Workplace Culture at Whittington Health NHS Trust: An Independent Report Commissioned by

Whittington Health NHS Trust

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Executive Summary

This report is the outcome of a six-month study into workplace culture at Whittington Health NHS Trust (WH). Central to the study is an exploration of perceived bullying and harassment (B&H) and their relationship, if any, to ideas of a common workplace culture.

It is important to emphasise that this is a study and not an enquiry. The researchers have no jurisdiction to suggest sanctions or actions, instead to report and advise on what they have found and to make any recommendations where appropriate. It is clear that, in commissioning this research, the Trust has begun to put in place a strategy to properly tackle bullying and harassment.

The study deployed a mixed-methods approach of staff survey and over 120 hours of one-to-one interviews mainly resulting in contacts generated by the survey. It is important that readers recognise that this is a cross-sectional study – a snapshot in a moment in time from a sample of staff at WH. The data have been used to produce an assessment of responses to questions/issues known to be associated with B&H but, because of its cross-sectional nature, the data cannot be used to indicate causality. The report is commissioned research led by Professor Duncan Lewis of Longbow Associates Ltd. for the Chief Executive of WH.

In many ways, WH already has sufficient systems and processes in place to adequately tackle bullying and harassment but requires a more interconnected pathway to unite these elements into a coherent strategy.

Key findings from the survey include:

- While 25% reported bullying/harassment, 72% did not.
- 35% of respondents reported observing bullying and harassment.
- Respondents reporting most bullying and harassment emanating from managers and colleagues
- Evidence of inappropriate manager behaviours and a perceived unwillingness by the Trust to do anything when issues were raised.
- Excessive work demands, poor clarity around role and staff fit to strategic goals and objectives, poor change management processes/engagement with change.
- Bullying and Harassment directly impacting upon communications and willingness to speak up which has implications for the effectiveness of the Freedom to Speak Up Guardian role.
- Bullying and Harassment negatively impacting organisational citizenship behaviours but not adversely affecting collegiate citizenship.
- Bullying and harassment directly negatively affecting line manager relationships and a perceived lack of senior manager commitment to safe psychological working which ultimately impacts on organisational effectiveness as well as job satisfaction.

Key findings from interviews:

- There is a perceived collusiveness between senior leaders that underpins an unwillingness to challenge inappropriate behaviours and provide effective leadership role models.
- Amongst the medical body and senior staff there are also inappropriate behaviours that must be addressed. Ill-treatment behaviours are a collective responsibility.
- Evidence of Laissez-Faire leadership behaviour which leads to destructive leadership through inaction, unresponsiveness and an inability/unwillingness to support junior colleagues undertake key tasks and responsibilities.
- Bypassing formal communication channels to go directly to the Chief Executive or Trust Chair when concerns are raised.
- A grievance culture that shows poor process and entrenched behaviours that is costing the Trust diminished employee commitment, early retirement and a defensive and fractious culture.
- Evidence of apparent discrimination behind alleged bullying/harassment as well as discriminatory practices between ethnic groups. Several accounts of purported age discrimination by managers. Also, limited evidence of the effectiveness of the existing anti-bullying and harassment scheme and for using the Freedom to Speak Up Guardian as a conduit for bullying and harassment.

Recommendations include for example:

1. Ensuring leaders and senior managers adopt a more robust and purposeful leadership style to support colleagues and tackle issues in timely and well-ordered fashion. Medical leaders and senior nurses/practitioners to also recognise their contribution to this issue and to its diminishment.
2. The medical body have a role to play in ensuring organisational effectiveness. They are role models and their behaviours inform others of how senior employees should behave. Senior medical staff and professionals are under scrutiny for inappropriate behaviour.
3. Addressing grievance issues more speedily and with greater purpose and ensuring grievance processes are fair and clear. This may require arbitration to tackle some long-standing disputes.
4. Greater scrutiny of existing data on issues known to underpin bullying and harassment by creating an action group, including the Freedom to Speak Up Guardian, Inclusion champion/advocates and trade unions, in a new partnership model empowered to drive change. This to be underpinned by a dedicated Executive leader and supported by a Non-Executive Director.
5. A manager network dedicated to support managers lacking in experience of managing conflicts. Managers to be appointed mentors and appraised in their managerial performance and supported through material best practice. All those who manage others should collectively grasp this issue.

6. Ensuring role clarity and change management engagement is directly addressed in performance appraisals, which are currently at sub-optimum levels in many departments. Staff should understand their roles and their contribution to organisational mission, goals and objectives.
7. Ensuring an anti-discrimination strategy built around diversity and inclusion is directly discussed in team meetings, individual appraisals and in other discussions. These should be a strategic priority with KPIs and regular measurement. This to be driven directly by the leadership of the trust and reported in quarterly Executive agendas.

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The researchers wish to acknowledge the contributions of every member of staff who completed the survey, took time to take part in interviews, and for those who wrote directly to the researchers by email and via postal services. Without their input, this report would not have been possible.

The researchers also wish to personally thank Kate Green, PA to the Workforce Director, for her help and assistance with meetings, appointments and accessing policies and documentation.

1.0 - Introduction

Bullying and harassment have emerged as commonplace features of British workplaces for over 20 years or more. Researchers have identified that some types of workplaces encounter more bullying and harassment than others, and health and social care work is one such sector.

The authors of this report were approached late in 2017 by the Chief Executive of Whittington Health NHS Trust (WH) about helping the Trust understand what might lie behind alleged incidences of bullying and harassment (B&H) at WH. This led to a research design, the output of which is this report.

Let us introduce two WH staff to you:

"I am fearful every time an email from the leadership team in my department arrives in my inbox. I shake and tremble. I think what will happen next and how am I going to manage this next encounter".

"I am made to feel an utter fool in front of her. She screams and shouts at me and bellows across the desk. I feel sick to my stomach".

These two brief excerpts were from interviews we conducted with WH staff. They relate to encounters between them and those that manage them. Neither has used bullying (or harassment), yet for both interviewees, they represent typical encounters that leave them feeling fearful and in real trepidation.

Do they typically represent the views of those who contacted us – in part yes, and in other ways no. This is because B&H covers such a spectrum of inappropriate behaviours that it is hard to pin down to a single, unequivocal pattern. Some B&H involves the shouting (and swearing) that some might typically think of as bullying, others, as in the first example, are fear-based, derived from intimidation, threats and experiences that leave employees terrified to open a simple email. Others find themselves harassed and demeaned by a lack of adequate response or support from leaders and managers to enable them to undertake everyday tasks and contribute in ways most employees take for granted. Regardless of the types of behaviours WH employees are exposed to, our report aims to shed light on their experiences and bring these to the attention of those tasked with leading the organisation. Our report will also offer potential solutions to the matters identified.

Professor Lewis has expertise in B&H research spanning 25 years including two large-scale publicly funded (ESRC) British studies, along with previous NHS work into B&H, discrimination and ill-treatment in British workplaces. He has published numerous studies

and papers and is a co-author of ‘Trouble at Work', the book of the largest-ever British study into workplace ill-treatment. Professor Lewis was an invited expert as part of a ministerial initiative designed to tackle B&H in NHS England and is currently in discussion with NHSI colleagues on this issue. He was recently an expert advisor to research studies on bullying and workplace ill-treatment in Ireland and Canada.

Delyth Lewis is a co-director at Longbow Associates Ltd. She worked in the NHS for 36 years, latterly as head of therapies for a mixed acute and communities-based NHS Trust. She is a Speech and Language Therapist by profession.

2.0 Background into Bullying and Harassment

Workplace bullying and harassment (B&H) has been recognised as a contemporary workplace issue that affects organisations of all sizes and in all continents (Einarsen et al., 2011; Fevre et al., 2011; Lewis et al., 2016). Bullying (and harassment) is complex with multiple causes at individual, group and organisational levels. Individual, social/group and organisational experiences illustrate how negative behaviours, a lack of challenge to such behaviours, organisational change, hierarchy and power, destructive management and leadership styles, and a broad range of stressors around a lack of job autonomy, insufficient resources, ineffective and poor levels of employee and management support are all potential contributory factors for bullying and ill-treatment (Baillien et al., 2011; Fevre et al., 2012; Lewis et al., 2016).

In the UK, there is no legislation covering bullying, although remedies do exist across a spectrum of Acts such as the Health and Safety at Work Act (1974), Protection from Harassment Act 1997 etc. By contrast, harassment is covered by the 2010 Equality Act with protections rooted in protected characteristics of race, gender, sexuality, disability etc.
Research evidence shows that effective leadership and management, along with a spectrum of employee support such as occupational health and counselling services, buffers the effects of bullying whilst their absence exacerbates it (Lewis et al., 2016). It was therefore deemed necessary to explore these issues within Whittington Health using a range of questions that originate in the Health and Safety Executive's (HSE) 'Management Standards'.

2.1 - Leadership/Management & Bullying at Work

With studies demonstrating that managers and supervisors lie at the heart of many British employees' experiences of B&H and that work environment stressors strongly correlate with B&H, it is unsurprising that leadership has become a key area for focused interventions, especially in the following areas:

- Conflict and generic management training
- Development of interpersonal skills
- Leadership and management styles
- Leadership and management culture that support interventions to reduce bullying

Whilst it is impossible to list decades of research on B&H here, the broad thrust of evidence is:

- Managers who possess skills in conflict management are less likely to encounter B&H in their departments or are less likely to be accused of B&H.
- Interpersonal skills, particularly around active listening to employee complaints and being aware of tensions in the workplace before they escalate, are likely to serve a manager well in defusing issues before they can develop into B&H.

- Organisational leadership that makes a sustained commitment to tackling B&H and demonstrates this commitment to employees is likely to be better placed in minimising claims of B&H.

It is worth noting that laissez-faire styles of leadership, where a manager, or leader, in effect, does not manage, or a leader does not lead, is more likely to be associated with workplace conflict and bullying (Skogstad et al., 2007) and the same is true of a manager who micro-manages, particularly professionals. These research findings are especially pertinent in the NHS.

Leadership and management actions that stress that bullying is worth tackling and that set out organizational cultures by role-modelling behaviours (Resch and Schubinski, 1996) are likely to encounter less bullying, particularly as employees closely and carefully monitor leader and manager behaviours. Thus, significant emphasis needs to be placed in top-level leadership behaviours and for these to cascade through all management grades. Visibility of appropriate leadership behaviours is crucial in establishing the organisational culture.
Building a climate of 'trust' is also regarded as central to reducing bullying (Keashly and Neuman, 2008). Employees who believe that top-level leadership are committed to minimising bullying are more likely to 'trust' that managers are working for an employee's best interests.

Hilary and Vyas (2016) reported that many organisations run on 'fear' with participants typically reluctant to participate for fear of being 'shot down' or ridiculed. Furthermore, 'bad news' is rarely passed upwards by front-line managers and there is a culture of tokenism without any real engagement. Often this leads to a collective belief from staff that any action plans will be largely ineffective, and they often adopt a 'why bother' attitude – a form of confirmation bias. These features are often found in organisations where staff perceive a bullying culture.

2.2 - Studies of Bullying and Harassment in Health/NHS contexts

The 2013 Francis Report into the Mid Staffordshire NHS Foundation Trust reported how a culture of bullying can harm an NHS organization. Bullying can affect the ability of staff to undertake everyday tasks, which ultimately impacts patients. Sir Robert Francis conveyed how inapplicable pressure reported by staff was ignored and not scrutinised. Research from other countries into health care work supports the Francis findings and shows how bullied staff are often less likely to speak up, to admit mistakes and more likely to be ineffective in teamwork. These can all be directly related to adverse consequences to patient safety and care (The Joint Commission, 2008; Victoria Auditor-General's Report, 2016).

In his 2015 report – 'Freedom to Speak Up' - Francis remarked how bullying was on many occasions reported because NHS employees had spoken up. Furthermore, the process of

speaking up resulted in feelings of isolation and led to reprisals, disciplinary action and counter allegations. As Francis (2015:13) stated, 'Quite apart from the unacceptable impact on victims, bullying is a safety issue if it deters people from speaking up'. It should therefore come as no surprise that bullying and harassment have unfavourable consequences for effective organisational performance, specifically through increased sickness absence, reduced productivity, higher levels of employee turnover, directly impacting the potential for new entrants into the NHS labour market, excessive litigation costs, damaged organizational reputation and of course patient experiences (Francis, 2013).

Fevre et al., (2009) and Fevre et al., (2012) reported how health and social care, and the public sector more generally in Britain were hotspots for bullying and mistreatment. These are broadly supported across Europe and elsewhere where there is a strong evidence base for health and social care workers being troubled by bullying (e.g. Niedl, 1996; Kivimaki, 2000; Cheema at al., 2005).

Within a British health and social care context, Fevre et al., (2012) reported that negative behaviours associated with incivility and disrespect were the most prevalent, but also that behaviours associated with unreasonable management in the form of demands and expectations also helped explain how employees feel ill-treated at work.

Understanding bullying across the NHS is often limited to the NHS employee survey, which, by design, often fails to ask the necessary questions to understand the phenomenon fully. For example, the survey asks: 'In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from' with three response categories: a) patients/services users, their relatives or other members of the public; b) managers; c) other colleagues. This approach is problematic because it leaves staff to interpret for themselves what harassment, bullying and abuse means. It also makes the unscrambling of each word unmanageable so that those decoding the data must use all three terms as meaning one and the same, which of course they do not. The NHS survey also fails to ask sufficient questions about negative behaviours that might underpin perceptions of B&H, or ask for information about perpetrators, or why individuals might perceive themselves targeted for such behaviours. Researchers have argued that to understand bullying, a range of questions need to be asked, typically encompassing a combined definition of bullying with a battery of negative behaviours (Nielsen et al., 2009).

Recent data for the NHS in England (2017) showed 13% reporting bullying by managers, 18% by co-workers and 28% by patients/relatives. Only 48% of incidents of bullying were reported, suggesting the scale of the problem is much greater (http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results).

2.3 – The costs of bullying to the NHS

Sickness absence is a considerable cost to the NHS with the HSE reporting that Health and Social Work was the industrial sector with the highest levels of work-related stress, depression or anxiety (http://www.hse.gov.uk/statistics/causdis/stress/). HSE data since 2001/02 has shown a flat trend for self-reported worker stress, thus indicating a broad but consistent trend, suggesting managers and leaders have failed to satisfactorily address this. Several NHS occupational groups, including nursing and midwifery, had some of the highest statistical rates of stressors amongst all occupational groups.

Evidence from THOR (the Health and Occupation Research Network) using GP data on sickness across a six-year time period showed that over one-third of cases cited negative mental health to workplace stress with a mean of 24 days per absence. GP's attribute workplace relationships as the second most common source of mental ill-health and when days off with sickness absence are analysed shows 35% were for interpersonal difficulties with a manager, 14% with other workers and 24% for bullying and harassment. Whilst this data is not specifically located to NHS workers, it does demonstrate the correlation between bullying and sickness absence more generally. Researchers have estimated that bullying causes additional absences of an average of 7 extra days per employee (Hoel and Cooper, 2000).

Boorman (2009) estimated NHS sickness absence costs at £1.7bn with an additional cost of £1.45Bn for agency staffing. Despite stringent efforts to bring this down (http://www.nhsemployers.org/-/media/Employers/Documents/Plan/Reducing%20Agency%20use%20in%20the%20NHS.pdf), costs remain stubbornly high. Marsden and Moriconi (2008) anticipated the costs of managing sickness absence across 8 organisations varied between 2%-19% but was lower in larger organisations similar to those found in the NHS. Even assuming a 2% rate, this would be significant for any NHS organisation.

The additional costs of bullying must be recognised for employee turnover where researchers have shown 60% consider leaving their employer with 15% actually left their employment (O'Connell, et al., 2017). Robinson and Perryman (2004) in their Quality of Working Life study in the London NHS estimated harassment leads to double the levels of employee turnover. Even estimating a modest 5% turnover rate of the workforce as result of bullying could add to significant workforce burdens and substantial budgetary pressures.

2.4 – Existing evidence of contributory factors to Bullying and Harassment in Whittington Health drawn from secondary sources.

Existing WH data obtained from the 2016 and 2017 NHS Staff Survey was examined to establish some baseline indicators. Staff engagement scores at WH were broadly comparable with other combined acute and community NHS trusts and were classified as

‘average' but with above-average scores for staff motivation and staff ability to contribute towards improvements at work.

In terms of bullying and harassment and attendant issues, WH had a 7% higher score for B&H from other staff compared to the 2017 average for similar trusts (31% versus 24%) with above average scores for work-related stress (45% versus 38%). WH also reported higher than average experiences of discrimination (19% versus 10%) with 17% of racial minorities reporting discrimination from a manager/team leader compared to only 8% of white respondents. Survey evidence from 2017 also showed that racial minorities reported higher levels of bullying and harassment in WH from other staff compared to white colleagues (33% versus 27%) with a margin that is unchanged since the 2016 survey. These figures suggest increased attention needs to be paid to addressing equalities expectations for all staff as outlined in the 2010 Equality Act.

The 2017 NHS survey also provided insights into the occupational groups most likely to report bullying. Note, although staff in the NHS can and do encounter bullying and harassment from patients/relatives of patients, evidence indicates that this is not as problematic to staff as when bullying emanates from other staff (Fevre et al., 2012). As such, the focus here is on interpersonal relations between staff at WH. The 2017 NHS data for WH showed nursing and nursing/healthcare assistants reported the highest levels of bullying and harassment from other staff with radiography and general management the next highest levels. Reporting the most recent experiences of bullying/harassment/abuse amongst these occupational groups was generally around 50% or less, thus suggesting a potential for under-reporting. That said, the 2017 survey showed an above average score for reporting B&H at WH compared to other similarly structured trusts and this trend needs to continue to improve if it is to address the concerns of Francis in his 2015 report on speaking up.

WH also provided access to a report by Picker in 2017 which compared WH to 20 other comparable NHS Trusts. This showed that WH had a slightly poorer performance for B&H from other colleagues at 21% compared to a 19% average in the other 19 organisations. Picker data also showed higher levels of B&H from other managers at 18% compared to 14% in the other comparable Trusts. These figures are compared to data from previous Picker surveys at WH and reveal a largely unchanging pattern, suggesting limited progress has been achieved.

Picker data from 2017 showed that potential ‘hot spot' areas for bullying and harassment from managers were in Trust Secretariat, Women's Health Services and Nursing and Patient Experience. When the data on bullying and harassment from colleagues was examined, the same three hotspots were revealed - Women's Health Services, Nursing and Patient Experience and the Trust Secretariat.

Picker data also showed discrimination from managers/other colleagues was 2% higher at WH than the other benchmarked trusts and this is a slightly worsening trend compared with WH data from 2015 and 2016.

Finally, the Picker data included over 400 write-in comments from respondents on issues that were important to them. These have been scrutinised for any claims of bullying, harassment, abuse or associated issues in order to establish any congruence with the findings in this study.

These data points provide a useful starting point for exploring B&H and attendant stressors in WH.

3.0 - Methodology

3.1 - Research Design

In line with the deliverables outlined by WH commissioners, the initial approach was to deploy a mixed methods research design. The choice of mixed methods is partly a pragmatic one because of the deliverables identified.

An organisation-wide survey of all WH staff.
Over 120 hours of one-to-one telephone interviews.
Over 20 hours of face-to-face interviews.

All qualitative data was captured by using handwritten notes. We adopted this approach because of the considerable pressure and anxiety talking about bullying is known to generate for individuals. All qualitative data were screened for themes that supported the British Workplace Behaviour Scale (BWBS) used in the survey and the HSE Management Standards for stress as well as any other emergent themes that were specific to WH employees. A process of axial-coding (Strauss and Corbin, 1998) was used to co-locate themes and build up a pattern of common threads.

3.2 - Sampling

The majority of staff (circa 4100) were initially contacted via email by the communications team at WH using text drafted by Professor Duncan Lewis advising them about the nature and extent of the study and inviting them to take part in an independent online survey. Weekly follow up emails were sent to all staff over a six-week period that the survey was live to encourage further responses and gain as wide a response base as possible. The initial response of 1300 replies was high for a survey of this kind, but some responses were only partially complete and thus unusable for the purpose of analysis leaving a usable response of 1172 surveys.

Some WH staff, including some bank/agency/contractor staff, were provided with a paper-copy of the survey because they did not have email access. These staff were also given a reply-paid envelope to send the completed survey back to the researchers (n=218). The paper copies of the survey were distributed by WH staff. 30 paper versions of the survey were returned to the researchers.

It is important that readers note that because of the time scales in reporting the findings that it is not possible at this juncture to establish statistically significant inferences from the data.

3.3 - Interviews

Some 90+ employees who had responded to the survey indicated they wished to take part in a telephone interview and were duly contacted by the researchers. The researchers also conducted interviews with members of the Executive at WH as well as with the Trust Chair and Freedom to Speak Up Guardian (FSUG).

3.4 - Questions Asked Within the Survey

To address the issues of ill-treatment behaviours it was proposed that the British Workplace Behaviours Scale (BWBS - after Fevre et al, 2010) was deployed. Professor Lewis is a co-author of this scale and it has been used previously both in the NHS, a national British study and a nationwide study in Ireland. The deployment of the BWBS would act as a starting point to establish the types of behaviours that may be prevalent in WH.

The survey was designed as an online self-completion survey using Qualtrics© software. Although designed to be easy to complete, the need to capture sufficient responses to a range of ill-treatment behaviours, as well as details of perpetrators and possible reasons why employees believed they had been targeted, meant the length of the survey could be problematic in terms of drop-outs and non-completions.

3.5 - Analytic Strategy

The qualitative data from the telephone interviews were captured using hand-written notes and analysed for themes. The conventional academic approach to analysing qualitative data is to organise the data in a 'coding' strategy. Our approach was therefore to have one master code, namely B&H and several subcodes. The subcodes were structured from the central themes emerging from the qualitative data. These themes were wholly drawn from the responses the researchers received in the interviews.

3.6 - Ethics and Confidentiality

Before the completion of any telephone interview, WH employees were advised that during the interview only hand-written notes were being taken. Assurances of confidentiality were given and that names would not be recorded or reported.

Participants were sent a Participant Information Sheet (see Appendix) prior to interview which outlined the nature of the study and informing them that they could withdraw at any time, even if the interview had begun, without their rights being affected.

4.0 – Findings

IMPORTANT INFORMATION

The survey received a total of 1172 useable responses. However, some of these were only partial responses meaning that some people did not answer every question and therefore scores may not always add up to 100% or be directly comparable from question to question.

4.1 - Demographics – who completed the survey?

Due to the confidential nature of the survey and concerns employees had about being identified in responding, the following demographics are provided simply to give a general overview of respondents. Where appropriate we will refer to demographics in relation to bullying/negative behaviours (see below)

Gender – 79.9% of respondents were female and 19.4% were male with 0.7% indicating they wished to be considered in another way.

Age - The mean age score of respondents was 44 years.

Sexuality – 86.8% described themselves as heterosexual with the remainder being alternative sexualities or preferring not to indicate sexual identity.

Working Status – 85% of respondents worked full time, 14.1% part-time (8-29 hours) and the remaining responses (0.9%) work on other contractual arrangements such as Bank, Agency or less than 8 hours per week.

Ethnicity - 44.7% described themselves as White British; 6.3% as White Irish; 13.7% as Other White Background; 7.7% as Black African; 6.1% as Black Caribbean; 3.9% as Indian; 1.1% as Pakistani; and the balance made up of other Black, Asian and other ethnic origins.

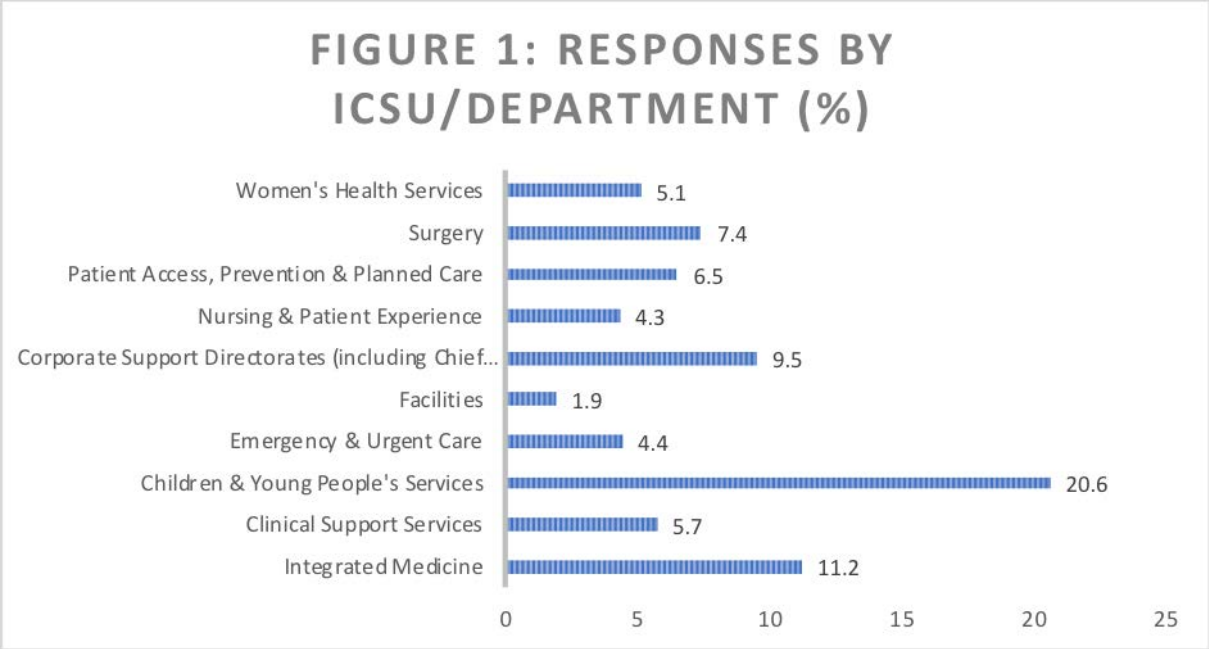
Religion – 50.1% of respondents described their religious affiliation as Christian (all denominations) with 31.4% stating they do not have a religion. The remainder reported a spectrum of other faiths and beliefs or indicated a preference not to state their response.

Disability & Long-Standing Health Conditions – 63% of respondents reported they did not have any disability or long-standing health conditions with 37% (n=157) reporting some form of disability or long-standing health condition. Of these, 20 people reported that their health condition/disability made doing their day-to-day activities difficult.

Trade Union / Staff Association membership – 56.1% reported they were a member of a trade union and less than 5.3% reported being a member of a staff association. 38.6% were not members of either.

Pay Banding – All pay bands were included amongst respondents

Responses by ICSU/Departments – See Figure 1 below



4.2 – Responses to questions on bullying and harassment

4.2.1 Have you been bullied or harassed

The survey had a single question asking respondents if they believe they had been exposed to B&H in the last 12 months at WH.

- 579 respondents said they had not experienced bullying (71.9%).
- 145 said occasionally (17.9%).
- 21 said monthly (2.7%).
- 23 said weekly/daily (4.9%).
- 16 reported they did not know if they had been bullied (2.6%).

Ethnicity and Bullying

Scrutiny of the data revealed a slight statistically significant relationship between ethnic groups and the experience of workplace bullying (effects = 0.035, $p < 0.05$). The results indicate that there was a tendency in which non-White British people reported higher levels of workplace bullying, compared to the White-British group. In simple terms, the more non-White the group, the higher workplace bullying being reported. Specifically, those employees who identified as Pakistanis were most likely to report the highest level of personal experience of workplace bullying. This group tended to report 1.34 times higher levels of workplace bullying than White-British people. Those who classified themselves as 'any other' ethnic group and those from an Asian background tended to report marginally higher levels of experience of workplace bullying (1.18 and 1.17 times higher respectively) compared to those who self-classified in the White-British group.

Trade Union/Staff Association Membership and Bullying

There is a perception in the literature on workplace bullying that membership of a trade union is more likely to lead to reporting bullying and reporting exposure to ill-treatment behaviours. This is ostensibly grounded in the belief that trade union members are better informed of their rights, with greater access to materials and information on bullying, compared to non-trade union members. Our study reveals a very marginal increase amongst those respondents who self-selected as a trade union or staff association member to the question on bullying (1.09 times higher than non-membership of Trade Union), but the rates of increase are relatively negligible.

ICSU/Department and Bullying

Based on the former ICSU structure, we examined the data to see which ICSU and other departments, including corporate, facilities etc., reported more, or less bullying. The ICSU reporting the highest risk levels of bullying were 'surgery and cancer' (1.17 times higher) compared to 'children and young people's services' which were in the lowest risk level of workplace bullying. The second group at high risk of reporting workplace bullying was 'Patient Access, Prevention and Planned Care' which reported 1.14 times higher levels than 'children and young people's services'.

Years of Service and Bullying

We asked staff to indicate their length of service to establish if there was a statistical relationship between length of service and bullying. The data showed a negative relationship between length of service and bullying (effect = -0.05, $p < 0.05$) such that junior staff (service not age) with 1-5 years of WH service reported the highest risk levels of bullying (1.19 times higher) than those at lowest risk levels (11-15 years of service).

Commentary

A total of 25.5% of respondents therefore reported that they have some experience of bullying at WH in the last 12 months. This is 5.5% less than the WH NHS 2017 staff survey but higher than the WH Picker 2017 results (note the Picker survey asked separate questions on bullying by managers and by colleagues). The variation in results could be explained by; a) this survey providing respondents with a definition of bullying which both the NHS and Picker surveys do not. Providing a definition might help respondents to have clarity in deciding if they had indeed experienced bullying and harassment (we did not use the term 'abuse' unlike the NHS/Picker surveys) and; b) the responses being obtained from different ICSUs compared to the Picker and NHS surveys.

Our results when analysed by ethnicity also back previous data from the NHS staff survey and Picker surveys on the perceptions that some staff feel discriminated against, or potentially are bullied or targeted for negative behaviours, because of their ethnicity. We will return to this later in the report when we deal with the qualitative data from interviews.

Similarly, the ICSU's/departments reporting inflated risks of bullying will also be scrutinised in the qualitative data for supporting evidence.

In terms of length of WH service, these patterns in the data have been reported elsewhere in the bullying literature (e.g. Fevre et al., 2012) and might indicate that resilience against workplace ill-treatment builds up over time and with experience. Nevertheless, and with increased pressure to recruit and retain staff at WH, increased impetus needs to be made in engaging those staff with less than 5 years' service, and particularly those in the first year or two of employment at WH, about their experiences at work. This is best achieved by regular performance appraisals and raising management awareness about junior service being a risk group for bullying.

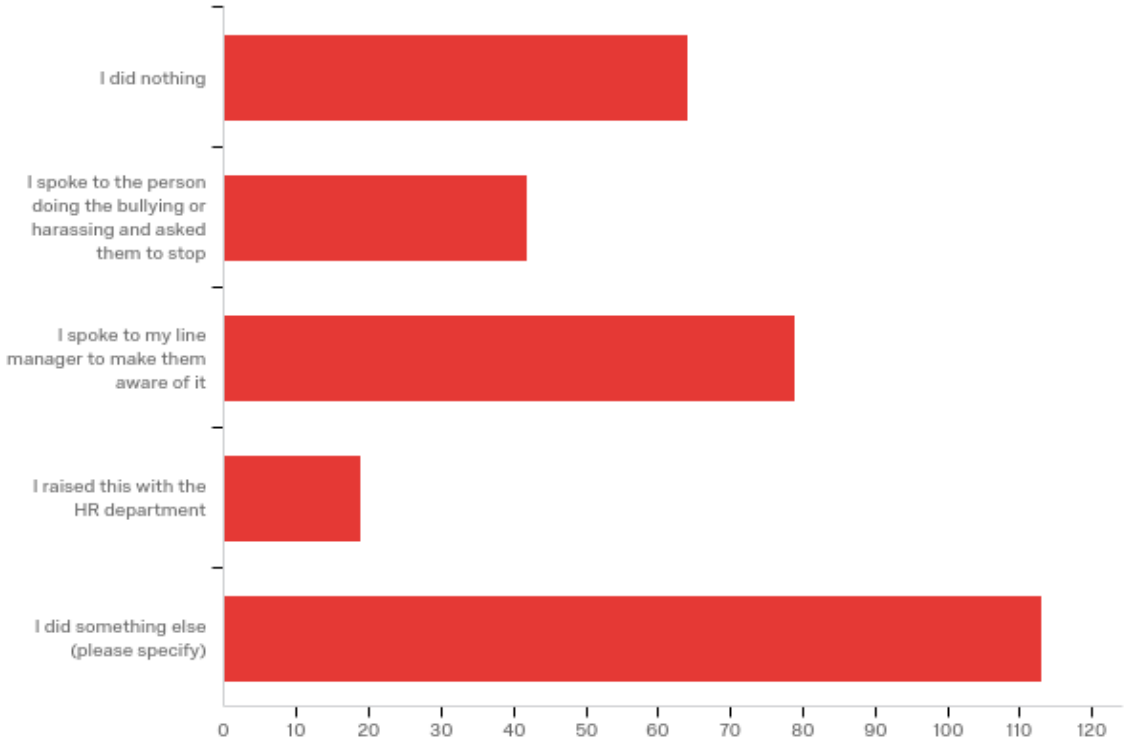
4.2.2 Witnessing or observing bullying and harassment at Whittington Health

One-third (35% - 278 people) of those surveyed said they had witnessed/observed B&H at WH during the last 12 months. Mostly this was against fellow colleagues (87%), although 34 people stated that they had observed a manager/supervisor also being bullied or harassed. Only one person reported they had seen a patient or relative of a patient experiencing B&H.

The survey asked respondents to indicate who they thought the alleged perpetrators was and two-thirds of the time (62%) this was reported as a manager/supervisor; 35% of the time it was a fellow colleague doing the bullying or harassing and 3% of the time it was a patient or the relative of a patient.

Respondents were also asked about what they did about the bullying or harassing they had observed/witnessed. Most respondents undertook some form of action by supporting the person being bullied, talking to their manager (or another manager), using the FSUG or talking to HR. However, 20% reported doing nothing. Of the 113 respondents who indicated 'I did something else', only 4 people mentioned the FSUG while 6 people indicated they spoke to the Chief Executive. These responses are summarized in figure 2 overleaf.

Figure 2: What respondents did when they observed bullying or harassment



Commentary

These findings clearly suggest B&H is a manager/colleague problem indicating it requires a management solution. Regardless of whether B&H is from a manager or colleague, it requires managers to alter their own behaviour or address the behaviour of colleagues. Whilst there is a solid foundation of 80% of those witnessing or observing bullying or harassment doing something about it, one fifth of respondents did not intervene, which suggests there is effort to be deployed ensuring colleagues know where and how to raise issues of concern and the importance of doing so. This is particularly appropriate for the FSUG role. It is also important that the Chief Executive maintains a distance in contact about inappropriate behaviour/bullying. If the Chief Executive is contacted too early in any process/procedure it negates her ability to act as a final arbiter in any dispute that may subsequently develop. It is inappropriate for the CEO of any organisation to be contacted about such issues in the first instance unless it is from a fellow member of her Executive discussing inappropriate behavior/bullying by another member of the Executive/Board.

4.3 - Exposure to negative behaviours

The survey asked respondents to report their exposure to 21 B&H behaviours, which are the cornerstone of the BWBS. Staff could respond with 'Never' through to 'Daily' categories. Note: researchers contend that bullying is only understood as regular and repeated exposure to negative behaviour over a prolonged period, usually months. As such, bullying is best understood by exposure shown as monthly through daily below. The 21 behaviours breakdown into 3 clusters as discussed below.

4.3.1 - Cluster A - Violence and Injury as a result of Violence

Two items were designed to measure violence and injury at work. Both items; a) 'Receiving Actual Physical Violence at Work' and; b) 'Injury in Some Way as a Result of Violence at Work', resulted in scores of 2.5% and 1.8% respectively.

Commentary

Violence is a recognised feature of health and social care work and is reported as a contributory factor to both sickness absence rates and to staff turnover. Later in this report, evidence is presented on perpetrators and it appears that most incidents of violence and any subsequent injury is due primarily to the actions of patients and the relatives/friends of patients. However, we were told in a telephone interview of an occasion when a member of staff was slapped across the face by another staff member. This was appropriately dealt with by WH. No other violent incidents were reported in telephone interviews.

Although researchers generally do not associate violence with bullying *per-se*, there is a connection between management inaction to address violence and perceptions of workplaces where violence is accepted as part of the rough-and-tumble of the job and thus bullying can also flourish (Bowie, 2002). WH must demonstrate to the workforce that it is providing leadership on tackling violent incidents at work, particularly around recognition by managers when staff experience ill-health as a result of injury because of violent behaviour.

4.3.2 - Cluster B - Unreasonable Management Behaviours

Unreasonable management behaviours are clustered around the following eight negative behaviours (see table 1 overleaf). In this table, we have removed the 'Never' category as this is not associated with B&H and have included a category labelled 'Cumulative'. This is a cumulative score of 'Sometimes' through 'Daily'. We also include a direct comparison to the 2011 British survey by Fevre et al., which originated the same scale.

Table 1 shows that between one-quarter to one-half of WH respondents reported exposure to 'Unreasonable Management' behaviours on an occasional or more regular basis. The most prevalent of these is:

- 'Having your views and opinions ignored'
- 'Being given unmanageable workloads or impossible deadlines'
- 'Pressure from someone else to do work below your level of competence'

Table 1: Experience of unreasonable management behaviours in the last 12 months					
Behaviour – How often have you experienced:	Sometimes	Monthly	Daily	Cumulative	Fevre, et al. (2011)
Someone withholding information which affects your performance	25.0%	4.7%	2.9%	32.6%	14.2%
Pressure from someone else to do work below your level of competence	22.9%	5.20%	7.2%	35.3%	11.9%
Having your views and opinions ignored	34.2%	11.8%	6.0%	52.0%	27.0%
Someone continually checking up on you or your work when it is not necessary	16.4%	5.3%	7.1%	28.8%	17.5%
Pressure from someone else not to claim something which by right you are entitled to	13.89%	5.07%	1.45%	20.41%	8.8%
Being given an unmanageable workload or impossible deadlines	31.2%	9.1%	9.1%	49.4%	29.1%
Your employer not following proper procedures	18.5%	5.6%	3.7%	27.8%	21.3%
Being treated unfairly compared to others in your workplace	18.1%	5.4%	4.3%	27.8%	14.8%

We examined the survey data to find where the greatest levels of risk for unreasonable management behaviours might be within WH. Our analysis revealed:

- Surgery and Cancer care to be the highest risk levels for unreasonable management behaviours followed by Women's Health Services. In contrast, Children & Young People's Services group were in the lowest risk group (being 0.79 times less likely to report unreasonable management behaviours).
- In terms of gender, males were marginally more likely to report unreasonable management than female respondents (1.09 times higher than the female group).
- In terms of sexuality/sexual orientation, heterosexuals were less likely (0.81 times less likely) to report unreasonable management compared to those who self-identified as lesbian, gay, bisexual, transgender or some other sexual identifier.
- In ethnicity terms, and in support of our earlier data, those who identified as Pakistani reported the highest risk of exposure to unreasonable management (nearly 1.5 times more likely to report this) than the lowest risk groups, which included Chinese, White and Black Caribbean respondents.

Evidence of Unreasonable Management Behaviours from our interviews with WH staff

Our interview data revealed a small, but not without considerable impact, inappropriate management/manager behaviours. All direct statements are italicised.

Whilst the researchers did not encounter evidence of wholesale unreasonable management behaviours, there was a consistent view in several interviews about the behaviours of some senior staff, including matrons, as well as some Band 7 managers. What frustrated many interviewees we spoke to was the failure of senior management to tackle inappropriate behaviours when issues were raised, as expressed here:

> *"She (a Matron) treats people in a very cavalier way and gets away with it"* and;
>
> *"When you question things, you are not listened to".*

Some interviewees felt they were ignored by those they raised issues to and others felt *"no one was prepared to listen".* This theme was consistent with one interviewee stating; *"I was told 'well she's a difficult person'….and that it was my problem, and it was down to me to manage things"*. We saw examples of emails sent to managers raising concerns but were unable to find any satisfactory response in the email trail subsequently.

These sorts of failures to respond, when issues of inappropriate behaviour are raised, can undermine the organisation, regardless of the level of the alleged perpetrator or recipient. It is these types of inappropriate acts that can indicate management inertia, which if left unresolved, may lead to more widespread problems that can spill over into patient care.

Commentary

The term 'Unreasonable Management' was created by Fevre et al., (2011) because their data (from the largest ever representative study of ill-treatment in British workplaces) showed the majority of these behaviours were from managers and supervisors. Managers have a responsibility to engage with the workforce and to listen to concerns as well as suggestions. As we see from some of the interview excerpts with some WH staff, this can sometimes fail. Whilst unmanageable workloads are often reported in the NHS, ignoring people's views and opinions or being given tasks that are outside of their competence framework regularly can undermine an individual's professional standing/credibility.

Behaviour such as 'Your employer not following proper procedures' (21.3% of respondents) has been shown to be associated with application of policies and processes by managers which some staff feel to be unfair. Other behaviour such as 'Someone continually checking up on you or your work when it is not necessary' (28.8%) are indicators of micro-management. We weren't presented with significant evidence of micro-management in our interviews with WH staff, but this did arise more than once. Whilst micro-management is generally unnecessary in professional environments such as the NHS, there are situations around employee performance that can leave employees feeling micro-managed. The key is to manage staff fairly and respectfully and to explain why work may be checked up on, and if within a performance management setting, is clearly set out. When staff tick the

behaviour 'Being treated unfairly compared to others in your workplace', it is often attributed to managers who treat one member of staff differently to another, typically around access to annual leave or shift work distribution.

In terms of comparison to the Fevre et al., (2011) British nationwide study, the scores for WH are considerably higher, often double, in all behaviours in the 'Unreasonable Management' category. Whilst caution needs to be exercised in comparing these two sources of data, the evidence suggests that these types of negative behaviour are problematic for WH and understanding them and their causes is critical in tackling perceived B&H. The risk groups of unreasonable management, including specific ethnic groupings such as Pakistani respondents, those self-classified as non-heterosexual, males and certain ICSU's, provide a focussed attention for intervention and for potential sampling in future studies, such as Picker for example.

4.3.3 - Cluster C - Incivility and Disrespect Behaviours

'Incivility and Disrespect' behaviours are clustered around the following 11 negative behaviours (see table 2 overleaf).

As with table 1 above, table 2 provides a cumulative score (sometimes through daily) and a comparator score for incivility and disrespect with the Fevre et al., (2011) study. Behaviours around incivility and disrespect were reported by Fevre and colleagues to be most prevalent in health and social care contexts, thus making them particularly relevant in this study. Furthermore, and unlike the unreasonable management behaviours, Fevre and colleagues found incivility and disrespect behaviours were more evenly distributed in terms of perpetrators, with colleagues and managers/supervisors equally likely to be cited.

We also examined the data to find where the greatest levels of risk for incivility and disrespect behaviours might be within WH. Our analysis revealed:

- Pakistani, 'Other Asian' and 'Any Other" ethnic categories to be the most likely to report exposure to incivility and disrespectful behaviours with between 1.50 and 1.68 times greater likelihood of reporting such negative behaviours. As with the unreasonable management behaviours, Chinese, White and Black Caribbean tended to be in the lowest risk categories.
- As we saw in unreasonable management behaviours, Children & Young People's Services were in the lowest risk group, with Surgery and Cancer Services and Facilities and Emergency & Urgent Care being the higher risk groups (1.36, 1.24 and 1.22 time more likely to report incivility and disrespectful behaviours respectively).

Table 2: Incivility & Disrespect Behaviours in the last 12 months					
Behaviour – How often have you experienced:	**Sometimes**	**Monthly**	**Daily**	**Cumulative**	**Fevre et al., (2011)**
Being humiliated or ridiculed in connection with your work	10.1%	4.0%	2.1%	16.2%	7.6%
Gossip or rumours being spread about you or having allegations made against you	10.3%	3.0%	2.4%	15.7%	10.5%
Being insulted or having offensive remarks made about you	10.0%	3.1%	1.4%	14.5%	14.7%
Being treated in a disrespectful or rude way	18.2%	6.0%	2.2%	26.4%	22.3%
People excluding you from their group	14.0%	2.4%	2.7%	19.1%	7.8%
Hints or signals from others that you should quit your job	6.5%	1.9%	1.4%	9.8%	7.2%
Persistent criticism of your work or performance which is unfair	7.1%	3.1%	2.5%	12.7%	11.5%
Teasing, mocking, sarcasm or jokes which go too far	6.9%	1.3%	0.8%	9.0%	11.1%
Being shouted at or someone losing their temper with you	12.9%	3.1%	0.8%	16.8%	23.6%
Intimidating behaviour from people at work	15.5%	3.6%	2.4%	21.5%	13.3%
Feeling threatened in any way while at work	8.6%	2.4%	2.4%	13.4%	10.9%

Evidence of Incivility & Disrespect Behaviours from our interviews with WH staff

Interviewees also correlated the types of behaviour they encountered with general incivility stating, *"she doesn't say 'good morning', which is only a small thing, but I find it upsetting"*. Several interviewees also felt there was an absence of role models such that the working environment was *"tense"* with *"management team meetings involving shouting and aggression"*. Others referred to this as *"toxic"* working. Regardless of workplace pressures, shouting and aggressive behaviours are unacceptable, particularly as they can be viewed as role models for less experienced staff.

Underpinning inappropriate behaviours were a belief, in some quarters at least, that WH is traditionally seen as a *"friendly workplace"* with a *"family-friendly feel",* but this was

changing with, as one interviewee told us, *"the human part of a conversation is almost disappearing"*. This has been noticed in other NHS studies by the researchers and WH staff we interviewed would say:

- *"People are abrupt with each other"* and
- *"People speak harshly with each other"*
- *"The manner in which I was spoken to was very rude* – people are not very kind to each other"

Uncivil behaviour featured in conversations with staff about their experiences with their Band 7 managers, who they described as *"very disrespectful, very intimidating*" and in another interview the manager was described thus, *"She talks at people in a nasty way, it is unpleasant and intimidating"*. One example told us of a Band 7 manager who stated - "*If I say jump, you jump".*

Several staff described their experiences of working alongside their managers as *"frightening"* or even *"terrifying",* as one said, *"I am too frightened to sit in an office alone with this matron"* and another stated:

"my manager terrifies me. I came into work when I was unwell. I went to work [because] I was too terrified to tell her that I wasn't well".

And another interviewee said;

"I didn't think of it as bullying at the time, but it led to chronic stress – being undermined".

And, yet another interviewee stated;

"My stomach churns every time I see an email from the leadership team [departmental leaders]

In other examples, some senior staff (Bands 8 and above) were described as *"putting people down"* and *"when I brought it up with her, she started threatening me"*. Such responses by managers are unacceptable. For this interviewee, she felt it affected her *"family life, I couldn't sleep, I lost my appetite and going to work became daily trauma",* while another interviewee we spoke to said "*xxx [redacted] has destroyed me*". This theme occurred in several other interviews where staff described being *"severely bullied by my line manager"* to the point that *"I was suicidal and off work for several months with stress and anxiety".*

Others said:

"I am just broken. They took away my confidence"

And

"I was a wreck. I was sobbing"

These impacts should not be underestimated as they have been shown to directly correlate with lengthened periods of sickness absence, under-performance, leaving employment and even seeking early retirement (see 2.3 above). Aside from the fundamental moral reasons for tackling bullying and harassment, in the current climate of challenging recruitment and retention for staffing in several parts of the NHS, bullying behaviours should be major contributing factors to workforce issues.

Commentary

Unlike Table 1 above, scores for incivility and disrespect are more broadly aligned with Fevre et al's 2011 findings. The exceptions to this are:

- 'Being humiliated or ridiculed in connection with your work' (more than twice as frequent in WH)
- 'People excluding you from their group' (more than twice as frequent in WH)
- 'Intimidating behaviour from people at work' (8% points higher in WH)

By contrast, WH does better than the Fevre comparator in:

- 'Teasing, mocking, sarcasm or jokes which go too far'
- 'Being shouted at or someone losing their temper with you'

The survey results suggest that there are pockets of incivility behaviours notably around exclusion, humiliation/ridicule or intimidation, but also across most of the other behaviours. These 'pockets' seem to be prevalent in certain ICSUs/departments and amongst certain ethnic minorities. The culture in some parts of WH demonstrate clear 'incivility and disrespect'. None of our interviewees cited their colleagues as the source of their problems, only those who held management roles. These problems existed from Band 7 upwards.

4.3.4 - Which behaviour do WH employees find most difficult to deal with?

We also asked respondents to select the singular behaviour they found most difficult to deal with across all 21 negative BWBS behaviours. The principal behaviours (most frequently cited) are presented in rank order:

1. Being given an unmanageable workload or impossible deadlines
2. Someone continually checking up on you or your work when it is NOT necessary
3. Being treated in a disrespectful or rude way
4. Being treated unfairly compared to others in your workplace
5. Intimidating behaviour from people at work

6. Having your views and opinions ignored
7. Gossip and rumours being spread about you or having allegations made against you
8. Being shouted at or someone losing their temper with you
9. Persistent criticism of your work or performance which is unfair.
10. Someone withholding information which affects your performance

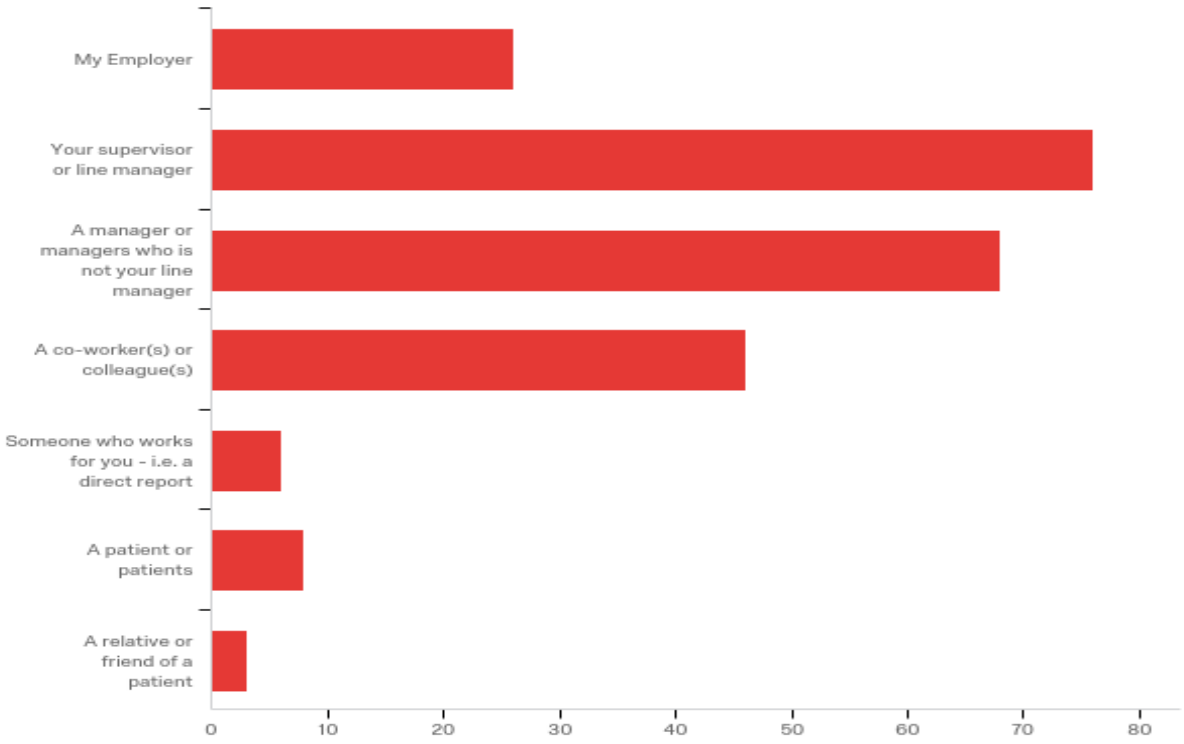
Commentary

These behaviours, confirmed by their high prevalence rates, are seen as being troublesome for employees to deal with. Whilst some are challenging to address in the current NHS climate (workloads), others are much more easily dealt with. Courtesy, fair management, respectfulness and dealing professionally with inappropriate behaviour could address many of these behaviours at source. The key is recognising them and addressing them directly.

4.3.5 - General Perpetrator Trends

We also asked respondents in the survey to indicate the person/s they felt were responsible for the single behaviour they found most difficult to deal with. Figure 3 below illustrates these findings.

Figure 3: Perceived perpetrators for the behaviour employees found most difficult to deal with:



Commentary

The data demonstrates a clear trend towards management and managers, including the general perception of the organisation itself, being responsible for the negative behaviours that staff found the most challenging to deal with. Colleagues/co-workers are the second most cited perpetrator with patients, or relatives/friends the next most noticeable. A small number of staff (6) also feel the behaviour emanates from their direct reports. The overall picture then is that there is a belief from respondents that there is a culture within the trust of B&H deriving primarily from managers but also that colleagues play a part in this. Either way, this is a management issue that requires attention, and this must start with action from the top-level leadership.

5.0 - Health and Safety Executive (HSE) Management Standards

Background

The HSE have a well-established survey instrument (The Management Standards) with high validity and reliability (see Mackay et al., 2004). This uses a battery of questions designed to assess workplaces at risk of known stressors, which includes two questions; one on bullying and another on harassment. Our analysis here is based on the HSE's own formulae for assessing stressor risk.

The 35 HSE questions are designed to measure responses to:

- Work demands, including patterns and work pressures
- How much control a person has in the way they do their work
- How much support an employee has from their line manager, colleagues and the organisation.
- How relationships are at work, particularly around unacceptable behaviour.
- How people understand their role in their organisation and whether they have conflicting demands
- How organisational change is managed and communicated in the organisation

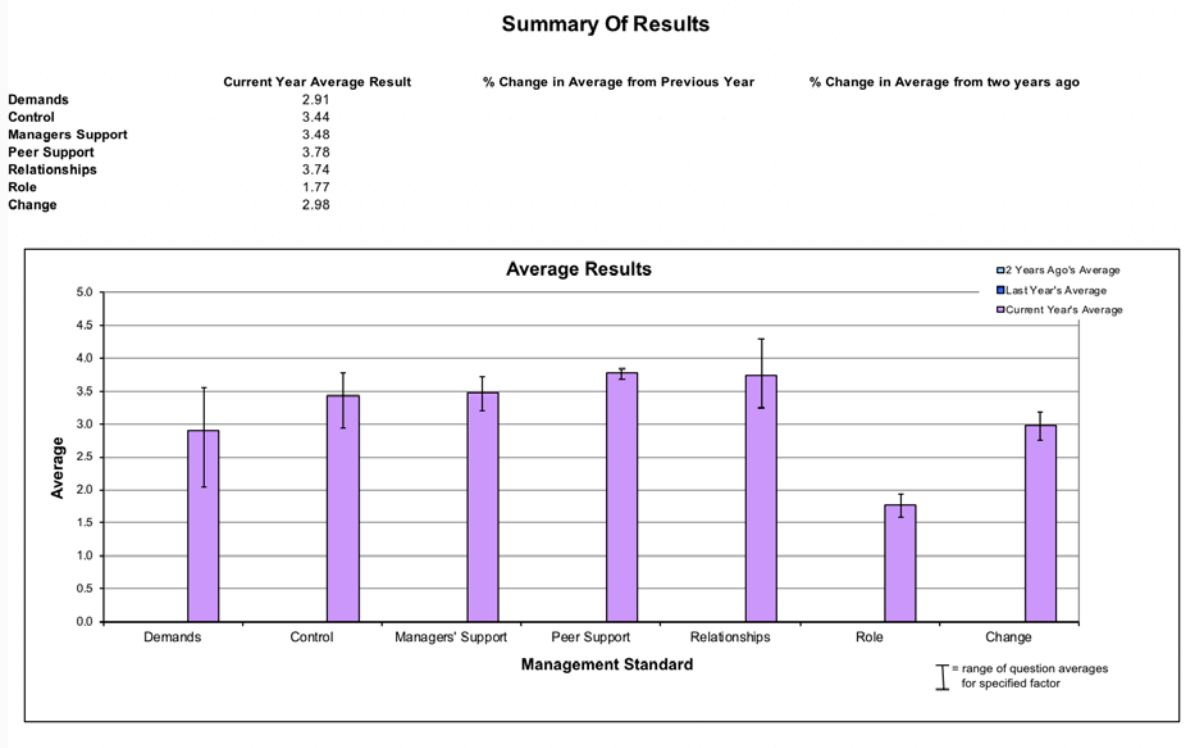
These factors represent a set of conditions that, if existing, reflect levels of organisation performance as well being a litmus test for health and wellbeing (HSE website - July 2014). Based on the HSE's own guidelines of a minimum number of participants to make analysis justifiable (800 responses), the WH responses (1000+) are well within acceptable levels.

Figure 4 below provides an illustration of the average scores (along with upper and lower score boundaries) for each of the seven categories of the HSE Management Standards. The general principle is a score of 5 presents the least risk to stressors at work, or the most desirable score, and a score of 1 presents the greatest risk of stressors, or the least

desirable. Thus, a cursory glance at Figure 3 below would suggest that WH is on average, above the median of a 2.5 score on most items with the exception of 'Role'. In order to understand these results further a more in-depth appraisal is required on each of these elements individually (see below).

Note: The output is designed to allow an organisation to annually monitor the scores for each item. Figure 4 therefore has a legend that shows % change year on year. These are not editable in the software; hence the scores are for one year only.

Figure 4 : HSE Management Standards for Workplace Stressors (Average Scores)



5.1 - Work Demands

Our earlier analysis on negative behaviours suggested a potential correlation with demanding work with nearly 50% of survey respondents indicating they were given an unmanageable workload or set impossible deadlines. Work Demands in the HSE Management Standards is comprised of the following set of questions, which seek to reflect the pressures experienced by employees as a part of their job. As illustrated in Fig. 4, this produced the second lowest score of all seven Management Standards and requires reflection of the potential stresses experienced by WH employees who completed the survey. The individual questions in the Work Demands cluster were:

Q.3 Different groups at work demand things from me that are hard to combine (2.88)

Q.6 I have unachievable deadlines (3.35)

Q.9 I have to work very intensively (2.04)

Q.12 I have to neglect some tasks because I have too much to do (2.82)

Q.16 I am unable to take sufficient breaks (3.08)

Q.18 I am pressured to work long hours (3.55)

Q.20 I have to work very fast (2.42)

Q.22 I have unrealistic time pressures (3.16)

Commentary

Of these 8 questions, two indicate above average stress levels:

- 'I have to work intensively' where 28% of staff surveyed reported always having to work this way. Overall 97% of staff who responded to the survey reported they sometimes, often or always have to work intensively.
- 'I have to work very fast' where 16.5% of staff surveyed reported always having to work this way and 91% of staff surveyed reporting they sometimes, often or always have to work very fast.

These types of stressors subsequently impact on other areas such as staff neglecting other tasks because of work pressures (Q12) with 75% of staff surveyed reporting this and juggling work demands from other groups (Q3) where 9% of staff surveyed said they always had to do this, 25% said they often had to do this and 42% said they sometimes had to do this.

These types of pressures consequently effect abilities to take breaks (Q16) with two-thirds (63.5%) of staff reporting to the survey that they sometimes, often or always lacked time for breaks, leading to time pressures that are unrealistic (Q22) where 63% reported they had experienced this.

On a more positive note, 54% of respondents to Q18 (I am pressured to work long hours) reported they seldom or never experienced this.

Overall, the 'work demands' results indicate significant numbers of respondents having exposure to some form of excessive work demands, but our interview data did not contain any reference to excessive work as a precursor to B&H.

5.2 - Control Over Work

Control over work is comprised of the following six items (median scores in brackets).

Q.2 I can decide when to take a break (3.75)

Q.10 I have a say in my own work speed (3.37)

Q.15 I have a choice in deciding how to do my work (3.59)

Q.19 I have a choice in deciding what I do at work (2.94)

Q.25 I have some say over the way I work (3.79)

Q.30 My working time can be flexible (3.18)

The amount of control a person has over their work and how it is done is best explained as 'autonomy' or, the ability to make decisions themselves about their work.

Commentary

The WH results are better for the questions relating to 'control over work' compared to those for 'job demands', particularly about deciding when to take a break (Q2), with two-thirds of respondents saying they always or often controlled this themselves. Similarly, nearly three-quarters of staff responding to the survey (73%) reported they mostly controlled the way they worked (Q25).

These results, unsurprisingly, also reflect speed of work (Q10) with less than 20% of staff reporting they had little or no control over work speed and (Q15) with only 13% reporting little or no control over choices about how to do their work.

Flexibility around working time (Q30) is also mostly good for respondents to the survey with 48% reporting flexible working time (this increases to 70% if we include those who were neutral in their response – neither agreeing/nor disagreeing).

Question (Q19) 'I have a choice in deciding what I do at work' showed that one-third of WH respondents are seldom or never have any control over what they do. This is perhaps unsurprising given the nature of NHS work tasks.

Overall, the results for autonomy/control over work indicate a more positive picture on workplace stressors for survey respondents. However, the nature of NHS work in a Trust such as WH must be recognised, and that some staff will have more control over their work tasks compared to others, e.g. community practices versus hospital for example. Once again, we did not encounter these sorts of issues in our interviews with staff.

5.3 - Manager Support

Manager Support is comprised of five items as follows (median score in brackets).

Q.8 I am given supportive feedback on the work I do (3.28)

Q.23 I can rely on my manager to help me out with a work problem (3.67)

Q.29 I can talk to my manager about something that has upset me at work (3.71)

Q.33 I am supported emotionally through emotionally demanding work (3.20)

Q.35 My line manager encourages me at work (3.56)

Commentary

Manager support has been shown through research to buffer the effects of B&H, thus these types of measures are important in a study of this kind. Around two-thirds of respondents to the survey (67%) said they could always or often talk to their manager about something that had upset them at work (Q29) which was the most positive result against stressor risk. Similarly, 58% of those surveyed reported they could rely on their manager to help them out with a work problem (Q23) and 60% reported receiving encouragement at work from their line manager (Q35).

Just under a half of survey respondents (45%) reported supportive feedback on their work (Q8) with a similar number 44% reporting emotional support (Q33) when faced with emotionally demanding work. Both results indicate scope for improvement in manager support of staff.

In line with the interview data, the results above that show two-thirds of respondents do not report bullying, but those that do have cited their manager/supervisor as the principal sources of their workplace problems with B&H. When management works well, employees feel supported; when it works less well, problems such as B&H can occur. The interview data told us that some employees found their manager behaviour problematic and that when they had raised this with others, their views and opinions had been ignored.

One interviewee had been given support in the form of mentoring, which they felt had been very useful. Others reported being allocated coaches and this had helped them. Other interviewees commented they felt they needed a mentor/coach stating *"I felt trapped, there was no support. I needed a mentor".* Another reported during their interview that they had made a mistake to which they had admitted responsibility, but this left them feeling their *"world had collapsed"* resulting in them *"not sleeping, not eating*" and *"I was a complete wreck – I had no-one to talk to".* It is important that steps are thus taken to support colleagues who have made errors, and not to leave them feeling unduly vilified and/or isolated. It is clear that WH has taken positive steps to support some staff and this may have a wider potential as an active intervention. However, supportive coaching/mentoring is no substitute for directly addressing inappropriate manager behaviours.

There is also clear evidence that members of the Executive team need to better prepare and support managers to undertake tasks. These range from carrying out investigations through to proper preparation for clinical supervision. We return to these maters later in our report.

5.4 - Peer Support

Four items measure peer support (median score in brackets).

Q.7 If work gets difficult, my colleagues will help me (3.68)

Q.24 I get the help and support I need from colleagues (3.84)

Q.27 I receive the respect at work I deserve from colleagues (3.76)

Q.31 My colleagues are willing to listen to my work-related problems (3.83)

Commentary

Peer or colleague support is also shown to buffer the effects of B&H. Overall, these four measures reveal colleague support to be positive with 60% of survey respondents indicating colleagues will help in difficult work situations (Q7) rising to 70% peer support levels for listening colleagues (Q31) and 72% for helpful and supportive colleagues (Q24). Colleagues are also respectful of each other in the main with two-thirds reporting positively on this question (Q27).

These results suggest that peer support is a strong feature of organisational culture among the respondents at WH. It is important to recognise that whilst around 70% of respondents find their colleagues supportive, around 10% do not. This is reflected in the overall score for bullying – most respondents do not encounter this, but around a quarter do.

The role of FSUG can also be considered appropriate in terms of Peer Support. Several interviewees raised the issue of this role with several finding this unsatisfactory. Whether this is due to expectations that the FSUG would provide solutions to their problems is unclear, but it is important that this role is seen to actively report all concerns to the Executive team so that statements such as *"I went to the Speak-up Guardian and was told 'yes, that's just what she is like, different managers have different management styles'"* and another said, "*I went to the Speak Up Guardian and nothing came of it"*. If this role is to be successful, staff must feel that their concerns are listened to, noted and escalated as appropriate and that boundaries around expectations are clear at the outset.

5.5 - Relationships at Work

Relationships (including questions on B&H) are measured by four items (median scores in brackets).

Q.5 I am subjected to personal harassment in the form of unkind words or behaviour (4.07)

Q.14 There is friction or anger between colleagues (3.32)

Q.21 I am subject to bullying at work (4.30)

Q.34 Relationships at work are strained (3.25)

Commentary

Overall, the results above support the findings in 4.2 above, namely that around 26% report some exposure to harassment (Q5) and 20% for bullying (Q21). On a more general note, 55% of respondents reported some levels of division between colleagues (Q14) and a similar level (54.5%) reporting strained working relationships (Q34). These findings suggest an embedded tension in some parts of WH.

The results suggest bullying is commonplace for around one in five staff, and harassment for one in four. The organisational climate is demonstrated through tensions and strained relationships for around a quarter of the workforce and suggests that the workplace is tense and prone to periods of anger/aggression that, for some, manifest as B&H. This was clearly evidenced in some of the interview testimony with serious lapses in professional management behaviour leading to examples of intimidating and threatening actions that led some staff to feel frightened about speaking up or even open emails and/or attending management and one-to-one meetings.

5.6 - Role Conflict

Five items measure role conflict as follows (median scores in brackets).

Q.1 I am clear what is expected of me at work (1.73)

Q.4 I know how to go about getting my job done (1.59)

Q.11 I am clear what my duties and responsibilities are (1.68)

Q.13 I am clear about the goals and objectives for my department (1.91)

Q.17 I understand how my work fits into the overall aim of the organisation (1.93)

Role conflict has been shown by researchers to be highly correlated to bullying at work because an absence of role clarity creates uncertainty leading to stress.

Commentary

These five items show a worrying indication of workplace stress and is reflected clearly in figure 3 where 87% of surveyed respondents indicated they are never or seldom clear of what is expected of them (Q1) with even more (93%) being never or seldomly clear how to get their work done. A similar number (87%) are unclear on duties and responsibilities (Q11) and 78% are unclear about departmental goals and objectives (Q13). These very poor scores are also reflected in how respondents perceive the fit between their work and overall WH aims (Q17) with 79% reporting little or no fit between themselves and the WH aims.

These results are the weakest across the HSE Management Standards for WH and suggest role conflict is a major feature of stress for most staff who responded to the survey. The

findings suggest a lack of clarity from organisational and departmental managers as well as WH leaders in expectations, responsibilities and strategic fit and should thus provide a basis for action by the leadership.

We also found evidence in our interview data for problems associated with role clarity with people stating; *"I wasn't prepared for the role"*. We heard on numerous occasions examples where staff had been asked to take on roles without adequate preparation, these ranged from carrying out investigations to preparation of business cases. In most cases, staff feel frustrated at the lack of support available to them to undertake the roles given to them and could be neatly summarised by this statement;

"There was no support as to how to do things. I was left feeling demoralised"

A major source of problems with role conflict stems from the approach taken in managing ICSUs. Front line service managers do not have control or access to their own budgets with these being held at ICSU level. This makes it impossible for managers to manage effectively and leaves many feeling disempowered and ineffective.

5.7 - Change at Work

Three items measure change at work as follows (median scores in brackets).

Q.26 I have sufficient opportunities to question managers about change at work (3.19)

Q.28 Staff are always consulted about change at work (2.76)

Q.32 When changes are made at work, I am clear how they will work out in practice (2.99)

Commentary

The results for organisational change indicate a sense of struggle for some staff regarding their consultation and explanation when change is made at WH. For example, 42.5% of staff respondents stated they strongly disagreed or disagreed about staff consultation on change (Q28). Similarly, less than half of respondents are confident they have opportunities to ask managers about changes at work (Q26). Around two thirds (67.5%) strongly disagree/disagree or are neutral about how changes will be practically applied when they are imposed.

These results suggest there is scope for improvement about the communication, process of change to ensure both consistency around changes made, and their likely impact. This indicates a leadership action for the Trust executive.

Change surfaced regularly in our interviews with staff with some describing changes as *"implemented blindly"*. This same interviewee went on to say; *"they weren't ours [changes] so we didn't believe in them"*. The process of change ties in closely to many of the other elements of the HSE Management Standards. For example, if front line managers are not in

control of their own budgets and have no say in budgetary management, how can the Executive expect these same managers to deliver changes to the front line of operations?

Some staff also complained bitterly about the lack of consultation around change and of not being listened to when they went back to management to state the post-change practices were not working. In the same vein, recent consultations on job role changes led some staff to feel this was little more than an exercise in employee engagement as minds had already been made up. Whilst it is not always possible to make changes and to incorporate employee demands, it is important to document employee voice and to show due regard to this in reaching a final decision. Demonstrating that staff have been listened to and their views acknowledged is an important part of owning and managing change.

Summary of HSE Management Standards

Using a traffic light approach, these results present a mixed picture for WH staff. Many respondents report reasonable levels of control over their work and positive quantities of management support and peer support and these should be colour-coded green. Job demands, and management/communication of change, indicate an amber coding with scope for improvement from the leadership and management in matters of change and in supporting staff operating under difficult demand circumstances. Organisational relationships and role conflict should be coded red. Whilst around three-quarters of staff do not report harassment, 20% report bullying and 26% harassment, or stated another way, 430 people reported being bullied or harassed using the HSE questions.

There are also clear underlying tensions in colleague relationships. It is possible that these are exacerbated by a lack of role clarity where the mainstream of respondents (typically 75-90%) appear to lack a connection between themselves, their department, and the organisation at large in terms of the work they do, and wider departmental and organisational aims. This disconnect creates high levels of uncertainty and thus stress. It is clear that at an individual level, staff professionalism means most staff know what to do and how to do it. The bigger problem appears to be a lack of wider collective cohesion. This is also reflected in some of the qualitative evidence emerging from interviews which we discuss below.

6.0 Concomitant Issues

6.1 Open Communication Ethos

We asked respondents six questions about their willingness to speak up in WH about issues that affect them or their work group. The six questions were:

- I develop and make recommendations concerning issues that affect my work group
- I speak up and encourage others in this department to get involved in issues that affect the group

- I communicate my opinions about work issues to my supervisor/line manager or others in this department
- I keep well informed about issues where my opinion might be useful to my team
- I get involved in issues that affect the quality of work life in my group
- I speak up with ideas for new projects or changes in procedures

We wanted to understand if there was a relationship between those who reported exposure to bullying and negative behaviours with their responses to these 6 questions.

Commentary

Intuitively we might expect those staff who report being bullied or exposed to negative behaviours not to engage with teams/colleagues/line managers in the ways indicated by the questions above. The data from WH signposts a mixed picture in this regard with some staff who report feeling bullied or being exposed to negative behaviours showing a continued willingness to remain engaged with their teams and line managers whilst others have diminished engagement. Closer scrutiny of the data is required for statistical purposes, but initial analyses shows three questions to be the most negatively affected by exposure to bullying and negative behaviour exposure:

- I communicate my opinions about work issues to my supervisor/line manager or others in this department
- I keep well informed about issues where my opinion might be useful to my team
- I speak up with ideas for new projects or changes in procedures

The data suggests that exposure to bullying and some negative behaviours creates destructive associations for some staff, which subsequently diminishes their willingness to speak out or become active team players (we return to this later in the qualitative data from interviews). These types of insights provide evidence to managers and leaders of the direct ways in which bullying/negative behaviour exposure has consequences for organisational effectiveness and thus should be embedded into annual performance development reviews of managers and employees.

Similarly, encouraging engagement with the FSUG is synonymous with an open ethos culture. However, as noted above, there is a clear need for boundary setting and clarity about both reporting incidences that reach the FSUG and actions thereafter.

6.2 Organisational Citizenship

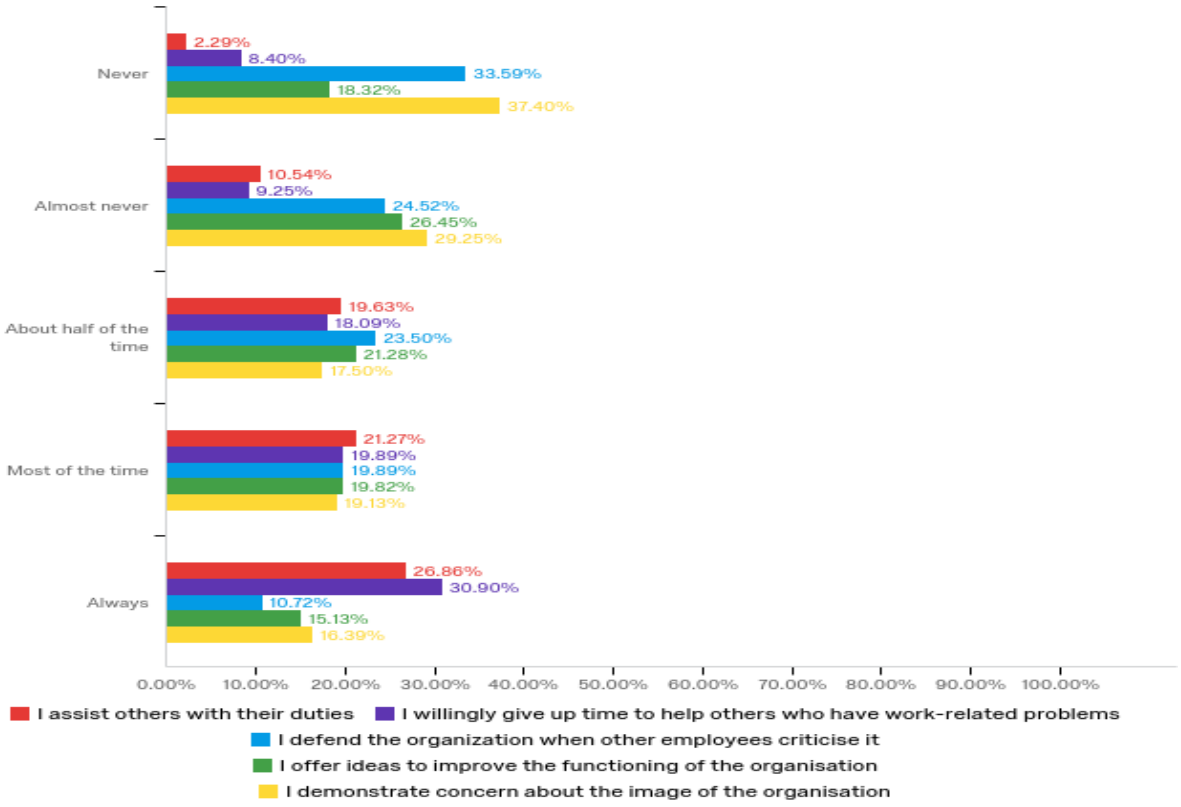
We asked survey respondents for their answers to 5 questions. These were:

- I assist others with their duties
- I willingly give up time to help others who have work-related problems
- I defend the organization when other employees criticise it
- I offer ideas to improve the functioning of the organisation
- I demonstrate concern about the image of the organisation

Commentary

The data from these questions reveals a mixed picture of citizenship within WH. Questions 1 and 2 (individual citizenship) generally fare better with most employees offering assistance to others (not all employee roles are of course capable of assistance from colleagues). This also supports our findings in 5.4 (peer support) above. In contrast, questions 3-5 on organisational citizenship are more negative with 58% of respondents never/almost never defending the organisation when criticised by other employees, 45% never/almost never offering ideas to improve the functioning of the organisation, and 67% never/almost never demonstrating concern about the image of the organisation. It therefore appears that there is collegiate citizenship, but organisational citizenship requires significant development. This also ties into the findings in 5.6 and 5.7 above where a lack of clarity about role and individual contribution, and a failure to feel part of change processes, leaves individual commitment floundering. Figure 5 summarises the responses to the questions above.

Figure 5: Responses to questions of organisational citizenship



6.3 Questions relating to line managers/supervisors

Respondents were asked to give their views on 10 questions relating to their line manager/supervisor. 726 respondents answered this question.

Table 3: Employee responses to questions about line managers/supervisors

#	Question	Strongly agree		Somewhat agree		Neither agree nor disagree		Somewhat disagree		Strongly disagree		Total
1	Listens to what employees have to say	42.01%	305	32.92%	239	10.74%	78	6.75%	49	7.58%	55	726
2	Disciplines employees who violate ethical standards	23.42%	170	24.10%	175	39.26%	285	7.44%	54	5.79%	42	726
3	Conducts her/his personal life in an ethical manner	49.31%	358	17.77%	129	26.17%	190	3.31%	24	3.44%	25	726
4	Has the best interests of employees in mind	44.08%	320	25.62%	186	15.01%	109	7.85%	57	7.44%	54	726
5	Makes fair and balanced decisions	39.39%	286	29.06%	211	14.33%	104	10.06%	73	7.16%	52	726
6	Can be trusted	47.93%	348	22.45%	163	13.36%	97	7.58%	55	8.68%	63	726
7	Discusses NHS ethics or values with employees	31.27%	227	27.96%	203	25.90%	188	7.85%	57	7.02%	51	726
8	Sets an example of how to do things the right way in terms of ethics	41.74%	303	27.00%	196	19.01%	138	4.41%	32	7.85%	57	726
9	Defines success not just by results but also the way that they are obtained	37.19%	270	26.58%	193	20.80%	151	7.16%	52	8.26%	60	726
10	When making decisions, asks you or other colleagues "what is the right thing to do?"	31.27%	227	29.89%	217	18.18%	132	10.06%	73	10.61%	77	726

Commentary

As we have already seen, most employees who responded to the survey rate their line manager well for manager support (see 5.3 above). This trend broadly continues in table 3

above, where between 48% and 70% of respondents strongly agree/agree that their line manager listens to them, is broadly ethical in approach, is fair in decision making and so forth. When we compare these results with those who reported yes and no to bullying, there is significant statistical association with all of the questions. For example, the question "Listens to what employees have to say" reveals a much higher level of disagreement amongst those who reported bullying (chi-square 85.2291, p-value <0.00001, sig. at p<.05). This same pattern exists across each of the remaining 9 questions demonstrating clearly the connections between those who report being bullied and the damaged perceptions of unfair, untrustworthy and unengaging management (see questions, 5, 6 and 10).

These findings mirror our earlier observations from interview data on the damage done by managers who do not respond to raised concerns, are unapproachable or who intimidate or threaten so that employees do not feel safe when around them. The Trust may wish to reflect on these when it considers how managers are appraised for their management roles and behaviours.

6.4 Questions about Senior Management commitment to Psychological Safety

We asked respondents who had reported bullying for a range of views on senior management's commitment to safe psychological working. Only 181 people responded to the bullying question and chose to answer these questions. The results should therefore be viewed with a degree of caution as they not representative of the general employee population in the Trust (see table 4 overleaf).

The results reveal that there is a greater chance of disagreement with each question than with agreement. This suggests a perceived lack of willingness by most of those who report bullying that there is a genuine senior management commitment to tackle B&H under the broad umbrella of psychologically safe working. We refer to this later in the report.

Table 4: Responses to questions on senior management commitment to psychological safety

Question	Strongly agree	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree	Strongly disagree
There is good communication here about psychological safety issues which affect employees	1.66%	5.52%	9.39%	18.23%	13.81%	22.65%	28.73%
Senior management show support for stress prevention through involvement and commitment	1.66%	9.39%	11.60%	17.13%	14.92%	16.02%	29.28%
Senior management considers employee psychological health to be as important as productivity	2.21%	4.42%	8.84%	16.02%	12.15%	20.44%	35.91%
Senior management clearly considers the psychological health of employees to be of great importance	2.76%	6.08%	11.05%	17.13%	13.26%	16.57%	33.15%
Senior management acts decisively when a concern of an employees' psychological status is raised	1.66%	8.84%	11.05%	22.65%	15.47%	14.92%	25.41%
Psychological well-being of staff is a priority for this organisation	2.76%	7.18%	11.60%	17.13%	12.15%	13.81%	35.36%
Participation and consultation in psychological health and safety occurs with employees', unions and health and safety representatives in my workplace	2.21%	6.08%	12.15%	34.25%	11.60%	12.71%	20.99%
In my workplace senior management acts quickly to correct problems/issues that affect employees' psychological health	1.66%	7.18%	11.05%	21.55%	12.71%	16.57%	29.28%
In my organisation, the prevention of stress involves all levels of the organisation	5.52%	4.97%	7.73%	19.89%	12.71%	17.13%	32.04%
Information about workplace psychological well-being is always brought to our attention by our line manager/supervisor	2.76%	7.73%	8.84%	18.23%	14.36%	20.99%	27.07%
Employees are encouraged to become involved in psychological safety and health matters	2.21%	7.73%	11.05%	27.07%	14.36%	14.92%	22.65%
Employee contributions to resolving occupational health and safety concerns in the organisation are listened to	1.66%	6.63%	11.05%	30.39%	13.26%	19.34%	17.68%

6.5 Satisfaction with work

We asked respondents 5 questions that can be classified as generic issues of job/work satisfaction. A total of 706 employees answered these questions. The questions were:

- Most days I am enthusiastic about my work
- I feel fairly satisfied with my present job
- I find real enjoyment in my work
- Each day at work seems like it will never end
- I find my job very pleasant

When we compared the results of those who reported bullying versus those employees who did not report bullying, we find those reporting bullying have:

- Diminished enthusiasm (chi-square 53.3142, p-value <0.00001, p<.05)
- Diminished job satisfaction (chi-square 72.7133, p-value <0.00001, p<.05)
- Diminished work enjoyment (chi-square 38.3429, p-value <0.00001, p<.05)
- Feelings of work never ending (chi-square 45.1412, p-value <0.00001, p<.05)
- Finding their job unpleasant (chi-square 68.488, p-value <0.00001, p<.05)

Commentary

As an illustration, those reporting being bullied were four times more likely to strongly agree with the statement 'each day at work seems like it will never end' compared to those who also responded that they strongly agreed to the statement, but who had not reported bullying. This confirms existing research that shows employees exposed to bullying are more likely to leave their employment and have diminished commitment and contributions whilst at work. Excerpts from interviews cited in the report thus far provide evidence of this.

7*.0 - Qualitative Insights from Interviews*

We have already provided some insights from our 120+hours of interview transcripts with WH employees. We now turn to discrete themes that emerged from these interviews but that sit outside of general bullying and harassment behaviours, or as features of the HSE Management Standards and other questions asked in the survey.

7.1 – Leadership & Management

We commence with leadership because all organisational issues start and end with leadership. We refer to leadership as the executive and those in senior roles in clinical and operations teams.

7.1.1 – Chief Executive & Trust Chair Visibility

In line with views of WH as a *"family friendly"* workplace reported earlier, there is strong evidence of the Chair of the Trust and the Chief Executive having high visibility both at the main hospital site and also in community locations. Whilst this is generally viewed positively, there needs to be a continued focus for staff in hospital and community settings to be engaged and communicated with appropriately. There can also be repercussions as a result of high leadership visibility. For example, the Trust Chair is regularly (daily) on site and keen to talk to staff at all levels. This can make it difficult to maintain distance and independence in the event of disputes. Similarly, we heard numerous accounts of staff bypassing normal communication channels to speak directly with the Chief Executive. This creates real difficulties when a final arbiter is required for decisions in sensitive situations. It is a difficult balancing act between accessibility and representation and the Trust is at risk of falling foul of its own procedures if communication has not followed the correct pathways. It is also critical that staff recognise the role of the Chief Executive is in strategically driving the organisation forwards rather than being a conduit for issues best dealt with by others.

7.1.2 – Allied Health Professionals

Allied Health Professionals (AHPs) report a lack of clarity about their line of accountability to both the requisite ICSU and the wider Executive team. The AHP staff perceive a lack of pathway to Board level for AHPs and a lack of representation for AHPs at any level. These require addressing by engaging with AHPs.

7.1.3 – Leadership Styles and Behaviours

We are constantly minded that we have an incomplete picture of behaviours, being only in possession of secondary testimony. Nevertheless, and being cognisant of the survey and interview data, we must report that there are perceptions in some quarters of members of the Executive being labelled as bullies. Whether this is true or not is not the issue – it is a perception. Some of the behaviours reported, and they were reported frequently, suggest some of the leadership teams in ICSUs, and amongst some of the Executive, are not meeting the leadership standards some staff expect. It is also important to report that some staff stated difficulties in their encounters with some senior medical staff (consultants). This

involved inappropriate behaviours and a sense of authority because of their status. Senior medical staff should also see themselves as part of the WH leadership with a collective responsibility for behaviour.

All our evidence points to the Chief Executive being positively viewed and approachable (see above). Staff generally welcome emails from the CEO that poor behaviour will not be tolerated, but they are frustrated by apparent inaction when such behaviour continues. There is some consensus of the Executive as *"cosy"* and *"collusive",* unwilling or unable to challenge themselves and others. Regardless of whether this perception is true or not, it should be addressed.

Whilst we cannot name individual members of the Executive group, there is a repeated perception of a laissez-faire approach to management/leadership by some, and a hostile and abrasive approach to employee concerns by others. The researchers do not believe these leadership styles are due to a pressured workplace. Unresponsive leadership styles are unacceptable, regardless of demands, and this sometimes extends to an inability or unwillingness to support less senior colleagues in the preparation and execution of their duties. There are clear examples of workplace conflicts in WH that could have been avoided had they been dealt with appropriately and expedited in a timely fashion. Underpinning some of the sluggish approaches to dispute handling is a belief from some staff about a *"chronic lack of interest"* by some senior leaders to their stated problems, resulting in the perception of leaders being *"weak and uninterested"*. Staff complained bitterly about their concerns being raised, only to encounter a lack of interest.

As a result, there is a perception in some quarters that the Trust leadership is sometimes weak, and this extends to ICSUs, and that staff are not valued. One ICSU was described as "*Totalitarian and Covert*". There is also a perception that ICSU leaders micromanage and are controlling, failing to let those below them manage with discrete authority. Importantly however, staff must not be allowed to simply bypass ICSU leadership and go straight to the Executive. The management and leadership hierarchy must function effectively and within the normal bounds of management structures.

In the challenging financial times that NHS Trusts find themselves in, it is also important that financial controls are not only delivered equitably, but that communications around them become clear and understood. There is a perception in some areas that financial processes around staffing are not approved in a timely manner and that in some circumstances, finance takes precedent over patients and that finance dominates all else. Whilst we are unable to confirm such views, they are contributory elements in perceptions of a harassing culture.

There is also a perception from some senior WH staff that staff become disheartened because innovations are often rejected at the last minute and following perhaps weeks of thought and effort. Feedback on innovative ideas is also perceived as unforthcoming by members of the Executive. In times of financial prudence, seeking pathways to innovation is key, but this requires an engaging and responsive leadership team.

When these leadership issues are combined, they create a perception of an ineffectively managed institution and this trickles down to lower levels of management. As an exemplar, a colleague who regularly attended meetings with members of the Executive commented how some Executive members acted inappropriately, pulling faces, doodling and sending messages to each other covertly. Whether this is merely a perception or not, it allows others to sense the Executive as ineffective and unprofessional.

The researchers encountered numerous conversations where frustrations were aired about certain members of the Executive who were *"ineffective"* leading to perceptions of a *"crumbling situation because of xxx's [redacted] inadequacies".* This was a consensus view by several senior managers, including other Executive members, and this now requires immediate actions. There is a catalogue of matters that should have been dealt with but were ignored or left to fester. These include serious disputes between members of the medical body that have led to some leaving and others remaining disgruntled and disaffected. Significant hours of senior staff time have been lost and wasted to disputes that could and should have been handled more effectively. Some of these are on-going.

The medical body, like all senior people in any organisation have a role to play in ensuring organisational effectiveness. They also act as role models and their behaviours inform others of how senior employees should behave. It is thus not only the Executive that is to be held to account but also senior medical staff and professionals *per se*. Ultimately, every employee is under scrutiny when it comes to inappropriate behaviour, but it is the Executive who must lead on this.

It is thus clear that action is required, and that proper challenge is made to both ineffective members of the Executive/ICSUs and to those who are rightly viewed as unsupportive and unwilling to engage colleagues in reaching amicable resolutions. That said, it is also clear that some of the long-standing disputes have become so toxic that finding resolution is fraught with difficulties; yet this remains an important attainment if elements of the organisation are to move forwards. Colleagues on both sides, those aggrieved and those in leadership roles, must seek to move beyond a 'he said- she-said' *modus operandi* and be willing to admit errors on both sides having been made.

7.2 HR Systems and Processes

As might be expected when conducting research into alleged bullying and harassment, the department, in this case 'Workforce' (HR), is the most likely to be encountered. Our synopsis here relates to our qualitative interview data only and we deal with policy and documentary matters later in the report.

Like many NHS Trusts, WH seems to be mired, at least in parts, in a grievance culture. Grievances are often viewed as the first line of airing an employee's concerns, although this has been superseded in some instances by deployment of mediation. Both grievances and mediation have their place in dispute resolution, but greater care and thought needs to be given by all sides before commencing such pathways. Several interviewees explained they lacked the necessary insight to either understand how a grievance would proceed, or how to manage one when appointed as an investigator. Our observations of both documents provided by aggrieved employees, and from their testimony, indicates that the process of grievance is far too lengthy, often for months and sometimes spilling over into periods of more than a year. This may well be a bi-product of a Workforce Department that is only now reaching some form of capacity (we return to this later), but nevertheless, resources and processes have not been sufficiently deployed to properly hear and deal with grievances.

Once grievances have been formally raised there is significant concern from some staff members that these have not been fairly managed. Examples of this include:

- A case manager believing it is acceptable for the subject of the grievance to also be the appointed HR representative.
- A belief that once a grievance has been raised there are repercussions from the manager who is the subject of the grievance.
- That the subject of the grievance attends meetings with the person raising the grievance.
- An employee called as a witness to a grievance and at the same time being asked to oversee recommendations.
- Witnesses being called to an investigation before the aggrieved had time to alert them that they were being asked to give witness testimony.
- Staff still not knowing the outcome of their grievance several months after lodging it.
- Staff copying in HR to their grievance but not receiving acknowledgment or further correspondence

These types of concerns arose time after time in our interviews with staff which suggests these are not isolated occurrences and that the management and functioning of grievances requires radical improvement. Some staff feel unsupported and isolated and even ridiculed by the grievance process and that this is both a Trust and HR issue.

Confidential statements are believed by staff to have been shared with the subject of the grievance, thus enabling them to prepare a defence. This process is normal in a grievance situation as any employee has a right to know what accusations have been made about them. What this demonstrates, supports our earlier observation that staff are unclear about what happens in a grievance process, such that they feel matters are unfair even when they are not. Communication about the process of grievance must improve and efforts intensified to ensure investigations are carried out to prescribed best practice.

The deployment of mediation as a tool of conflict resolution is broadly welcomed and staff recognise its value, however, there are instances of mediation being used when significant, and lengthy disputes are deep seated. HR colleagues must reflect on the appropriateness or otherwise of mediation and know when, and when not, to use it. It is not a one-size-fits-all solution.

There is significant unhappiness from sections of the WH workforce about the HR function generally. This is not unusual in our experience of this type of work, but it does require action. For example, HR staff were described as *"rude", "bullish", "they don't listen", "very poor at grievance handling", "taking an offensive approach", "difficult"* and even *"toxic"*. Some of these views stem from poor administrative responses to grievances, non/slow-replies to complaints, failure to take managers to task for not following proper procedures and a systemic belief that grievances are always found in favour of managers. These create a lack of trust in HR systems and processes which in turn generates significant problems in tackling issues like bullying and harassment, which so often stem from manager behaviours as we have seen above. When staff told us *"HR didn't care – I wanted to end my life",* it sends very powerful messages that HR is not simply a process function, it is dealing with people in vulnerable situations and with significant health outcomes if ineffectually dealt with. HR must be arbiters of fair systems and processes, open to scrutiny. Grievances rightly have their place, but a proper partnership approach to solving disputes and conflicts requires all parties to work together to find better routes to dispute resolution.

It is well reported in the workplace bullying research literature that it is the targets (victims) of bullying who often get relocated in their employment, rather than the alleged bully. This view was also reported to us in interviews. It is critical that WH employees do not perceive such a tactic as a reward for bullying. If there is clear evidence of wrongdoing by one party, it is they who should be admonished, and if necessary relocated, not the target of the bullying.

7.3 Discrimination

Although examples of discrimination were not common in our interviews with staff, there is sufficient evidence to note it as a potential area of concern. Examples brought to our attention included:

- Ageism (several accounts):
  - where staff were asked by their manager when they were retiring
  - staff felt underutilised because their skills were somehow devalued because of their age.
  - being asked to meet with HR regarding their retirement even though they had not expressed a desire to retire.
  - Age being used to question competence as a vehicle to *"encourage"* people to retire.
- Ethnicity:
  - East European colleagues being told by Afro-Caribbean colleagues that their culture was *"rude"* leaving them feeling picked upon.
  - Some cultural groups speaking in their mother tongue which leads others to feel isolated.
  - Staff rotas being organised in favour of the dominant cultural group.

We also met senior colleagues who felt that diversity and inclusion was not taken seriously by the trust, despite its multi-cultural location. They praised the efforts of those working towards inclusion but felt that Workforce and senior managers needed to grasp the nettle to tackle embedded discrimination both in conscious and unconscious bias forms. The current approach to inclusion requires active engagement by all and led with purpose. It is critical that the Executive and senior managers display constant vigilance to tackle discrimination, especially in light of rising incidences of hate crime in the UK as well as recognising discrimination is not simply a black and white issue.

7.4 Freedom to Speak Up Guardian/Anti Bullying and Harassment Advisors

The role of FSUG across the NHS was an initiative prompted by the Francis Report of 2014 and now organised by each NHS Trust. As reported earlier, this is an important role and not just in respect of bullying and harassment. What is critical is that staff have confidence in the role and in the processes associated with any whistleblowing issues raised. WH provided summative accounts from the FSUG regarding bullying with 21 cases recorded in 2017. Evidence from the inclusion lead was also small with regularly only 1 or 2 cases per month being recorded.

Creating appropriate 'voice' mechanisms is essential to addressing B&H. The researchers conclude that whilst there is some intended good work between all parties, there is limited evidence for a true partnership model of working between the Trust and trade unions. Such a model of partnership is central to resolving B&H issues and other NHS Trusts such as

Mersey Care could provide useful insights into partnership working which could be built upon by WH.

The Trust may also wish to consider the structuring of the role of the FSUG moving forwards because the current incumbent is also a senior manager and some questions of impartiality have been raised with the researchers. Although 8 additional inclusion champions have been trained to support the work of the FSUG, their title is potentially at odds with the broader remit of the FSUG as inclusion is normally associated with equality and diversity agendas. A title such as Speak Up advocate would be more appropriate. Inclusion is one task and tackling bullying and harassment another; there is clear crossover, but one might not speak to the other.

As with the grievance issues raised earlier, it is crucial that the role of FSUG is clearly articulated to staff to avoid uncertainty over responsibilities and expectations. The same is true of the anti-bullying and harassment scheme. It is also worth ensuring the inclusion champion roles cover each ICSU and support departments. This is important given the current FSUG guardian also works in an ICSU and there may be concerns from staff in the same ICSU about raising issues.

The Trust also launched their Anti-bullying and Harassment scheme in June 2016 by training (externally) 17 in-house advisors. These were not mentioned by any of our interviewees. Similarly, when respondents to the survey were invited to indicate what they had done about any B&H they had witnessed, from over 100 responses to the category 'other', only one person mentioned speaking to the advisors. Data from the inclusion champion on this scheme also supported our findings. This suggests there is work to be done raising awareness of this role and giving advisors much greater visibility. They should also be hard-wired to the FSUG for reporting and to ensure they function independently of Workforce.

8.0 Policies, Processes and other documentation

The researchers were given unrestricted access to all policies and attendant documentation relating to bullying and harassment. It was unnecessary to scrutinise some policy arenas (for example sickness absence policy and whistleblowing) since these did not feature as hotspot topics in the survey data or from conversations in interviews with staff. Only those attendant policies linked directly to the data have thus been inspected.

8.1 Grievance and Discipline Policies

We have already commented extensively on concerns raised about grievance procedures and now turn to documentation to ensure this meets expected norms.

The disciplinary policy was due to be reviewed in October 2017 but does not appear to have done so. This requires urgent action. The policy is lengthy at 22 pages and was found to be

excessively complex and wordy. Given the overdue nature of its review, this policy should be thoroughly re-examined.

The grievance policy was also due for review in March 2018 and this may or may not have been undertaken; if not, this is also an urgent priority, especially in light of the findings of this report. The policy was found to be of an appropriate length but would also benefit from a thorough review with a view to simplification and to achieving clarity. For example, sections 8.8.11.1 (and sub elements) do not read lucidly. The aim must be simplification and clarity so as to be understood by all employees from all backgrounds.

8.2 Bullying and Harassment Policy

None of those interviewed raised issues about the B&H policy. An examination of the policy found this to be up-to-date having been reviewed in 2016, although there is no review date indicated. Some observations of the policy are:

- The length and format of the policy is conventional but some of these could be better ordered so that the first 3 pages of administration matters are placed at the end of the policy. Any employee would wish to go straight into matters of concern to them, not to administration of the policy.
- The length of the policy and language used within it were broadly appropriate although there is always scope within policy arenas to simplify and shorten, particularly given the multi-cultural nature of the workforce.
- Bullying is always regarded as serious misconduct. This approach has weaknesses. For example, many people targeted with inappropriate behaviour simply want the behaviour to stop. In considering whether to raise their concerns under the policy, they may not wish to see the alleged bully face potential dismissal. It is suggested that the text is amended to indicate bullying can be considered across a spectrum of conduct breaches from admonishment for inappropriate behaviour through to more serious sanctions.
- The language of zero tolerance is well meant but how realistic is this as an aim? The researchers suggest this is removed.
- The policy draws on best practice such as that offered by Acas and this is to be commended.
- Examples of unacceptable behaviours are broadly sound and include the use of social media and electronic media.
- Role of Managers section – as has been shown throughout this report, most incidences of bullying have been associated with managers/supervisors. The policy does not sufficiently explain what an employee should do if their concerns relate to their own line manager. Similarly, in 6.1 the policy seems to indicate what happens when the behaviour is from a colleague or a third party. This further suggests the issue of managers bullying is skirting the issue. This should be corrected. The section

on managers also refers to “firm but fair” management. Why is the word “firm” required?

- There are conventional routes outlined to resolution but personal action (i.e. speaking to the alleged perpetrator first) is not always practicable or sensible, particularly with so many alleged incidences of B&H emanating from managers. There needs to be a clear alternative pathway for employees to raise concerns when the alleged bully is their line manager.
- It is possible that, with consultation with trade unions, that the policy be renamed Dignity and Respect Policy given that so much identified negative behaviour is around incivility and disrespect and further, that B&H is such a contested term that many employees struggle to correctly label their experience.
- The policy includes a section on making vexatious claims and this is welcome.

8.3 Dashboard Performance Indicators

One area identified within the Dashboard used by WH for Key Performance Indicators (KPI) was performance appraisals. Only two divisions meet current KPI thresholds with several falling short of targets, although there have been improvements over recent years. This provides support to our earlier findings (section 5.6) on the absence of role clarity expressed by many of the staff surveyed. Appraisals are the crucial vehicle to establish an individual’s personal contribution and fit to departmental and organisational aims, goals and objectives. If many ICSU’s and departments are not meeting appraisal targets, there is a clear impact on role clarity.

8.4 Care Quality Commission (CQC) report (February 2018)

The researchers examined the CQC report for connections to the B&H issue. The report, although broadly recognising the good and even outstanding elements of WH performance stated: “The Trust needs to do more work to improve the culture for staff particularly around bullying and harassment. It was unclear how the Trust planned to address these” (p.6). It is clear that, in commissioning this research, the Trust has begun to put in place a strategy to properly tackle bullying and harassment.

9.0 Conclusions

This study was a response to a request from the Chief Executive to help the Trust get to grips with above average scores for bullying and harassment compared to other NHS Trusts in England based on the NHS Staff Survey and to respond to concerns raised by the CQC report and Picker surveys. It is commissioned research and is not an inquiry.

This study has taken approximately 6 months from commencement to completion. The data includes survey responses from over 1100 employees and in excess of 120 hours of telephone and face-to-face interviews. Existing data from NHS staff and Picker surveys have been examined as have policy and other reports and documents.

The report aims to help Whittington Health address concerns surrounding bullying and harassment, give confidence to the Board and other NHS bodies of the intent to address bullying and harassment, and to shed light on the complexities of what underpins claims of bullying and harassment. Our conclusions are structured around 6 clear themes.

9.1 Theme 1 – Executive and Senior Leaders

Our conclusions are that there are no obvious signs of bullying and harassment amongst the Executive, but there are well-defined problems of examples of ineffective leadership. These include a belief from many staff of a "collusive" and "cosy" Executive who lack a willingness to challenge their own and other's behaviours. Underpinning this view is a perception of a laissez-faire approach to leadership by some, and a hostile and abrasive approach to employee concerns by others. Both claims appear to have some basis. Delays in responding to issues that may not have originally presented as a bullying and harassment problem, an absence of support for junior colleagues, and failing to wrestle with disputes effectively have combined to significantly affected many staff. Much of this is completely unnecessary.

Outside of the Executive, some of the senior leaders, including senior medical staff but also down to Band 7, at ICSU levels and in support departments is unacceptable. There are numerous examples of staff being fearful of opening emails, attending meetings and having one-to-one exchanges with some managers. Staff do not usually describe themselves as *"broken", "a wreck"* or *"it destroyed me*" without good cause. The significant majority of our interview data was about inappropriate manager behaviour, although the survey data also points to inappropriate behaviours existing between colleagues. It is clear that the problem of bullying and harassment is a key issue for the Executive and upholds the claims made by the February 18 CQC report as a problem worthy of action. This also ties in closely to our second theme.

9.2 Theme 2 – Grievance Culture and Management

Our interview data revealed a catalogue of grievances, many of which appear to have been poorly managed. Early and more appropriate intervention by some members of the Executive could have minimised these considerably and quite probably prevented them from escalating to the levels some grievances have. There is no doubt that some of these are long-lasting and deeply held. Several grievances have questionable processes attached to them with some staff rightly questioning if processes have been correctly followed. Once again, much of this could have been avoided if there was proper partnership working and a collective willingness to address concerns.

The grievance culture is partly aggravated by a pressured HR function which is only now beginning to structure itself appropriately. Even so, there are continued excessive workloads for some HR Business Partners and it will be necessary to re-design the existing HR resource to provide dedicated support to tackle grievances properly and support the challenge of addressing bullying and equality issues. The culture within Workforce is also viewed negatively by some staff with a real need to rebuild trust. Once again, a proper partnership pathway with trade unions is needed and this must exist with, and alongside, the FSUG role.

9.3 Theme 3 – Role Clarity and the Management of Change

Our HSE survey questions probed responses to known stressors. Three areas produced results indicating above average levels of stress. Although work demands indicated large numbers of survey respondents being exposed to some form of excessive work demands, our interview data was bereft of excessive work as a precursor to B&H. Nevertheless, excessive work demands are clearly an issue for many WH staff and if poorly managed can lead to managers harassing and bullying the workforce.

In contrast we found clear and somewhat surprising evidence for confusion amongst staff as to their contribution to overall organisational and departmental mission, goals and objectives. The Trust's performance, although an improving one, in executing performance appraisals is a contributory factor and the interview data consistently talks of a lack of preparedness to execute roles and responsibilities. This is in part because some of the staff perceive elements of the Executive as lacking interest in them or the challenges they face. The approach to controlling front-line budgets by ICSU leaders is both frustrating and irrational to many staff.

The process and management of change is a recurring theme in work environment stressors linked to bullying and harassment and WH is no exception. The Trust must redouble its efforts to engage staff facing change and to ensure this is not a *fait-accompli* so that processes of listening to and engaging with staff are material in their intent and not simply

an exercise. Ownership of change can only be achieved by listening to employee voices and empowering those at the front line to drive change.

9.4 Theme 4 – Discrimination

Although not a significant 'noise' in our interview data, its appearance in the survey with certain ethnicities and ages as potential risk groups of harassment and bullying, gives an amber warning of a call to action. Discrimination has appeared elsewhere in other WH data sets and these, coupled with our own data, suggests further work is needed. Equality Action Plans are in place but perhaps these are not sufficiently escalated to and by some members of the Executive. The current system is not working as effectively as it should. In the challenging environment of NHS labour markets, this is becoming both a moralistic and strategically important issue. Claims of ageism or other discriminatory forms are both illegal and unnecessary. Diversity and Inclusion should become a dedicated area for action.

9.5 Theme 5 – Communications Pathways

There are well-defined examples in our report of some staff bypassing normal communication channels and progressing straight to the Chief Executive or Trust Chair. This should not continue and should be actively discouraged unless the matter is of critical patient safety or potentially gross misconduct. The Trust's culture of a friendly workplace is of course critical too, but the current method risks policy and process being undermined, and proper investigations thwarted. Similarly, ICSU modes of leadership/management should also change to disburse as much authority and budgetary control to those who lead services. There is a real risk that managers of services are otherwise undermined and will not buy into change processes because they have little control over their everyday spheres of work. AHPs also need appropriate voice mechanisms in organisational structures.

9.6 Theme 6 – Why Bullying and Harassment is at 25%

Our final theme combines themes 1-5 above in explaining why B&H should stand at 25.5% in the survey with 35% stating they had witnessed bullying and harassment. Our appraisal of the data is that this is a leadership and management issue because regardless of the source of B&H behaviours (and our interviewees told us they felt it was manager behaviours whilst the survey indicated both managers and colleagues), it requires leadership and management action. This action cannot succeed if elements of the senior leadership adopt a *laissez-faire* approach to management. Unresponsive leaders, or those unwilling or unable to support colleagues learning the craft of leading and managing, or even putting others directly at risk of being accused of bullying or harassment by failing to provide support, places WH at risk. HR must also work tirelessly to rebuild trust and to revisit their strategy of grievance management and manager preparation for tackling bullying.

We heard countless examples of very inappropriate behaviour by senior staff, including senior medical staff, which must not have existed in isolation. Evidence was repetitive and

the impact upon some staff considerable, to the point at which it reverberated in an unambiguous frustration at a lack of action. This is certainly a commonly held view in some parts of the Trust and whether true or not, is damaging and requires urgent remedial action. Once again, the FSUG, a HR team intent on a process of rebuilding trust with trade unions and colleagues, plus a strategically more powerful diversity agenda could work with the Executive to quash such perceptions. The FSUG does not feature as a natural pathway for employees witnessing bullying, despite the 21 cases reported in 2017. This has to be overcome and quickly.

The insights gained in interviews were invaluable as they not only independently offered understandings of why bullying and harassment might exist, but also offered colleagues the opportunity to talk openly about elements of their working lives that otherwise could remain hidden and unresolved. Some described this process as *"therapy – talking like this"* while others used the interview process to consider pathways to helping achieve resolution. We have incorporated these where appropriate into our recommendations below.

In many ways WH already has sufficient systems and processes in place to adequately tackle bullying but requires a more interconnected pathway to unite these elements into a coherent whole. Central to this is a requirement for leaders and managers to be willing to embrace sensitive matters that sometimes they themselves are at the heart of. The Executive team must drive this and be cognizant of their own shortcomings; the staff are watching and have high expectations of leadership. The Chief Executive and Trust Chair must be the final back-stop and not the first port of call when things go wrong.

Bullying and harassment is fundamentally about inappropriate behaviour. Sometimes the connections between behaviours and perceptions of bullying is not immediately apparent. Our report has provided these insights. Examples of a lead nurse who told one of our interviewees *"you are pissing me off"* provides a sense of the unpleasant and degrading treatment that underpins bullying.

This report will require a mature response that moves from actively seeking criticism to one of learning and sensitive emotional intelligence. Equally, the Trust must actively pursue a true partnership model with trade unions to finding resolutions. This requires a less combative approach from all sides. In a proper partnership approach, all parties might recognise that raising grievances is not always wholly appropriate or productive.

Finally, a number of staff complained bitterly about the salary differences for serving in Islington and Haringey. Whilst not within the bounds of bullying and harassment, we would be doing a disservice if we did not bring to the attention of the Executive the considerable depth of feeling this situation has caused. Any resolution would be very well received by those affected.

10.0 - Recommendations

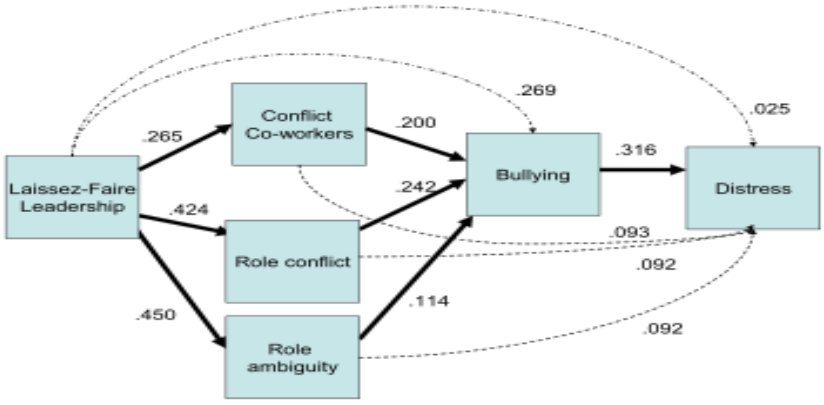
Our recommendations are not placed in rank order.

10.1 - Leadership Culture

It is clear that elements of the WH staff view the leadership as uncritical and "cosy". We are unable to confirm or deny such claims, but are duty bound to report them. Our view is that these perceptions are somewhat widely held and thus not without substance.

Research has shown the damage caused by a disinterested leader or manager in terms of bullying and harassment. The diagram below (see Figure 6 - after Skogstad et al., 2007) shows how laissez-faire leadership creates role conflict, role ambiguity and conflict between co-workers. These directly correlate to bullying and ultimately to employee distress.

Figure 6: Laissez-faire leadership and correlates to bullying



Our earlier observations show unmistakable connections between role conflict/ambiguity and stress (see 5.6 above) and the failure of some senior leaders to respond in a timely and supportive manner to everything from grievance claims, emails and even down to meetings and general communications. This creates conflicts and distress and is a form of destructive leadership (Einarsen et al., 2007). This is not destructive in some purposive way, but more through ineffectual management/leadership behaviours. The Chief Executive must therefore prioritise this issue with her Executive team and hold to account those whose actions have significantly contributed to such levels of disquiet amongst the workforce. The status quo is not an option and the Executive needs to recognise their actions and that others see them as role models. However, and importantly, senior medical staff are also part of the leadership at WH and they too must be cognisant of their behaviour and must work alongside the Executive in role modelling behaviour.

It is imperative that the Chief Executive is left to manage the strategic direction of the Trust and to work with the Trust Chair in maintaining his role in effective scrutiny and monitoring of the function of the Board. Maintaining an arms-length distance from everyday disputes is

essential for them both. They must make sure the workforce understands this and that they apply this consistently.

The process of managing and instigating change is also a responsibility of the Executive and their appointed agents. Every effort must be made to acknowledge staff concerns around change, audit them and to offer reasoned arguments if staff concerns are not to be upheld. Rational managerial behaviours are the maxim here.

10.2 – HR/Workforce

It is clear that the restructuring of HR/Workforce has taken time and is finally beginning to yield results. Nevertheless, there are still resourcing issues which could be alleviated by considering the operations/structure within Workforce. One role should have an element solely dedicated to the management of grievances and being the nominee for working in an energised partnership model with trade unions. This person would need extensive skills and be unencumbered to find innovative solutions to address issues as they arise (within bounds of policy and practice). A second role could take on provision of dedicated ICSU support because at present the HR Business Partners (HRBP) are unable to provide the dedicated front-line support to managers that is so critical in tackling B&H – in short, their workloads are such that they can only ever be reactionary rather than trenchant in tackling inappropriate behaviours from wherever they arise. Each ICSU should have one dedicated HRBP with support functions also allocated dedicated HRBP contacts. This may already exist but more HRBP's are needed because they cover more than one ICSU.

The head of Workforce, her deputy and all HRBP's should adopt a more proactive fact-finding approach to tackling bullying and harassment by spending as much time as possible in the sphere of WH operations. This is of course challenging given work demands, but it is possible to diarise, across a 12-month cycle, all areas of the Trust to ensure front line managers/leaders have an opportunity to talk face-to-face on workforce issues. There is a clear need to break the perceived miasma of HR only representing managerial interests to one of HR as the moral champions of all employee rights. This is only achieved by proactive engagement rather than simply service delivery. If the resources can be found, a restructure of the Workforce function may be necessary, not simply with the aim of reassigning roles and responsibilities but ensuring a cultural shift to reduce the fractious and defensive attitudes that have perhaps dominated the past.

10.3 - Scrutiny of Existing Data and Power to Drive Change

The Trust already captures a spectrum of data that might indicate problems of bullying and harassment (e.g. sickness absence, exit data etc). What is needed is proper scrutiny of all indicators where B&H might be occurring. Any elements of the Trust considered 'hot-spots' need rapid action with managers in those areas afforded additional support and training to reduce matters to at least median levels for the Trust. This should embrace other elements such as the Freedom to Speak Up Guardian and inclusion champions (but renamed) as well

as those holding responsibilities for equality and inclusion. Our recommendation is that this data is presented monthly to the Executive with dedicated actions and monitoring of key issues (leaving matters to quarterly reporting presents real risks of events escalating quickly such that tools of mediation, for example, become sterilised).

We have previously recommended the creation of a steering group for such a task. We leave that to the Trust to consider, but this requires an Executive lead and a nominated Non-Executive overseeing the KPI's associated with data scrutiny.

10.4 – Managers and PDR Reviews

Scrutiny of existing Dashboard data shows that appraisal processes, although improving, require further work. Appraisals are critical to engaging staff and giving them a voice and ensuring they understand their roles and providing them with role clarity and their fit to the organisations' mission and goals. Ostensibly built upon current and planned performance, there is significant scope to engage staff on issues such as bullying, harassment and discrimination. As a result, we recommend:

- All managers are tasked with attaining a 95% completion rate for appraisals of their team members/direct reports.
- A new appraisal form is designed to ensure issues of behaviours/discrimination are covered in the appraisal dialogue. This ensures managerial commitment and allows for voice mechanisms.
- Appraisal forms should signpost employees to the FSUG and attendant services if staff are concerned about raising such issues to their line manager.
- Appraisals of managers should include the numbers of grievances raised, any other conflicts occurring within that manager's realm and any issues from exit interviews that have raised matters of inappropriate behaviour. Leaders must tackle such matters head on and hold managers to account where appropriate. This would demonstrate a real commitment to the workforce and diminish the 'cosy' view of the leadership team.

10.5 - Supporting and Developing Managers

We recommend the following actions to support managers:

- Establishing a contract of respectful behaviour so that a manager can brief each employee during appraisals, at induction and in team meetings as to what the expectations of the Trust are. This should explicitly make clear issues of equality and diversity and of inclusion. It is imperative that it is not overlooked by managers as inappropriate behaviours are central to bullying and harassment perceptions and to discrimination.

- Creation of a manager network to enable managers to learn best practice from those more experienced. This can function in both formal and informal ways as necessary and will depend upon the skills of the manager needing help.
- All newly appointed managers without adequate manager experience to receive a mentor/buddy partner for the 1st 12 months of their managerial practice. This to be built into both the mentor's and mentee's appraisal procedures.
- Creation of a blog of best management practice drawing upon WH managerial staff and utilising freely available sources such as NHS, Acas, Equality and Human Rights Commission etc.
- A manager network could play an active role in briefing staff who might be thinking of taking on a management role and in helping to shape competencies for the future managers of WH. Importantly, management is not for everyone and a manager network might help others to decide career pathways. Quarterly management development sessions for all staff considering managerial roles could help this process.

10.6 - Tackling Discrimination

The Trust has already commenced work on meeting its statutory obligations for equality, but this must move beyond compliance to be driven through all levels of the organisation and across all groups. The Trust may wish to appoint a Non-Executive champion (if one does not currently exist) for equality and inclusion to work with existing Trust expertise to make this a standing item on Trust agendas. Specifically, we recommend:

- All managers are reminded of requisite Trust policies on equality and inclusion. Managers ensure this is an agenda item at team meetings and where appropriate, to remind colleagues of the implications of the 2010 Equality Act and the Trust's strategy in this regard. This is not an overstatement, simply a reinforcement of Trust values and beliefs.
- Age discrimination is a specific agenda item for Workforce to take up with managers.
- There is a myriad of free materials on discrimination at work and the Trust must utilise these at every opportunity. Tackling discrimination requires constant vigilance.
- Minority groups must also be reminded of their role in ensuring inclusion and that the language of the workplace is English, unless a patient whose language is not English is engaged with.

10.7 – Grievance Management

There is a degree of stereotyping from all sides when disputes arise. This can often result in a form of cognitive bias referred to as 'Reactive Devaluation' – devaluing an idea because it emerges from an adversary or opponent. This must end. All sides in a dispute are holding back WH and diminishing the potential of serving the best interests of patients because they are pugnacious in their attitudes, constantly demonstrating 'Reactive Devaluation'. There is

a need for this to stop and for parties to collectively find resolutions. This is beyond simple mediation and may require independent conciliation or arbitration to minimise the risks of litigation.

In line with our earlier observations on issues of grievance, we recommend the following actions:

- Review and update grievance and disciplinary policies. Policy needs to make clear in its preamble what its purpose is.
- In formal grievance meetings, and with permission of all parties, interview transcripts are produced within 48 hours for checking and sign off. The trust might also wish to move to digitally recording interviews for accuracy (with permissions).
- Grievance timelines to be suitable and heard within a maximum of 90 days or less. Any overrun must be wholly justified, such as long-term sickness for example.
- All parties to be informed of outcomes (within boundaries of confidentiality).
- Ensure that any witnesses to grievances do not have attendant roles for delivering outcomes.
- Policies should reflect a commitment to conflict resolution. Mediation has a role to play but is not a failsafe solution to all ills. The policy must explain the use/non-use of mediation.
- All staff must understand the process and outcomes associated with a grievance. This could be achieved by a simple flow chart document or audio/video resource to aid understanding.

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Annex

Participant Information Sheet

April 2018 **A Study at Whittington Health NHS Trust**

Invitation

You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully. Talk to others about the study if you wish. Taking part in this study is entirely voluntary and will not affect your rights in any way.

Purpose of the study

The research is being undertaken by Professor Duncan Lewis. Duncan is Professor of Management at Plymouth University and runs a specialist research consultancy specialising in bullying and harassment. The research has the support of Whittington Health Executives. The information that is gathered will be used to improve policies and practices in Whittington Health NHS Trust.

Professor Lewis and his team are keen to understand your working experiences and specifically the behaviours you encounter in doing your job. He will do this by asking for your involvement in an interview. This will be conducted by a specialist researcher with experience of this type of work and take place by telephone.

Why me?

This research is important in helping to understand why bullying and harassment should be problematic in Whittington Health. Your employer has agreed for you to take part in this research with the aim of trying to understand and improve working conditions for all employees.

You are free to withdraw from this study at any time during the interview and without giving a reason. A decision to withdraw at any time will not affect you.

Confidentiality?

This research is completely confidential. Your views are important if we are to fully understand what work is like for employees in Whittington Health. You will not be identified by name and we guarantee that everything you tell us remains under the control of the research team. Your employer will not be given a copy of what you tell us. The interview will not be recorded.

What if I have any concerns?

If you want to know more about the study or the content of the focus group, you can contact Prof Lewis by email at Longbow.associates@virginmedia.com and he will reply to any questions you may have.

What happens to the results of the research?

The data from the focus group will be used along with other data gathered from interviews with Whittington Health employees and from the survey you may have completed to produce a report. The report will be used to highlight appropriate issues from our findings in Whittington Health NHS Trust and to help the Trust address these. You will not be identified in this report.

Professor Duncan Lewis
Lead researcher

Workplace Culture at Whittington Health NHS Trust: Key Findings & Recommendations from a Report Commissioned by

Whittington Health NHS Trust

July 2018

Professor Duncan Lewis

Plymouth University Business School

&

Longbow Associates Ltd

Longbow
Associates Ltd.

Background

This mini report is based on a six-month study into workplace culture at Whittington Health NHS Trust (WH). The study is made up of a survey and over 120 hours of interviews with WH staff. No one has been identified as a result of speaking to the researchers and all information is held solely by them. Confidentiality was guaranteed. The study also examined policies and procedures that might relate to the issues being examined. The main report (68 pages) is available to any member of staff who wishes to read it. The main and mini reports have been written by Professor Duncan Lewis of Longbow Associates Ltd and Plymouth University. Duncan is an expert in bullying and harassment research and has undertaken significant work on bullying and harassment for the NHS.

Key Findings

- The Trust has begun to put in place a strategy to properly tackle alleged bullying and harassment (B&H).
- WH has appropriate systems and processes to tackle B&H but requires a more joined up approach to unite these to make clearer pathways to deal with it.
- 72% of staff who responded to the survey did not report any B&H but 25.5% did. A further 35% reported observing bullying and harassment.
- Staff who answered the survey reported most B&H came from managers and colleagues, but most interviewees reported bullying by managers/leaders.
- WH staff observe the behaviours of some leaders and are frustrated at what they see/hear. The most common 'unreasonable management' behaviours reported were; 'Having your views and opinions ignored'; 'Being given unmanageable workloads or impossible deadlines'; and 'Pressure from someone else to do work below your level of competence'.
- Behaviours associated with general incivility were less of a problem, but two behaviours stood out; 'Being humiliated or ridiculed in connection with your work'; and 'People excluding you from their group'. These behaviours come from managers and co-workers.
- The demands of the job, a lack of clarity about their role, and the management of change at work, were the major sources of stress for WH staff who responded to the survey. Two of these (role clarity and management of change) are relatively easy to address by the WH leadership.
- Overall, the staff who replied to the survey reported good support from their peers and managers, but this was reduced when staff reported being bullied or harassed. Most staff felt in control over the work that they did.
- Some staff feel the Trust is not doing enough to tackle bullying when they raise issues of concern. This mainly showed itself as an unwillingness by senior staff to take concerns seriously.
- Many staff who responded to the survey reported a lack of clarity about their role and how they could/should contribute to the effectiveness of WH.
- The Freedom to Speak Up Guardian and the Inclusion Champions/Advocates are important roles going forwards and these are not being as effective as they should in tackling B&H.
- Those affected by B&H feel more detached from their WH citizenship. Bullying also negatively impacts on relationships between some staff and their managers and

those reporting B&H have reduced job satisfaction which results in diminished WH effectiveness.

- The Chief Executive is generally viewed positively and is seen as supportive. However, many staff take issues directly to the CEO and this is inappropriate. The same is true of the Chair. Both the CEO and Chair have important roles leading the organisation.
- Some WH staff believe several of the senior leaders of the Trust, including senior medical staff, are not providing effective leadership role models. This shows itself in a number of ways, but is best summed up as:
    - Hands-off, inaction, slow to respond when asked for help by junior staff
    - Failing to prepare less experienced staff to undertake management tasks
    - Supporting a grievance/blame culture
- Some WH staff feel discriminated against, either because of their age or their ethnic background. There is a need for a co-ordinated effort by the Trust leadership and all staff to tackle discrimination.
- Allied Health Professionals feel they lack a voice and representation within WH.

Key Recommendations

The following are some of the key recommendations taken from the main report.

1. All leaders of WH, including senior medical staff, must demonstrate appropriate leadership styles and behaviours. Responding in a timely fashion and supporting junior colleagues who ask for help to undertake tasks/roles must be forthcoming.
2. Role modelling behaviours is important. If senior staff shout and swear this sets a poor example to other staff.
3. Staff raising concerns about others behaviour must be taken seriously. It is not acceptable to say, 'that is just how she is' or, 'he is like that with everyone'. Inappropriate behaviours must be raised and tackled, and every employee has a responsibility to raise issues of concern.
4. Senior medical staff have a role to play in ensuring organisational effectiveness. They too are role models and their behaviours inform others of how senior employees should behave.
5. There is a need for staff to understand what is entailed in taking out a grievance against another staff member. Grievances are costly, time consuming and often inappropriately used. It is important that any staff member can take out a grievance, but that they understand how grievances work and what is allowed and not allowed.
6. When grievances are raised, they must be tackled more speedily and with greater purpose. Grievance processes must be fair and clear.
7. WH needs to make better use of existing data by creating an action group, including the Freedom to Speak Up Guardian, Inclusion champion/advocates and trade unions. A new partnership model is needed to drive change. This must be driven by a member of the Executive and a Non-Executive Director.
8. A manager network to be created, dedicated to support managers lacking in experience of managing conflicts. Managers will need mentors and be appraised in their managerial performance and supported through material best practice.
9. Clarity around roles and contribution is needed. Similarly, the processes and management of change requires real engagement with WH staff. All of this has to

take place within the performance appraisal process. Staff must understand their roles and their contribution to organisational mission, goals and objectives.

10. Diversity and inclusion must be directly discussed in team meetings, individual appraisals and in other discussions. This is a strategic priority to be driven directly by the leadership of the trust and reported in quarterly Executive agendas.

Concluding Remarks

Tackling bullying and harassment requires leadership commitment. This commitment must feed down from the Executive through the heads of ICSUs down to all manager grades. Bullying and harassment can only be reduced when there are appropriate channels for employees to be able to speak up. This is obligatory for all WH staff. Staying silent is not an option in the same that suffering in silence is not an option. Similarly, inappropriate behaviours affect all levels of every organisation and WH is no different in this regard. Every employee is a role model for every other employee, but particularly when in a senior medical or leadership role. The old maxim of 'treat others as you would wish to be treated' is very appropriate, particularly in an organisation where health and care are fundamental to its purpose.