. Abuse of staff used to be monitored by NHS Protect, which was scrapped in 2016.

"By not counting staff assaults, we are making them invisible. I cannot see an argument against counting them," says Katrin Hohl, professor of criminology and criminal justice at City University, London.

In 2017-2022, a total of 11 880 alleged sexual crimes on NHS premises were reported to 37 police forces. This includes at least 5164 sexual assaults and at least 3084 rapes. Other offences included exposure, masturbation, and voyeurism. But these figures represent only "a very small fraction" of the total recorded cases because police forces do not consistently record the location of crimes, says Hohl.

The investigation's findings are "significant," with the levels of abuse perpetrated by patients "under-reported" so far, says Rosalind Searle, professor in organisational psychology at the Adam Smith Business School,

THE TRUST'S REACTION TO MY SEXUAL ASSAULT IMPACTED MY MENTAL HEALTH

Fleur Curtis, 43, was sexually assaulted on three occasions by a junior doctor in 2016 and 2017 when she was working as a physician associate at the Princess Royal Hospital in Telford.

The assaults, and the trust's poor handling of her complaint, left her experiencing panic attacks and post-traumatic stress disorder, forcing her to quit her job in 2020. "I'd worked for the NHS all my life, and had a career that I loved, but I just felt that I had no other option than to leave" says Curtis. "The worst thing was how the trust handled my complaint, that had a massive impact on my mental health."

In the latter part of 2016, Curtis noticed a doctor from a different ward using her ward's doctors' office. He would stare at her, and in December 2016, she says, he pulled up a chair next to her, leant on her, and put his hand on her thigh. "If this had happened to me outside of work, I would have reacted. I would have moved, I would have screamed and shouted, but you just don't expect a doctor at work to do that," she told *The BMJ*.

A few weeks later, Curtis says that she was working in the office again when the doctor pulled his chair right up to where she was working. She pushed her chair back and stood up to get away, but he stood up at the same time and he pushed his groin against her. "I could feel he had an erection. It was gross," she says.

The third incident happened in February 2017, as Curtis was walking into the doctor's office. She says he pretended to stumble and fell on her left breast and continued to hold it.

"Again, I just froze," she says. "It was at that point I thought 'I need to report this. I'm not imagining it, and it's getting worse.'"

On 13 February 2017, Curtis used the Datix incident reporting system, a digital system used in hospitals to collect data for clinical adverse events and staff complaints, to report "unwanted physical contact." When she asked if he would be suspended, she was told that no patients had complained and that suspensions are "bad for doctors' careers." She says, "I basically threatened to go to the media if he wasn't suspended with immediate effect."

The trust held an emergency meeting that evening, 23 February, and the doctor in question, Mahendar Katarapu, a specialist registrar working on a one year fixed contract in general and acute medicine, was suspended while an investigation took place. "During the investigation I found the trust had received complaints similar to mine before it happened to me," Curtis says, and several more were reported to the trust after Curtis had made her complaint. In total nine Datix reports were made, and other concerns raised verbally.

After its investigation,

Shrewsbury and Telford Hospital NHS Trust dismissed Katarapu on 10 July 2017 for gross misconduct, and the GMC erased Katarapu from the registrar after a Medical Practitioners Tribunal Service fitness to practise hearing, which ended in December 2020.

Katarapu appeared at Shrewsbury Crown Court in January 2018, charged with seven allegations of sexual assault involving four women between August 2016 and March 2017. After the case was heard, and a retrial over two charges that took place in June 2018, he was cleared of all charges.

At Curtis's request, Shrewsbury and Telford Hospital NHS Trust commissioned an independent report into its handling of her concerns. The report, produced by Vista (a company specialising in HR investigations) and seen by *The BMJ*, concludes that "on balance, the evidence does not show that the trust dealt with [Curtis's] concerns appropriately" and could be said "to have fallen short of what might reasonably be expected."

The report lists several areas in which the trust could make improvements, from its response speeds and support offered to victims and witnesses to how it handles investigations and evidence that might be required in a criminal case.

A spokesperson for the trust said that it could not comment on individual cases but has "acted upon recommendations to improve support and training for staff."

They added: "We are fully committed to creating a safe, supportive environment for all colleagues and have embedded Freedom to Speak Up, and many other routes, throughout our organisation to encourage any concerns to be raised and acted upon."

University of Glasgow, who has examined medical regulators' failures in managing sexual assault and harassment. "These are places that people should be safe, and these data are suggesting that, actually, both staff and patients might be unsafe from potential abuse perpetrated by either staff or patients," she says.

Lack of dedicated policies and training

Most NHS trusts have a range of policies that cover some aspect of sexual safety, such as managing violence or safeguarding children and adults, but most—187 of the 207 trusts that responded to an FOI request—do not have sexual safety policies: dedicated policies that set out how to safeguard staff, patients, and visitors from harm and what processes to follow when cases are reported. The 20 trusts that did have dedicated policies reported more cases than those that didn't. Trusts that did not report any sexual safety incidents tended not to have policies.

"This is absolutely shocking and I think shows a terrifying naivety on the part of those trusts, the huge majority, without a specific policy," says Elizabeth Duncan, a partner at Slee Blackwell Solicitors. "How they can possibly hope to keep patients and staff safe in the absence of policy and guidance is beyond me."

Latifa Patel, the BMA's representative body and workforce lead, says that she assumes that trusts without dedicated sexual safety policies are "sitting on huge numbers of unreported incidents," which she describes as "a truly disturbing implication."

In addition to a lack of policies, a study published in May found that only one NHS trust offers staff training on how to intervene when they witness sexual harassment at work.

Children and elderly people raped on NHS premises

Police recorded 180 cases of rape of children under 16 on NHS premises between 2017 and 2022, with four children under 16 being gang raped, *The BMJ* and *Guardian*'s investigation found. There were a further 186 reports of children under 16 being sexually assaulted and 127 reports of crimes including grooming, assaulting a child by penetration, sexual communication with a child, inciting sexual activity with a child, and causing a child to watch a sex act.

The data were taken from 32 police forces that responded to either *The BMJ* and *Guardian*'s FOI request or to requests sent by other organisations or individuals.

It is not possible to tell from the data where these incidents occurred, but Liz Kelly, professor of sexualised violence at the London Metropolitan University, thinks there is a child safety issue in mental healthcare settings. She told *The BMJ* that she calls on police forces to record the location of crimes in more granular detail for a better understanding of where most incidents are happening, allowing for solutions. Previous research has also uncovered sexual assaults of elderly people on NHS premises.

Staff on staff abuse

Trusts reported just 902 incidents of abuse against staff by colleagues, which is "the tip of the iceberg," says Becky Cox, co-founder of Surviving in Scrubs, a campaign group that seeks to raise awareness about sexual harassment and assault in the healthcare workforce.

The BMJ and *Guardian*'s data show that 193 of the 212 trusts reported 10 or fewer staff on staff incidents between 2017 and 2022, which is implausible for trusts with their numbers of employees and shows the need for better policies and reporting systems, says Simon Fleming, orthopaedic registrar and co-author of *Sexual Assault in Surgery: a Painful Truth*, commissioned by the Royal College of Surgeons in 2021.

Staff are reluctant to report sexual assault, says Fleming. The BMA's Sexism in Medicine survey found that 66% of women doctors who did not report incidents of sexist behaviour did so because they felt nothing would be done. Women don't want to make a fuss, don't think it will make a difference, or think that it will ruin their careers, Fleming says. "And that's on top of all the usual things like shame, guilt, anger, having been silenced, having been slut shamed, having PTSD [post-traumatic stress disorder] and associated trauma."

The reported 902 incidents of abuse against staff by colleagues, is the tip of the iceberg
Becky Cox

Trusts show a reluctance to suspend perpetrators due to overall staff shortages
Deeba Syed

"I know hundreds of female doctors who've been assaulted, thousands who've been harassed, and a decent number who've been raped within the NHS," he says. One person even shared a story about a consultant boasting to his team that he raped his wife. Incidents "at work" happen not only on NHS property, but elsewhere, such as at conferences and in work car parks, he says, "where certain consultants often perceive that the normal legal and social boundaries don't apply anymore.

"Quite a few people describe being offered a lift to a clinic or to a remote site, and then something happens in the car." Surviving in Scrubs and another campaign group National Survivor User Network told us that they backed calls for an independent inquiry into sexual assault and harassment in the NHS.

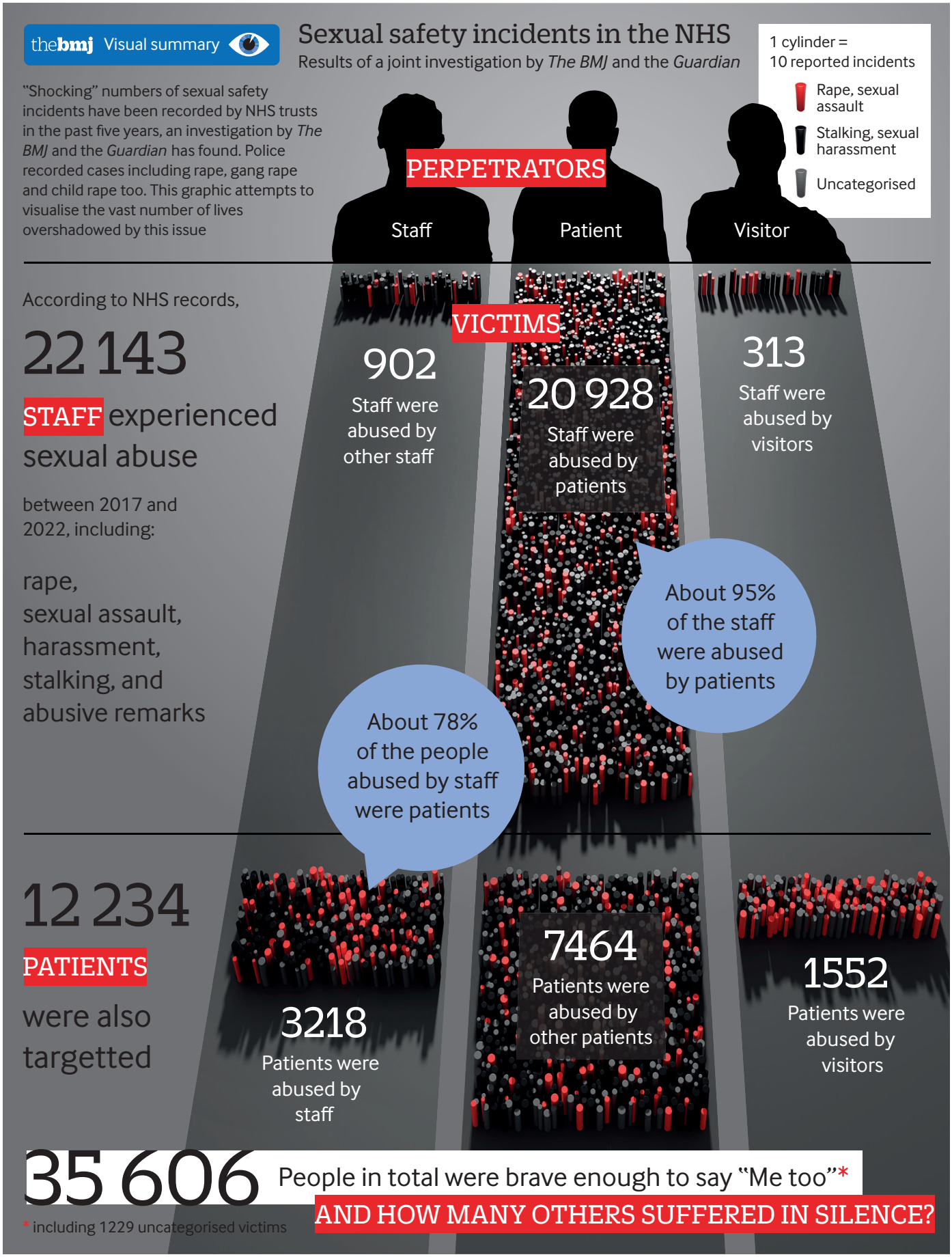
Trusts rarely take action

More than 4000 NHS staff were accused of rape, sexual assault, harassment, stalking, or abusive remarks towards other staff or patients in 2017-2022, yet few have faced action from their employers, *The BMJ* found.

Trusts took disciplinary action against only 577 staff for such incidents in this five year period. Only 149 of the 212 NHS trusts that provided data on sexual safety incidents also provided data on the level of disciplinary action against staff.

When complaints are made against colleagues, women claim that NHS trusts show a "reluctance to suspend perpetrators due to overall staff shortages," says Syed. Instead of being supported, some staff that complained to their employers have been threatened with or put through disciplinary processes, she says. "In some cases, they were even referred to the professional regulator for allegedly failing to meet their duty of care to patients, which has left those women feeling frightened and intimidated into dropping their cases," Syed says.

Lawyers with experience of bringing cases against NHS trusts for sexual safety incidents also say that trusts are reluctant to deal with cases


thebmj Visual summary
Sexual safety incidents in the NHS
Results of a joint investigation by The BMJ and the Guardian
"Shocking" numbers of sexual safety incidents have been recorded by NHS trusts in the past five years, an investigation by The BMJ and the Guardian has found. Police recorded cases including rape, gang rape and child rape too. This graphic attempts to visualise the vast number of lives overshadowed by this issue
1 cylinder = 10 reported incidents
Rape, sexual assault
Stalking, sexual harassment
Uncategorised
PERPETRATORS
Staff
Patient
Visitor
VICTIMS
According to NHS records,
22 143
STAFF experienced sexual abuse
between 2017 and 2022, including:
rape, sexual assault, harassment, stalking, and abusive remarks
902
Staff were abused by other staff
20 928
Staff were abused by patients
313
Staff were abused by visitors
About 95% of the staff were abused by patients
About 78% of the people abused by staff were patients
12 234
PATIENTS
were also targetted
3218
Patients were abused by staff
7464
Patients were abused by other patients
1552
Patients were abused by visitors
35 606
People in total were brave enough to say "Me too"*
* including 1229 uncategorised victims
AND HOW MANY OTHERS SUFFERED IN SILENCE?

and perpetrators effectively, often choosing to settle cases rather than accept liability and deal with longstanding problems. "Generally speaking, they'll want to try and sort of sweep it away, because that's easiest," says Jayne Harrison, a partner at Richard Nelson.

Trusts can be reluctant to report incidents to the police and sometimes put insufficient restrictions on staff under investigation, several lawyers told *The BMJ*. "We are aware of cases of doctors under police investigation in relation to multiple counts of alleged sexual offences against patients, with a history of previous safeguarding investigations and findings by the [GMC], being permitted to continue practising during the police investigation period, including intimate examinations on women," says Catriona Rubens, associate solicitor at Leigh Day.

"The only conditions being there should be a chaperone present and a log kept of all the intimate examinations conducted. The idea that a doctor is allowed to continue practising and carry out intimate examinations while under that kind of scrutiny must be horrendous for the victims to know as well."

When a staff member is under investigation or suspended, it doesn't show up on a Disclosure and Barring Service check, she added, which leaves perpetrators free to gain employment elsewhere. Perpetrators often resign when an allegation is made, allowing them to move on to a different hospital, care home, or agency, says Amanda Warburton-Wynn, a partnership officer for sexual violence and domestic abuse at Cambridgeshire County Council, who spoke to *The BMJ* in a personal capacity.

Little progress at mental health trusts

The investigation found that nearly three quarters of the sexual safety incidents on NHS premises occurred in mental health trusts. More than 93% of the cases in which a patient was abused by another patient occurred in these settings.

The BMJ will be hosting a webinar on this topic on June 8. Sign up here: bit.ly/BMJwebinar

The BMJ uncovered multiple cases of gang rape in mental health trusts. In the five years from 2017 to 2022, 56 gang rapes were recorded on NHS premises by 10 police forces in England. The real figure on gang rapes is likely to be higher because not all police forces in England provided detailed breakdowns of crime codes that enabled specific types of offences to be counted.

Leicestershire police force alone recorded 18 cases of gang rape, all but one of which took place in a mental health unit. The offenders were never identified—often because the victim was unable to support police efforts—so they could go on to assault other patients.

It seems that little progress has been made since the Care Quality Commission (CQC) raised the alarm over sexual safety in mental health facilities in a 2018 report, which found that sexual safety incidents were "commonplace" and occurred so frequently that staff became "desensitised" to them and felt ill equipped to respond to them.

OPINION Rosalind Searle

How many more people will be abused before we act?

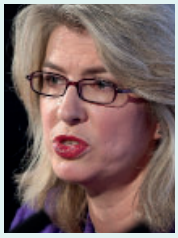
Failures to record, investigate, and respond enable perpetrators, but three sanctioning mechanisms can help tackle this

This investigation offers some explanation of why sexual harassment and abuse remain enduring concerns in the NHS, finding a lack of sexual safety policies in many organisations and failures to record and then investigate such cases.

Collecting and recording data are central to organisational understanding of these phenomena. The investigation highlights failures to take sexual violence seriously and to value gaining a more sophisticated understanding of three distinct sanction mechanisms—self, social, and legal sanctions—that are required to reduce these violations in workplaces and society.

Sexual harassment and abuse do not occur in isolation. Our research has associated these behaviours with workplaces that are already hotspots for bullying and harassment from both patients and staff. Perpetrators exhibit aggressive, goal directed behaviours for their own satisfaction and to enhance their feelings of power and control, with little or no regard for their targets. Research shows that this behaviour is habitual—once started, it is difficult for the individual to self-reflect and control it. Perpetrators often test how others react to their transgressive activities and whether their behaviour is tolerated in that environment. They use cognitive reframing and behavioural strategies to overcome their inhibitions, denying or downplaying the consequences of their behaviours.

Perpetrators select locations for privacy and access to suitable targets—especially people who are vulnerable, powerless, or might be considered unreliable witnesses.



Perpetrators often test the reaction to transgressive activities; whether their behaviour is tolerated
Rosalind Searle

Jimmy Savile's crimes showed the vulnerabilities of healthcare workplaces and the attraction for abusers—people can move around largely unchallenged by both staff and the visiting public.

Perpetrators are found to use specific career choices such as agency or locum work to improve their access to targets. Some workplaces, notably mental health facilities, are hotspots for perpetrators as they are the location of a wide range of professions including psychiatry, nursing, and psychology staff. There are also issues with family medicine and obstetrics and gynaecology, although these vary by profession and access. Focusing on such locations to ensure data are gathered is valuable, especially as the investigation indicates that data collection is inconsistent.

Only 16 of the 47 mental healthcare providers that responded to our FOI requests have dedicated policies, despite government commissioned sexual safety standards requiring this. NHS England commissioned the National Collaborating Centre for Mental Health to draw up the standards after the CQC's 2018 report.

The report said that mental health trusts had difficulty separating men and women on mixed sex wards and called for trusts to supervise common areas where a substantial proportion of incidents took place. It said that clinical leaders of mental health trusts often didn't know what good practice looked like, were not always aware of the effects that unwanted sexual behaviour had on patients and staff, and lacked knowledge of how to respond to what seemed to be consensual sexual activity between patients (a particular problem on longer stay wards).

Duncan says that most cases of sexual assault in mental health trusts had involved staff such as occupational therapists, support workers, or nurses grooming patients into a "relationship." Patients receiving psychiatric treatment are vulnerable and might be less likely to contact the Patient Advice and Liaison Service (PALS) about abuse, so end up calling a lawyer in desperation, she added.

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These staff were rarely prosecuted, because cases rarely went to court, probably owing to concerns about the credibility of the victim because of their illness and how they would stand up to cross examination, says Duncan. "This means, in my view, that some of our most vulnerable members of society have the smallest chance of seeing justice," she says.

Sarah Hughes, chief executive officer of mental health charity Mind, says: "It is unacceptable that in the five years following those reports so many people continued to be let down in such an appalling and traumatic way."

What can trusts do?

Trusts need to be guided by NHS-wide policies on how to deal with allegations, including when to suspend staff and when to report individuals to the police, and should act swiftly to deal with complaints, say Tamzin Cuming and Carrie Newlands, from the Working Party on Sexual Misconduct in Surgery, a group of NHS surgeons, clinicians, and researchers who are working to raise awareness about this issue. Compliance with these policies should be a standard CQC reporting item, they add.

Any policies should always be introduced alongside training on what constitutes unacceptable behaviour, says Alison Millar, a partner at Leigh Day. If "low level"

Given that perpetrators' self-regulation is impaired, two other mechanisms should be used to help deter and prevent their behaviours. Social sanction is an important means of inhibiting perpetrators, but only if the perpetrator fears the negative reactions of others. Considering ongoing issues of recruitment and retention in health workforces, having fewer staff reduces the means to notice other's abusive behaviours and then the capacity to intervene. As perpetrators often hide their activities, only subtle clues might be available to indicate that something is not quite right.

More insidiously, perpetrators can deliberately subvert workplace norms and culture, often relying on ambiguity. They might only make sexualised comments to junior female staff, for example, masking it as a joke to make it easier to disregard. Yet what is occurring is boundary shifting, desensitisation of bystanders and targets, and reduction of social sanctioning.

Clear policies of sexual safety and mandatory staff training on these policies are important in re-establishing social boundaries, reducing the ambiguity of what is acceptable behaviour from staff and patients, and raising awareness about reporting. For those who are experiencing sexual harassment and violence to feel confident about reporting, they must trust that senior and responsible role holders are willing to listen and act on their concerns. Yet such roles are often held by perpetrators or those more focused on protecting the organisation. Building a trusted organisation requires the application of sanctions, showing justice for the targets of abuse and that safeguarding of staff and service users is a priority. The current investigation indicates what could be interpreted as a wilful disengagement manifest in the failure of controls to detect or prevent sexual abuse. Not collecting data on sexual harassment and violence does not change its occurrence—rather, it suggests that the organisation is incompetent and lacking in good intentions.

Effective legal sanctions and punishments are the final means to inhibit perpetrators. This investigation again shows shortcomings in the NHS, with inconsistent and inadequate recording making early detection impossible, and inconsistent sanctions leading to further ambiguity. Early evidence of sexual transgression is often discounted. These failures fuel perpetrators' moral disengagement and sense of exceptionalism and permit abuse. They pervert justice and support for targets. Downplaying incidents of sexual abuse, especially those perpetrated by patients, reduces staff wellbeing, job satisfaction, and workplace safety, and increases staff intentions to quit the workplace and profession. The culture of silence that follows supports the decline of moral, financial, and care quality in the organisation and the erosion of public trust, permitting abusive activities.

2022 saw the highest level of sexual violence reporting in the UK. When these events occur at work, they undermine the safety and integrity of that workplace. Specific sexual harassment and violence policies need to be developed and used if we are to have the means of changing the lives of perpetrators, targets, and bystanders.

Rosalind Searle, professor and chair in human resource management and organisational psychology, Adam Smith Business School, University of Glasgow

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incidents are tolerated, people will be reluctant to report sexual violence.

The Working Party on Sexual Misconduct in Surgery told *The BMJ* that it is also calling for mandatory reporting of all serious sexual safety incidents to the police and regulators. It wants proven sexual misconduct in the workplace to be recorded on the staff records of a perpetrator and shared with new places of work.

Some experts are uncomfortable with mandatory reporting. "Isn't it that adult's choice as to whether a report is made to the police or not?" says Liz Kelly, professor of sexualised violence at the London Metropolitan University. "Especially adults who've had an experience of having control taken away from them over their body." The more useful thing is for people who have been assaulted to be referred to a specialist sexual violence service so they can be supported, she says.

All agree that action is needed fast. "Employers must ensure that victims are supported and feel empowered to report sexual harm and resolve to take appropriate action," adds Patel. "It is heartbreaking to see the extent to which the NHS has failed to provide this safety to patients and healthcare staff."

Steve Barclay, health secretary, said that the government has doubled the maximum sentence for those who are convicted of assaulting health workers like doctors and nurses. "NHS leaders have a statutory duty of care to look after their staff and patients and prevent harassment, abuse, or violence in the workplace. I expect employers to be proactive in ensuring staff and patients are fully supported, their concerns listened to and acted on with appropriate action taken where necessary," he says.

"We are also working closely with NHS England as it takes action to prevent and reduce violence against staff, including through body-worn camera trials and a national violence prevention hub to ensure NHS staff can work in a safe environment."

Ingrid Torjesen, freelance journalist, London

Adele Waters, freelance journalist, London

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OPINION Simon Fleming

With sexual offences, what you permit, you promote

It is everyone's responsibility to hold predators accountable

Growing evidence shows that healthcare worldwide has a problem with sexual violence. Increasing numbers of people, predominantly women, are coming forward to share their experiences. When it comes to sexual predators, what we permit, we promote. Think of people at work who "gave you the ick," "were walking, talking red flags." Many of us will be aware of people who fit this description, and some of us will have experiences of sexual harassment, assault, or rape by such sexual predators.

In England and Wales, evidence indicates that, by the age of 16, one in 20 women will have experienced attempted rape or rape. Moreover, 98% of the perpetrators are men. In healthcare specifically, the best data we have, allowing for under-reporting, indicates a 60% rate of sexual harassment 10-15% rate of sexual assault, and 1% rate of rape.

Rape culture and the hierarchical and patriarchal structures we work in silence and dismiss the voices of survivors. Writer Rebecca Solnit explains, "Rape culture asserts that women's testimony is worthless, untrustworthy…who is heard and who is not defines the status quo." The NHS has such a culture of hierarchy, patriarchy, and power.

So here is a question—if reading about sexual violence doesn't fill you with either fury or disgust, why not? This might be due to familiarity with these experiences or normalisation and acceptance of what is toxic, at best, and criminal, at worst. Or it is simply denial because the truth is too uncomfortable?

Sexual Assault in Surgery: a Painful Truth was published in 2021. It highlighted a global culture of silence, of patriarchy, and of normalising sexual offences in surgery. It was the first paper of its kind in the UK. In the two years since, many healthcare organisations have released statements denouncing the attitudes and behaviours described. Many more have remained silent, perhaps hoping it might all simply go away. Some have set up working groups, although the finite timeline of these groups is a concern because it risks performative and pacifying action. Suggesting that the work of changing and maintaining culture will one day be finished shows a fundamental lack of understanding of the scale and severity of the problem. Making healthcare a safe, fair, respectful, and diverse place should be a core value, a uniting thread that runs through the fibre of everything we do.

Numerous stories of predatory behaviour have been shared with me by people in the NHS. Since August 2021 I have heard the following: a consultant who played with the nipples of patients while they were under anaesthesia; someone saying they think there is no rape or sexual assault in the NHS, arguing that people who say there is have misunderstood or "don't have a sense of humour"; another complained they shouldn't have to worry someone is going to "cry rape" if they put their hand on their thigh; a "well known sexual predator" who is kept away from students, "Everything will be fine," my correspondent wrote, "You know how it is."

Nobody is above reproach or challenge
Simon Fleming

But it doesn't have to be this way. We do not need more surveys. We do not need vague statements or more silence. We need decisive action. This means anonymous reporting systems, active bystander training, systems that allow growth and learning but also demonstrate accountability, using superlative resources, like the Operate With Respect materials from the Royal Australian College of Surgeons.

We must face the problem and tackle it directly. That means not shying away from the fact that it makes us uncomfortable, embarrassed, ashamed, or guilty and acknowledging when we have failed to listen to people who have experienced sexual violence.

Nobody is above reproach or challenge. Right now, the hierarchy we exist in allows these incidents to go unchecked and, when reported, allows them to be hushed up and brushed under an increasingly threadbare carpet. We need to recognise that some people showing predatory behaviour might need a "cup of coffee conversation" and some might need an awareness intervention, but also that some have committed explicit crimes.

We all have a part to play in changing the culture. As more of us have uncomfortable conversations about how to make the NHS safer for patients and staff and we accept the premise of "what we permit, we promote," ask yourself—what side of history do you want to be on?

Simon Fleming, orthopaedic surgeon, Barts Health Trust

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