A review into culture and bullying at University Hospitals of North Midlands NHS Trust

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brap and Roger Kline review of bullying and harassing behaviours across University Hospitals of North Midlands NHS Trust (UHNM)

March 2022

FINAL

CONTENTS

1. INTRODUCTION

1.1 CONTEXT

In August 2021, University Hospitals North Midlands Trust (UHNM) commissioned brap and Roger Kline to conduct a review of bullying and harassing behaviours across the Trust. The purpose of the review was to understand:

- the nature of bullying/harassment within the Trust (what types of behaviour are staff being subject to?);
- the basis of bullying/harassment (is poor treatment linked to people's protected characteristics or other aspects of identity (such as language spoken);
- the scope of bullying behaviour (how frequently are staff subject to bullying behaviours and are they concentrated in particular sites, job roles, or bands? Are staff subject to bullying from patients/visitors or primarily from colleagues?);
- the response to any unprofessional behaviours (do people feel confident reporting or challenging poor behaviour? If not, why?); and
- the conditions that allow bullying behaviours to continue (what aspects of organisational culture may be contributing to the persistence of bullying? Are stress, workloads, or poor management practice roots causes?)

The review was prompted by anecdotal claims of inappropriate behaviour within some parts of the Trust. (The Trust has a range of mechanisms to monitor levels of bullying and harassment, including national and local surveys, reports from the Freedom to Speak Up Guardians, Dignity at Work reports, and staff listening events.) In addition, a survey conducted by BAPIO/LNC raised concerns about the treatment of doctors and how this intersected with issues around race. As such, this review sought to explore whether the treatment of Black and minority ethnic (BME) people was different to that of White British staff.

1.2 METHODOLOGY

Research for this review was conducted in five stages.

In the first stage, introductory meetings with union colleagues, Guardians, consultants, and senior leaders in the Trust were held to develop an overview of some of the issues the Trust faces in respect of bullying and harassment. These were wide-ranging conversations with the purpose of identifying themes to be explored in phase 2.

In this second phase, all staff were invited to speak to brap/Roger Kline. As a result, 34 one-to-one interviews were held with individuals who expressed an interest in talking to about their experiences of working at the Trust. 61% of participants identified as BME; 39% as White British.

In phase 3, an online survey was disseminated to all staff. A paper-based version was provided to those who normally receive paper-based versions of the national NHS Staff Survey and anyone else who requested one. The survey was administered by Picker Institute Europe.

The survey was completed by 3,506 people. We understand this to be a response rate of 31.2%. A response rate of at least 25% was obtained from each division. Most responses came from Children's Women's and Diagnostics (CWD) (26% of all responses), Surgical (20%), and Medicine (20%) (see table 1).

Table 1: survey respondents by Division

	Divisional response rate (%)	% of total responses
Central Functions	52	18
Children's, Women's and Diagnostics	30	26
Estates, Facilities and PFI Division	36	5
Medicine Division	25	19
Specialised Division	28	11
Surgical Division	30	20

Response rates by staff group varied from 54% for Administrative and Clerical staff to 15% for Additional Clinical Services (table 2).

Table 2: survey respondents by staff group

	Staff group response rate (%)	% of total responses
Add Prof Scientific and Technic	38	5
Additional Clinical Services	15	12
Administrative and Clerical	54	31
Allied Health Professionals	33	5
Estates and Ancillary	20	3
Healthcare Scientists	43	5
Medical and Dental	35	13
Nursing and Midwifery Registered	28	26

Seventy-nine per cent of respondents identified as White British, 11% as Asian/Asian British (including Chinese), 2% as Black/Black British, and 1% as an other ethnic group. Table 3 shows the extent to which these figures are representative of the Trust workforce as a whole.

Table 3: survey respondents by ethnicity

	White British	BME	Not specified
% survey respondents	79.5	20.5	-
% Trust workforce	78.1	18.9	3.0

Table 4 below shows survey respondents' ethnicity by staff group. As can be seen, a large proportion of BME staff (43.6%) are medical and dental. In contrast, 37.1% of White staff work in administrative and clerical services, with another 25.3% working as nurses or midwives.

Table 4: survey respondents' ethnicity by staff group

	White British (%)	BME (%)
Add Prof Scientific and Technic	5.0	2.8
Additional Clinical Services	12.4	10.0
Administrative and Clerical	37.1	10.5
Allied Health Professionals	5.7	3.7
Estates and Ancillary	4.1	2.0
Healthcare Scientists	5.6	2.9
Medical and Dental	4.8	43.6
Nursing and Midwifery Registered	25.3	24.4
	100.0	100.0

A response rate of about 30% is roughly what we would expect from a survey of this type, and we believe it provides a sufficient basis on which to draw conclusions about staff experience within the Trust. Organisations we have worked with in the past occasionally ask if people with negative experiences are more motivated to complete this kind of survey and, if so, whether that skews the final results. In our experience, negative experiences often act to dampen people's enthusiasm to engage with reviews such as these, particularly if people have taken part in previous engagement exercises that have not led to substantive change. Nevertheless, in the course of feeding back results we compare response rates to those of other organisations we have run similar surveys with. Hopefully, this provides some context against which to judge how well the Trust is performing.

Phase four consisted of follow-up focus groups with 39 individuals working in a range of teams and departments. Individuals taking part in this phase were those responding to a request from the Trust asking for research participants. The purpose of this stage was a) to understand the experiences of those who, unlike those participating in phase 2, did not necessarily think they had been bullied/harassed, b) to understand more about organisational culture, and c) to unpick some of the issues arising from the survey.

Finally, during phase five, we conducted 18 one-to-one interviews with senior leaders and other managers in the Trust. The purpose of this phase was to a) explore their knowledge

and confidence in affecting organisational change and tackling racism, and b) understand their leadership styles/management approaches and those of their colleagues.

All interview participants at every stage were assured anonymity.

1.3 DEFINITIONS OF 'BULLYING' AND 'HARASSMENT'

During the research phase, participants were allowed to self-define what 'bullying' and 'harassment' meant to them. The purpose of this was twofold.

First, and most important, we wished to capture the range of experiences that are negatively affecting staff and which they deem to be bullying or harassing, regardless of whether this met formal criteria. In doing so, we hoped this review would respond to the range of factors that can shape workplace experience.

Second, feedback from colleagues in the preliminary stage of the review (outlined as phase 1, above) encouraged us to keep as open a definition as possible. Past research into bullying in the NHS has sometimes stressed the power imbalances between alleged perpetrator and victim (for example, Ariza-Montes et al's work into bullying amongst healthcare workers highlighted 'the target's inability to defend [themselves] from aggression'[1], while Pisklakov et al's research explicitly states bullying involves 'an imbalance of power or strength between aggressor and victim'[2]). Initial feedback from phase 1, however, suggested there may be issues in the Trust involving less senior colleagues 'bullying' their managers. Similarly, researchers have sometimes suggested behaviours have to form a persistent, repeated pattern of intimidation over time to constitute 'bullying'. Feedback from phase 1, however, suggested there were a number of individuals who were upset, humiliated, or intimidated by one-off incidents involving staff and patients. Given these considerations, we commenced the interview and survey stages of this review with an open definition of both 'bullying' and 'harassment'.

1.4 TERMINOLOGY AND LANGUAGE

Throughout this report, we use the term 'BME' to refer to people who are of Black or minority ethnic heritage. In doing so, we use the definition from the UK census which, in turn, is used in the NHS Workforce Race Equality Standard Technical Guidance. The following abbreviations are used:

BME Black and minority ethnic
EDI Equality, Diversity, and Inclusion

Please note this report contains offensive racial terms.

[1] Ariza-Montes, A. et al. (2013) 'Workplace Bullying among Healthcare Workers' in *International Journal of Environmental Research and Public Health* 10
[2] Pisklakov, S. et al. (2013) 'Bullying and Aggressive Behaviour among Health Care Providers: Literature Review' in *Advances in Anthropology* 3(4)

1.5 REPORT AUTHORS

brap is a charity transforming the way we think and do equality. brap works with over one hundred NHS trusts and other healthcare providers every year, providing support and development around issues such as organisational change, leadership development, and inclusive cultures. Roger Kline is Research Fellow at Middlesex University Business School. He authored 'The Snowy White Peaks of the NHS' (2014), designed the Workforce Race Equality Standard (WRES) and was appointed as the joint national director of the WRES team (2015-17). His recent publications include *The Price of Fear: Estimating the financial cost of bullying and harassment to the NHS in England* (2018), co-authored with Professor Duncan Lewis.

2. CONTEXTUAL INFORMATION

A preliminary stage of this research was to review a range of data from the most recent surveys available, including the 2020 NHS National Staff Survey[3], local surveys and investigations, the 2020 Workforce Race Equality Standard report, and the recent LNC/MSC survey. The headline findings are summarised below. This section sets out some of the findings from this review.

2.1 STAFF SURVEY ENGAGEMENT SCORES AGAINST BENCHMARK COMPARATOR

The Trust's national benchmark comparators are 'acute and acute and community trusts'. The overall UHNM national NHS staff survey response rate (2020) was 45% with a slightly lower response rate for BME staff (which is a national phenomenon). The national response rate for all trusts was 47%.

The staff engagement data examines nine staff survey metrics which in combination capture staff engagement scores for each of the main staff groups (including medical and dental). Three staff groups (additional clinical services, estates and ancillary, and healthcare scientists) have some response scores significantly lower than the average score for benchmark trusts. Just two of the nine staff groups (estates and ancillary, healthcare scientists) have overall staff engagement scores below (just below) that of benchmark trusts.

This data also considers staff engagement scores by ethnicity. BME staff have higher engagement scores than White staff. This is a national trend and may not necessarily be a reflection of the experience of either bullying or racism.

2.1.1 NATIONAL STAFF SURVEY RESPONSES

The national staff survey groups responses within 10 themes.

- EDI
- health and wellbeing
- morale
- immediate managers
- quality of care
- bullying and harassment
- violence
- safety culture
- engagement
- team culture

Theme results for UHNM compared to benchmark trusts shows UHNM responses are slightly less favourable than in benchmark trusts notably for Team Working where there is a more significant (adverse) difference. On EDI, UHNM is exactly the same as the benchmark trust average and on bullying and harassment it is marginally worse (8.0 compared to 8.1) and on both these themes there has been a slight improvement in UHNM scores against the benchmark trusts since 2016.

[3] The 2020 NHS Staff Survey was the most up to date data at the time this report was prepared.

Compared to the benchmark trust average there has been a marginal overall improvement from 2016-2020.

We considered each divisional response rate against the UHNM average for each of the 10 themes. We did so in order to explore what patterns might exist within the overall Trust responses. We identified five divisions (out of 18) scoring significantly worse than the Trust averages for two or more of the 10 themes. Nursing scored significantly better than the Trust average. See Appendix for full results.

We then considered for each department within all divisions whether the scores were significantly lower or higher than the UHNM average for each of seven NHS national staff survey questions which, together, capture most of the key issues within our brief:

- Q4j I receive the respect I deserve from my colleagues at work;
- Q5b Satisfied with support from immediate manager;
- Q13b Not experienced harassment, bullying or abuse from managers;
- 13c Not experienced harassment, bullying or abuse from other colleagues;
- 13d Last experience of harassment/bullying/abuse reported;
- 15b Not experienced discrimination from manager/team leader or other colleagues; and
- 18f Feel safe to speak up about anything that concerns me in this organisation.

We identified almost one half of the 69 departments across all sites where on three or more of these questions the response scores were 10% or more below the Trust average. A slightly smaller number of departments had three or more responses that were 10% of more above the Trust average. In a smaller number of the departments the response scores were very significantly poorer than the Trust average.

2.1.2 WORKFORCE RACE EQUALITY DATA

Indicator 1: Percentage of BME staff by grade data shows a steep (adverse) ethnicity gradient for both clinical and non-clinical staff across the workforce as a whole, that is much lower representation the higher the grade for Agenda for Change staff.

Indicator 2: The relative likelihood of White staff being appointed from shortlisting compared to BME staff is 1.41.

Indicator 3: The relative likelihood of BME staff entering the formal disciplinary process compared to White staff is 0.64. The equivalent figure for acute trusts nationally is 1.19, so this figure represents a significantly better experience for BME staff compared with the national average.

Indicator 6: Between 2016 and 2020, the percentage of BME staff claiming to have experienced ‘harassment, bullying or abuse from staff in the last 12 months’ remained stable at 30.0%. Furthermore, the gap between their experience and White staff (27.0%) has slightly narrowed in that period.

Indicator 7: Percentage of staff believing that their trust provides equal opportunities for career progression or promotion is BME (78.2%) and White (87.8%); that is, it is significantly worse for BME staff (almost twice as likely that BME staff will not believe there are equal opportunities for career progression or promotion). However, in the last two years the responses have significantly improved at UHNM both compared to 2018 and compared to the benchmark average for BME staff (72.5%)

Indicator 8: Percentage of BME staff that personally experienced discrimination at work from a manager, team leader or other colleagues is three times higher than the figure reported for White staff. The UHNM BME staff figure is marginally better than the benchmark average.

Indicator 9: Percentage of board members by ethnicity compared to BME workforce within NHS trusts by region was poor (0) (but has since changed due to the recruitment of BME board members).

2.2 THE RECENT MSC SURVEY IN PARTENSHIP WITH BAPIO

The recent MSC survey which was carried out in partnership with BAPIO concluded there was a serious level of bullying and harassment, linked particularly (though not solely) to ethnicity amongst the medical workforce within the Trust.

The survey results are not easily compared with the national staff survey results because the questions are different, notably in respect of not setting a time period within which adverse treatment was experienced. The MSC/BAPIO survey was a survey of doctors. There may be other occupational groups or departments where a similar data pattern exists. Either way that might enable an understanding of the extent to which specific factors within the management or culture of doctors are the primary cause (or not).

Although race discrimination is identified as a key driver it is unclear, since it is not explored further in the survey, whether this was primarily White/BME discrimination or also included discrimination between other different ethnic groups of doctors.

The MSC/BAPIO results are also different in one potentially significant respect to the normal response curve on Q10 – ie that more bullying and harassment was reported from colleagues than managers.

One third of respondents suggested UHNM had a ‘good culture’ in relation to bullying and harassment. This may align with data from the NHS Staff Survey referred to in section 2.1.1 above, suggesting there may be significant differences in experiences between specialities or sites.

3. FINDINGS IN RELATION TO BULLYING AND HARASSMENT

3.1 PREVALENCE AND SCOPE OF BULLYING AND HARASSMENT

Survey respondents were asked if they:

- are currently experiencing bullying or harassment;
- had experienced bullying or harassment in the past two years which has now stopped; and
- had experienced bullying or harassment more than two years ago (but which has now stopped).

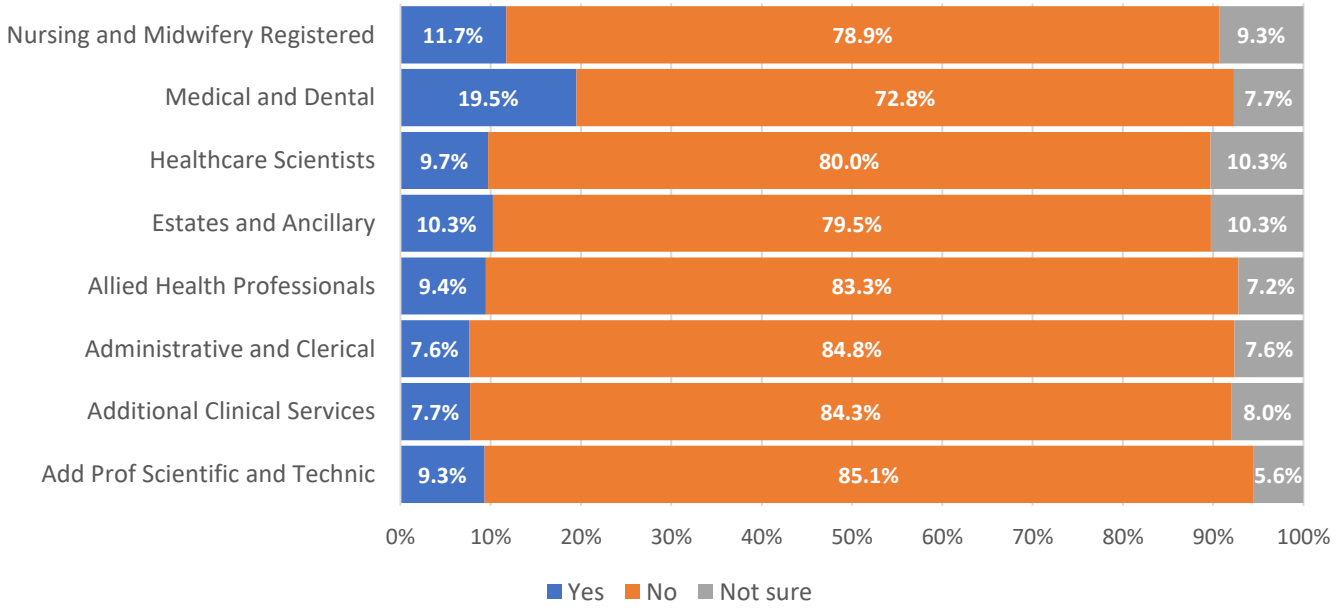
Participants self-defined 'bullying' and 'harassment'. This is discussed in more depth in section 3.3.

About one in 10 survey respondents (11%) claim they are currently suffering from bullying or harassment. One in five (19%) experienced bullying or harassment in the preceding two years that has now stopped. 21% of respondents report experiencing bullying/harassment prior to 2019 that has now stopped.

Responses by staff group

As fig 1 shows, 19.5% of medical and dental staff claim they are currently suffering bullying or harassment – by far the largest proportion in any staff group. It is also worth noting the relatively high number of healthcare scientists and estates and ancillary staff who are 'unsure' as to whether they are experiencing bullying or harassment (over 10% in each case).

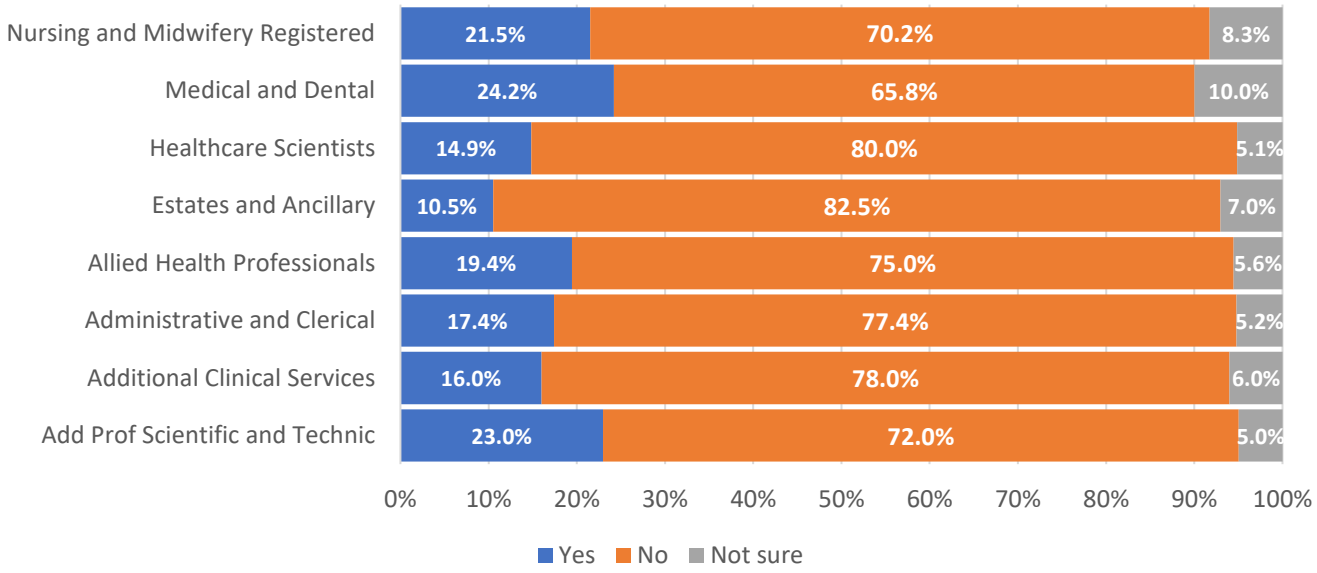
Fig 1: 'Are you currently experiencing bullying or harassment?' by staff group[4]



[4] Complete data tables underlying charts are outlined in Appendix 5.

Fig 2 presents a longer term view of staff experiences and suggests concerted efforts to improve relationships between nurses and midwives have had some effect. It is also worth noting the reduction in the proportion of staff in the 'Additional Prof Scientific and Technic' and 'Allied Health Professionals' groupings who are experiencing bullying or harassment. It also suggests that amongst healthcare scientists there has been no improvement with a slight deterioration amongst estates and ancillary staff.

Fig 2: 'Have you suffered bullying or harassment within the last two years that has stopped?' by staff group



Responses by band

Some of the clearest disparities within variables arise when disaggregating data by band. As fig 3 shows, doctors are roughly twice as likely as other band groups to say they are currently suffering from bullying or harassment. Furthermore, the data is consistent with a narrative arising from staff interviews: namely, that the Trust historically had an issue with inappropriate behaviour, but this has greatly improved in recent years for most people except doctors.

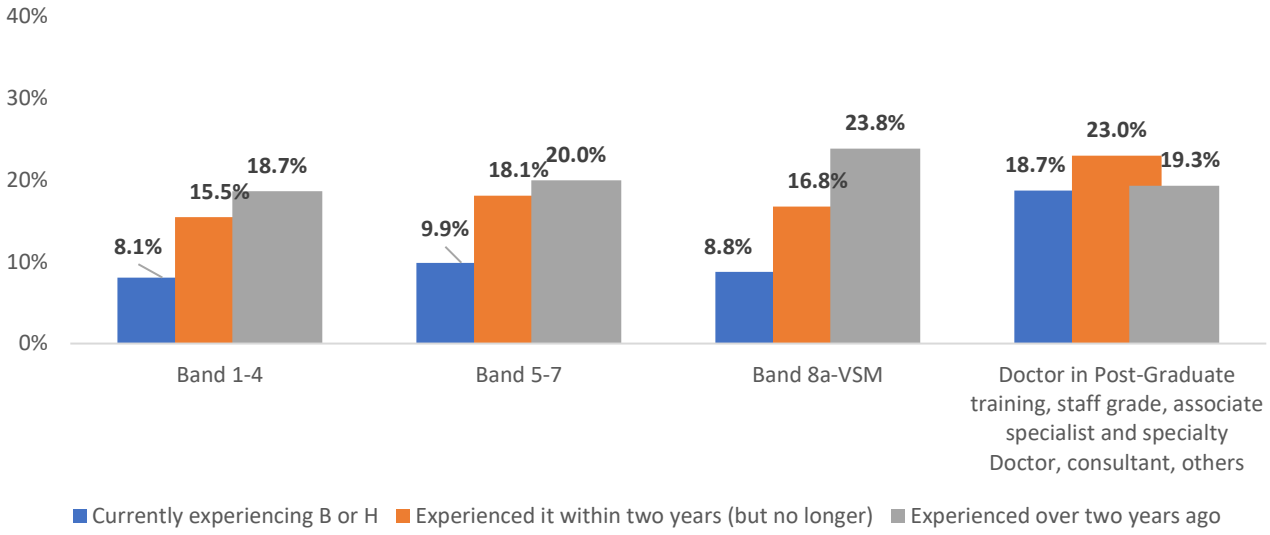
Responses by Directorate

Charts below show responses by directorate where n ≥ 100.

As fig 4 below shows, the directorates currently experiencing the highest rates of bullying and harassment are Imaging (16.9% of staff report experiencing this in some form); Emergency Medicine (16.3%); Specialist Medicine (15.7%); and Trauma (15.6%).

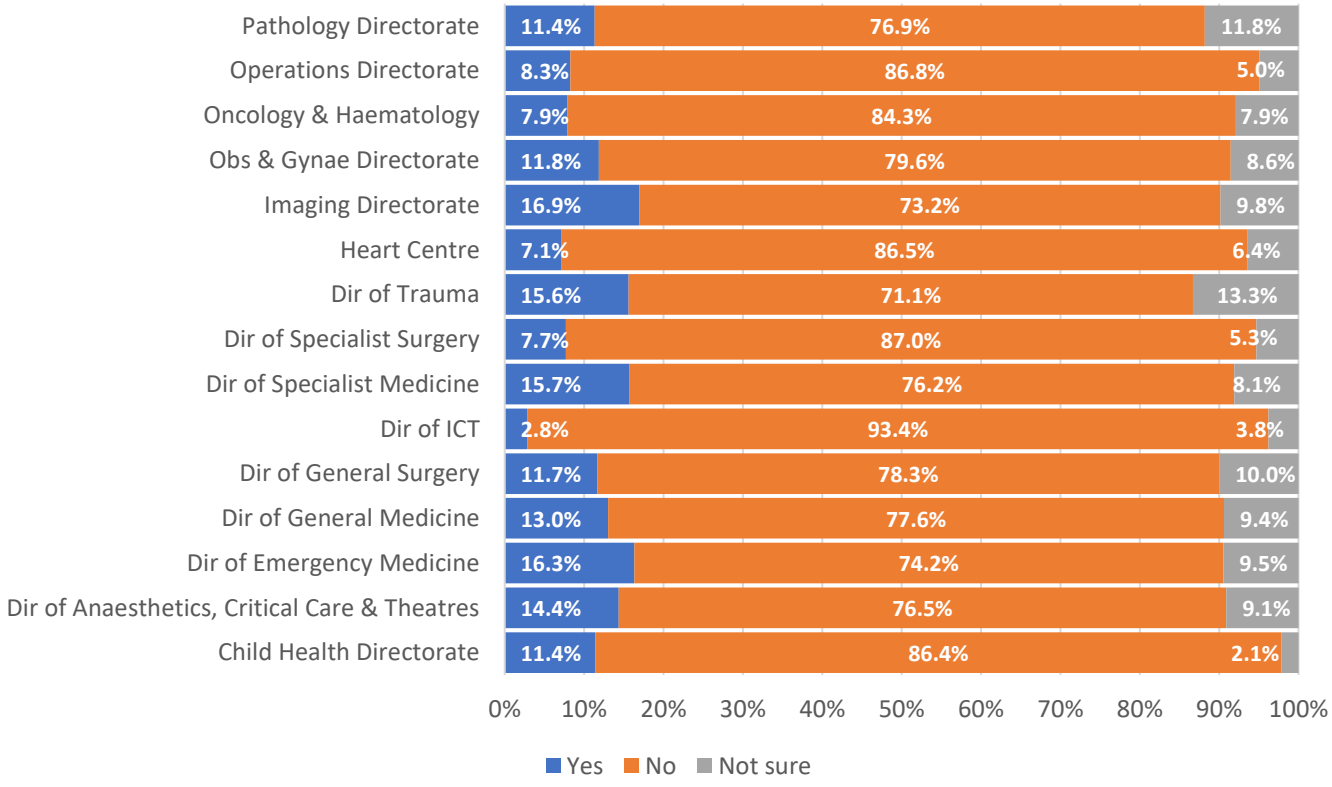
Although it is not immediately clear from the chart, non-clinical directorates in general experience lower levels of bullying and harassment than clinical ones (most non-clinical directorates had fewer than one hundred responses, which means they do not appear in fig 4. See data table in Appendix 5 for all data). Invariably, non-clinical directorates report bullying/harassment rates of less than 10%, with the Directorate of ICT being a clear Trust-

Fig 3: Experiences of bullying or harassment by band grouping



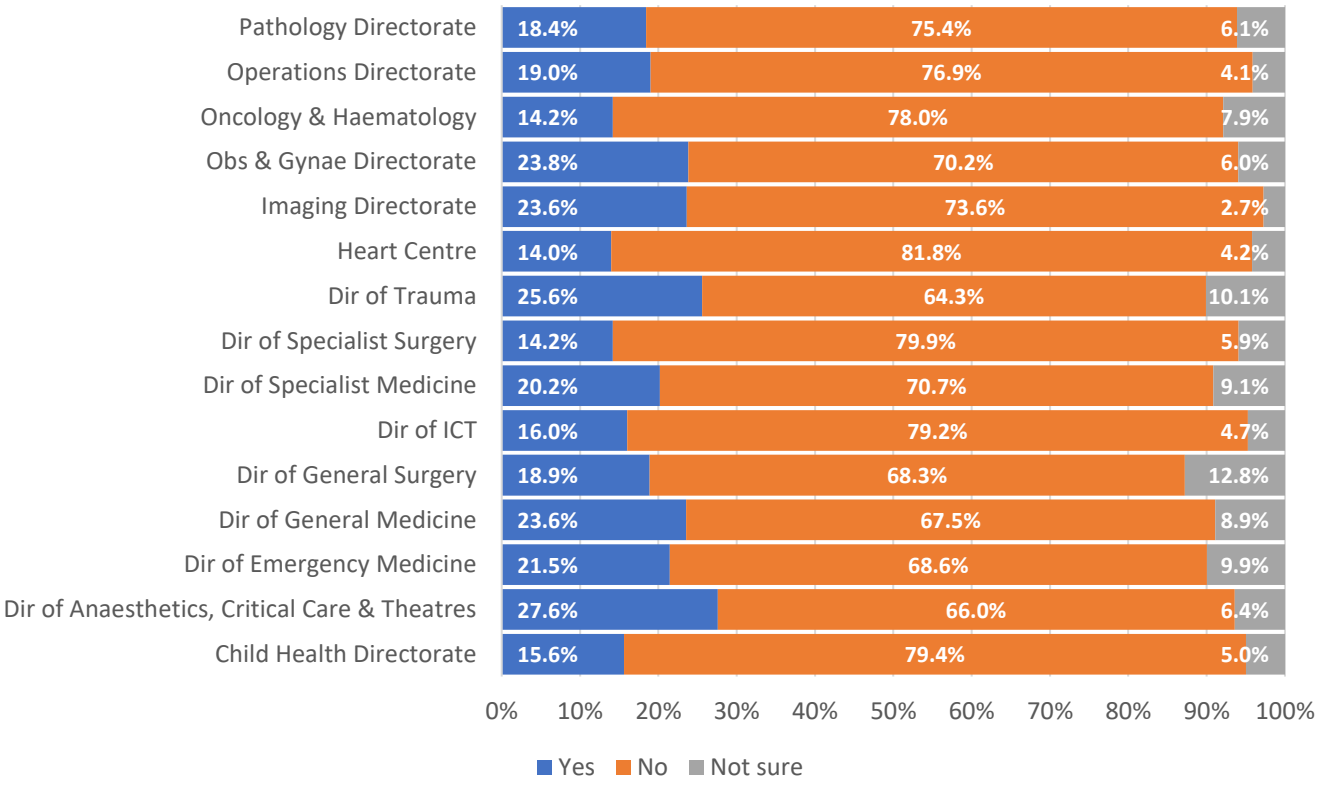
wide outlier in achieving a bullying/harassment rate of less than three per cent. This contrast between the experiences of clinical and non-clinical staff is mirrored across most (if not all) other trusts, and generally reflects the differing pressures, time constraints, and established hierarchies facing the two groups. However, it may be the case there is learning from the ICT Directorate that can be transferred elsewhere.

Fig 4: 'Are you currently experiencing bullying or harassment?' by directorate



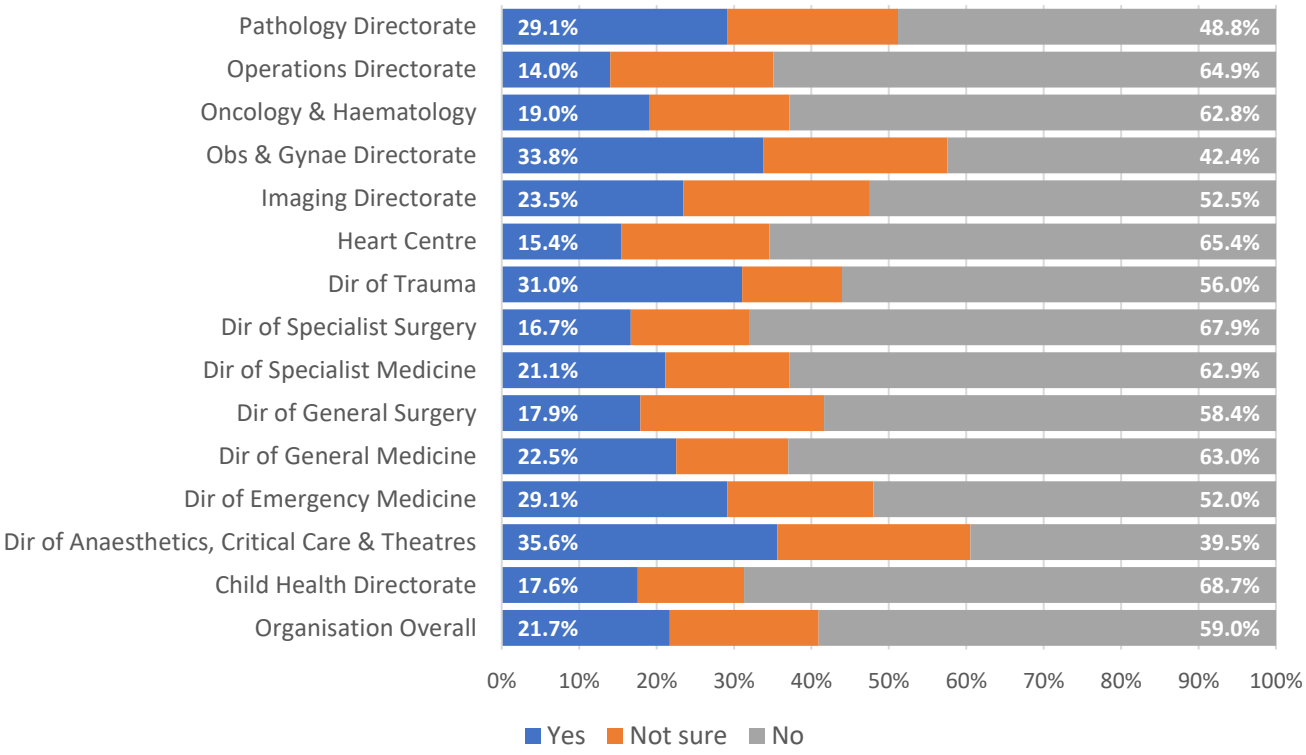
For some longer-term context, fig 5 shows the proportion of staff in particular directorates (where n ≥ 100) who claim to have experienced bullying or harassment in the preceding two years, but which has now stopped.

Fig 5: 'Have you suffered bullying or harassment within the last two years that has stopped?' by directorate



Finally, survey respondents were asked if they felt there was a culture of bullying within their department (see fig 6). The proportion of those responding 'yes' across the whole Trust (21.7%) is comparable with organisations we have run similar surveys with. However, some areas perform better than others. For example, 36% of staff within Anaesthetics, Critical Care and Theatres feel their department has a bullying culture; 34% in Obstetrics and Gynaecology, and 31% in Trauma. We note Imaging is not an especial outlier within the Trust (although that still means one in four individuals who responded to the survey feel it has a bullying culture).

Fig 6: 'Do you feel there is a culture of bullying in your department?' by directorate

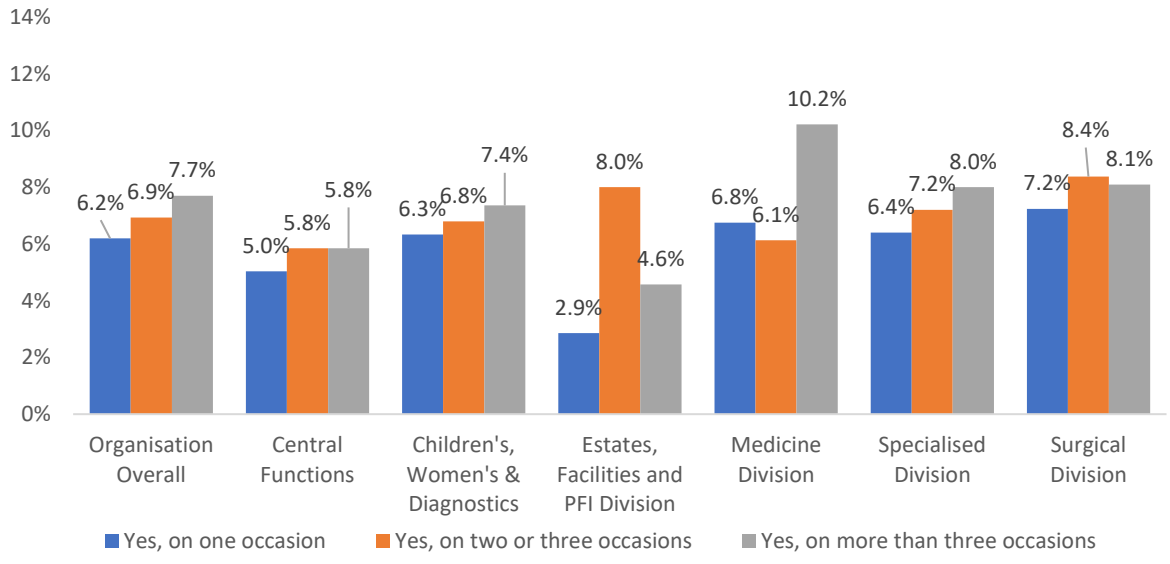


3.2 SOURCES OF BULLYING AND HARASSMENT

3.2.2 MANAGERS

One in five people (21%) report experiencing bullying or harassment from a manager in the last 24 months. Fig 7 shows the frequency of these experiences by division. A significant number of people are experiencing what they regard as bullying or harassment on a frequent basis (ie more than three occasions). Indeed, these figures are slightly higher than we would

Fig 7: 'Have you experienced bullying or harassment in the last 24 months from a manager?' by division

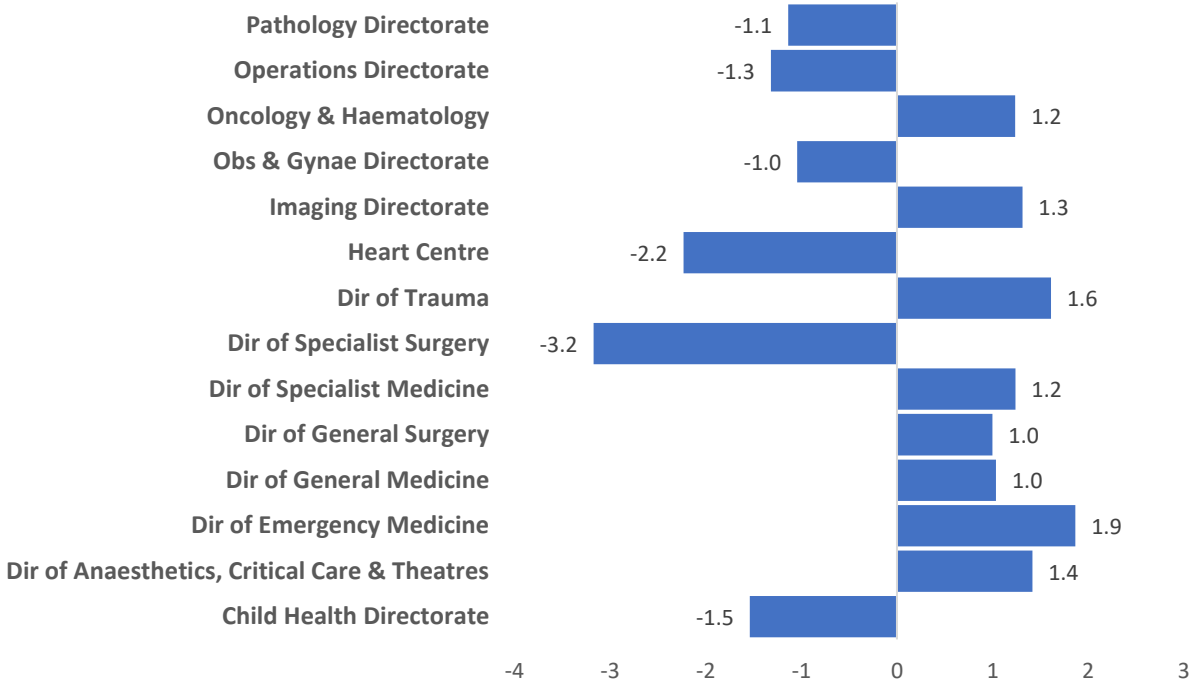


expect given other organisations we have worked with. In part, this is probably a reflection of how respondents define harassment (incivility and abruptness, for example (see section 3.3 for elaboration)). However, it is important not to overlook the frequency at which staff in the Medicine and Surgical Divisions report experiencing bullying/harassment from their managers.

For context, on average 12.6% of respondents to the national NHS Staff Survey claimed to have experienced harassment, bullying, or abuse at work from their managers (given a 12-month reporting period). The equivalent figure for UHNM is slightly higher: 13.8%.

Fig 8 shows how more or less likely staff in particular directorates are to say they 'have experienced bullying/harassment from a manager on more than three occasions in the last 24 months' compared with the Trust average (7.7%). Minus figures indicate staff in a particular directorate are less likely to experience this behaviour than the Trust average: a positive figure indicates the opposite. Staff in Emergency Medicine, for example, are nearly twice as likely as their Trust colleagues to say they have experienced frequent bullying/ harassment from a manager. Trauma Directorate staff are 1.6 times more likely to experience this than others. In contrast, Specialist Surgery and the Heart Centre emerge as areas of good practice within clinical settings. Staff within the ICT Directorate are 7.8 times less likely to say they have experienced bullying/harassment from a manager (this has not been included in fig 8 to allow the disparities between other directorates to be seen more clearly).

Fig 8: compared with Trust average, number of times more/less likely staff are to say they have experienced bullying/harassment from a manager on more than three occasions, by directorate



Of those who had experienced bullying/harassment, 15.0% attributed this to their ethnicity, 13.1% to their age, and 9.0% to their disability status. Over a quarter (26.2%) felt this was

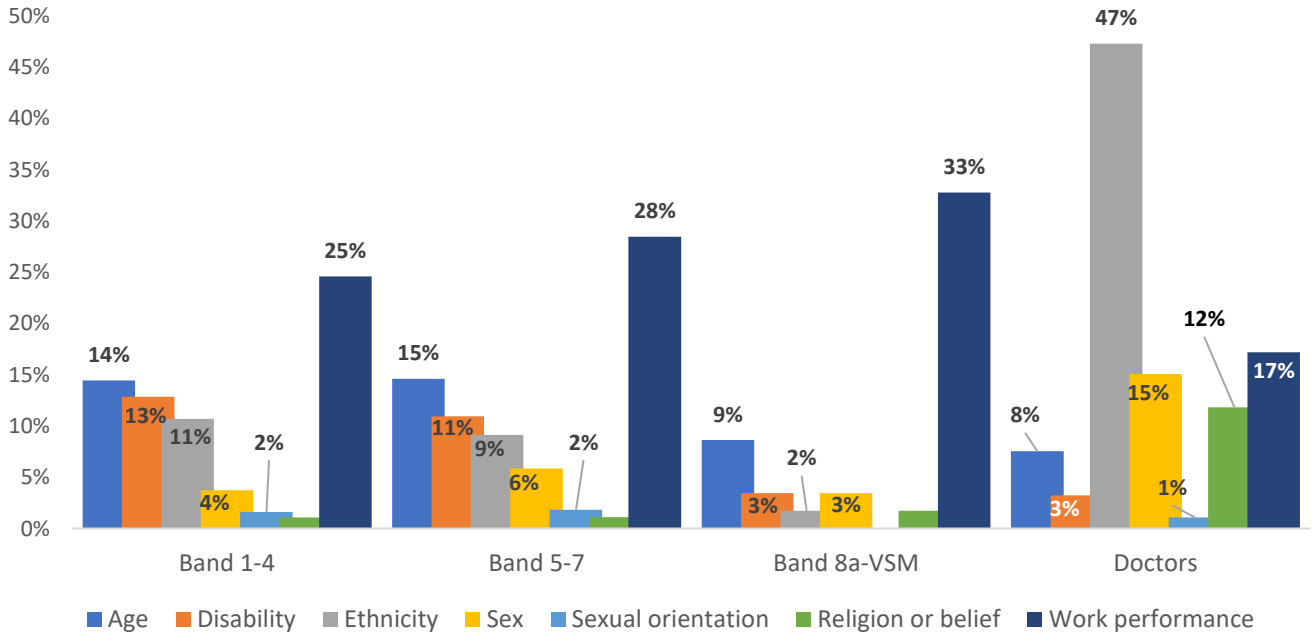
connected with their work performance (table 5). The majority of respondents attributed their experiences to the personality and disposition of their manager (reflected below in the 'Other' category), with many people suggesting their manager was 'unpleasant', 'naturally rude', 'continually stressed from work', or simply unaware of how 'jokes' or offhand comments could be perceived. Other respondents attributing their experience to an 'Other' factor relayed feeling victimised or bullied for previously raising concerns about management practice or, more commonly, for supporting someone who had.

Table 5: grounds upon which respondents feel they have been bullied/harassed by a manager

	%
Age	13.1
Disability	9.0
Ethnicity	15.0
Sex	6.4
Sexual orientation	1.5
Religion or belief	2.6
Work performance	26.2
Other	64.6

About a third of interview participants suggested ethnicity-based discrimination is a specific issue at the Trust, and this is borne out by survey data to a significant degree. Of those from a BME background who felt they had experienced some form of bullying or harassment from a manager, 60% attributed this to their ethnicity (compared with 3% of White British respondents). In contrast, of those who self-defined as disabled, 31% felt it was the result of their disability; 6% of women felt their experiences were the result of their gender; and 19% of lesbian, gay, and bisexual respondents attributed their experiences to their sexual orientation. Fig 9 below shows differing attributions to the experience of bullying/harassment

Fig 9: grounds upon which respondents feel they have been bullied/harassed by a manager (excluding 'Other'), by band grouping



by band grouping. As can be seen, doctors report significantly different concerns. Twelve per cent attribute their experience of bullying/harassment from a manager to their religion/belief: four times the whole-Trust average. Six percent attribute their experience to their gender (more than twice the Trust average). Most clearly, however, they are three times more likely to attribute experiences of bullying/harassment from managers to their ethnicity (47% of doctors compared with 15% of all staff).

Perhaps surprisingly, reasons for these differences in experience did not emerge systematically in either survey comments or one-to-one interviews. However, a small proportion of doctors noted the greater diversity of medical and dental staff (61% of colleagues in this group are from BME backgrounds, compared with 19% of staff in the Trust as a whole[5]), and suggested that if racism or inter-ethnic conflict were to arise it would most likely occur within this group. Furthermore, there is some suggestion, based on medical staff's feedback, that some of the bullying/harassment they feel they face is linked to their status as internationally trained professionals. A large number in this category felt not only is there suspicion regarding their qualifications and expertise, but they are also more likely to suffer racism than UK-born BME colleagues.

Additionally, it is clear that many senior leaders attribute tensions amongst doctors, at least in part, to inter-ethnic cultural factors, most commonly animosity between Pakistani and Indian doctors or those from Muslim and Hindu backgrounds (the two are obviously not mutually exclusive).

Finally, and separately, respondents who had experienced bullying or harassment were asked if they had felt able to report their concerns. Only 28% felt able to do so. This is much lower than we would expect.

Respondents from different ethnic groups placed different emphases on their reasons for not doing so. Table 6 below shows the types of reasons provided by White British and BME respondents. The frequency shows the percentage of respondents who cited the concern (figures don't add up to a hundred as a respondent's reason may cover a number of issues). Survey responses triangulate with feedback from interviews. In particular:

- many staff feel concerns around bullying/harassment have to be reported to their manager or another senior colleague within the department or division. Access to other forms of support (such as unions or HR) was patchy. Although awareness of the Guardian role as a mechanism for registering concerns was not entirely evident in survey findings, anecdotal feedback suggests this is an important (and increasingly important) avenue for staff to seek support;
- many people are concerned about the repercussions of raising concerns.[6] While the survey identified a small number of these, it is more common for people to talk in general terms about individuals in the past who have been 'forced out'. A particular exception to

[5] UHNM Workforce and Service User Demographic Information, as at 31 March 2021

[6] See Carter et al on the two main reasons for people not reporting bullying being fear of repercussions and there being no point as processes are often ineffective. Carter M, Thompson N, Crampton P, et al 'Workplace bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to reporting' *BMJ Open* (2013) 3:e002628

this are doctors, who claim to have been threatened with not having their licence revalidated (see section 3.3, below);

- many people feel the threshold for having their concern acknowledged as a grievance is too high. In part this reflects the nature of the behaviour being identified as bullying/ harassment: rudeness, abruptness, and incivility (see section 3.3). Staff are wary of labelling these as 'bullying'. In part, it also reflects the evidential standards the Trust usually requires to progress these sorts of issues. Staff relayed raising concerns with HR but being told these could only be progressed formally under the Trust's Grievance Policy; and
- finally, it appears there are a number of managers who feel a certain level of incivility or rudeness is just part of the natural day-to-day dynamics of being in the workplace. This was raised explicitly by about 10% of survey respondents. It was also apparent to some extent in our interviews with Trust staff. One manager talked about bullying and harassment in contrast to 'other, significant' issues he had to deal with. Another suggested the chain of command in the Trust was important in ensuring only 'important' issues reached him (and that issues around bullying or incivility did not meet this threshold).

Table 6: reasons for not reporting concerns

Responses from White British respondents:

CONCERN	EXAMPLE COMMENTS	FREQUENCY
Alleged bullying or harassment was perpetrated by line manager of other senior colleague	• [I didn't report a person's behaviour] because that person was the person who I should have gone to to escalate • bullied by both my senior sister and matron, didn't have anyone else to turn to • the incident happened with the highest member of management within my department	20.4%
Management team represent a clique, who will protect each other [connected with above]	I feel NHS managers and HR all stick together and ultimately will defend bad behaviour of managers.	21.6%
Incidents/behaviour wouldn't be taken seriously	• you are belittled when reports are made – I have tried to raise issues before • who would deal with it when every problem gets hidden and blocked at a band 8 level? • what would be the point? Nothing ever changes here and she would only have denied it anyway	28.6%
Advised not to by manager (or others)	• when trying to escalate all I got was comments like 'it's just their way', 'I've known them for years', 'they don't mean it', 'don't report it because it could be racist' • because the Manager thought it was just moaning not a work related issue • I was told that we were lucky to have [x] working with us	10.5%
Fear of repercussions	• It could affect promotion opportunities in the future • I need my job	29.6%

	• Don't want to get redeployed. People often referred to Occ Health to stop them making a fuss	
Managed to resolve issues informally	• I spoke to my manager he stopped eventually	11.3%
Other	• I didn't know who to talk to • at the risk of sounding pathetic, the situation makes me feel very undervalued and worthless sometimes • I didn't feel I could evidence [my manager's] behaviour	2.8%

Responses from BME respondents:

CONCERN	FREQUENCY
Alleged bullying or harassment was perpetrated by line manager of other senior colleague	11.7%
Management team represent a clique, who will protect each other [connected with above]	9.8%
Incidents/behaviour wouldn't be taken seriously	31.7%
Advised not to by manager (or others)	7.8%
Fear of repercussions	33.4%
Managed to resolve issues informally	1.5%
Other	3.9%

In addition, BME participants also raised another set of concerns:

CONCERN	EXAMPLE COMMENTS	FREQUENCY
Fatigue/feel worn down/ feel embarrassed	Feel ashamed, a failure, embarrassed that the confident person for which I was once known had become weak and soft. Unable to stand up for myself, putting my job and hence my family life at risk.	7.8%

3.2.3 OTHER COLLEAGUES

Twenty-two per cent of survey respondents report experiencing bullying or harassment from a colleague in the last 24 months. Fig 10 shows the frequency of these experiences by division. Slightly more people (8.4%) experience frequent bullying/harassment from their colleagues than they do their manager(s) (7.7%).

Indeed, Estates and Facilities appears the only division in which staff are more likely to experience bullying/harassment from a manager than a colleague. The Medicine Division again reports higher levels of bullying/harassment compared to other divisions, although Surgical and CWD are also areas of concern. Within the Medicine Division, incidents of frequent bullying/harassment are distributed across different directorates in the following way:

- Specialised Medicine: 14% of survey respondents report experiencing bullying or harassment from a colleague on more than three occasions in the past 24 months:
- Emergency Medicine: 11%: and
- General Medicine: 10%.

It is also worth noting the distribution of incidents within CWD:

	% respondents experiencing b/h on more than three occasions	% of CWD figure
Imaging	12.1%	25.6%
Pathology	7.9%	21.8%
Child Health	11.9%	20.5%
Obs and Gynae	9.8%	17.9%
Outpatients	7.8%	7.7%
Pharmacy	4.6%	3.8%
Clinical Technology	7.7%	2.6%

As can be seen, incidents within CDW are concentrated within Imaging and Child Health.

Fig 10: 'Have you experienced bullying or harassment in the last 24 months from a colleague?' by division

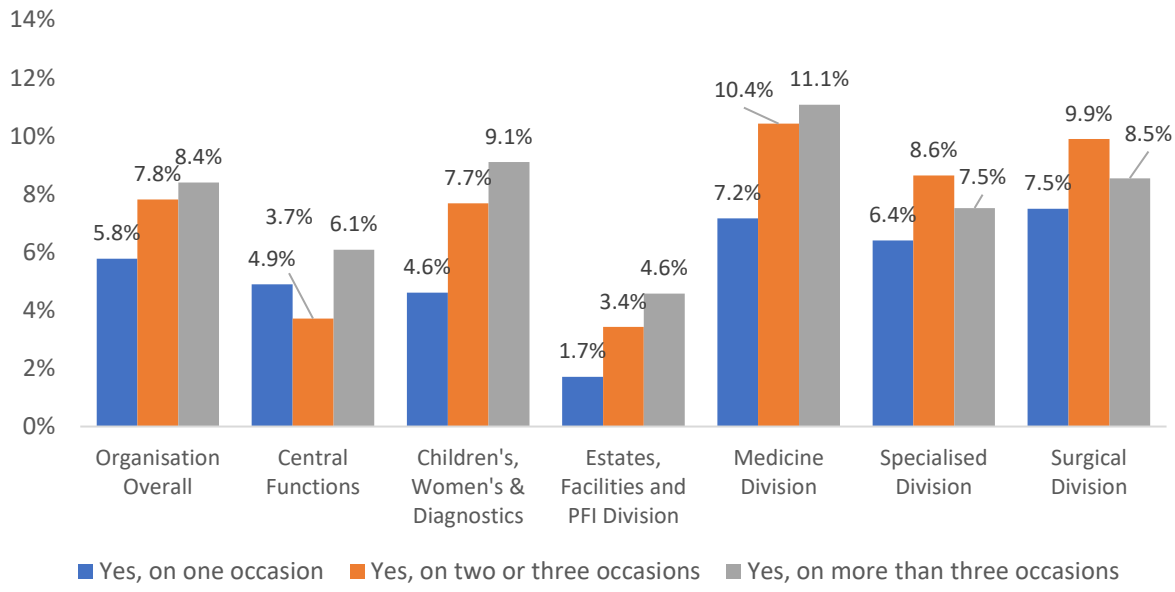
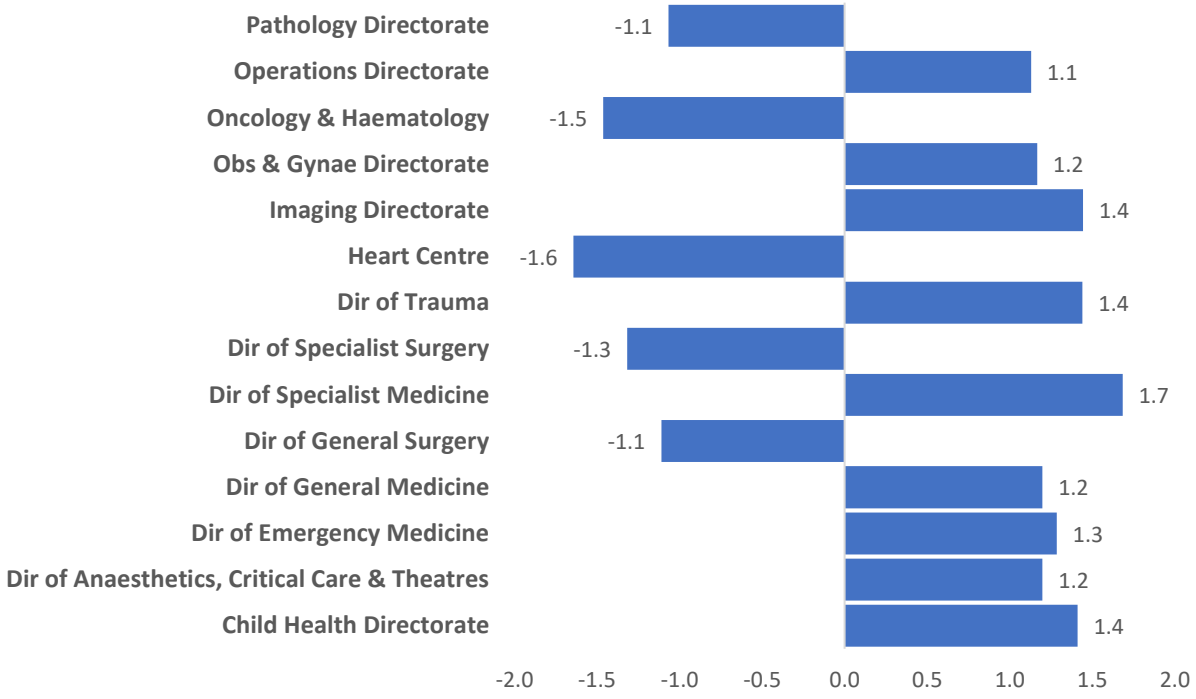


Fig 11 shows how more or less likely staff in particular directorates are to say they 'have experienced bullying/harassment from a colleague on more than three occasions in the last 24 months' compared with the Trust average (8.4%). As can be seen, staff in Specialised Medicine are 1.7 times more likely than other Trust staff to say they have experienced frequent bullying/harassment from a colleague. Imaging, Trauma Directorate, and Child Heath staff are 1.4 times more likely to experience this than others. In contrast, Specialist Surgery and the Heart Centre again emerge as areas of good practice within clinical settings.

It is also worth noting staff within the ICT Directorate staff are 8.4 times less likely to say they have experienced bullying/harassment from a colleague (as before, this has not been included on fig 11 to allow the disparities between other directorates to be seen more clearly).

Fig 11: compared with Trust average, number of times more/less likely staff are to say they have experienced bullying/harassment from a colleague on more than three occasions, by directorate



Of those who had experienced bullying/harassment, 20.1% attributed this to their ethnicity, 13.1% to their age, and 8.7% to their gender. Twenty seven per cent felt this was connected to issues around work disputes. The majority (60.0%) attributed their experiences to 'Other' reasons. Free text comment response show this invariably meant the personality of their colleagues. As with responses to management bullying/harassment, respondents highlighted how some colleagues make inappropriate or offhand remarks and appear unaware of how rude they can come across. There is also some suggestion that people working under time pressures and resource constraints can become increasingly stressed and tempers can fray.

Table 7: grounds upon which respondents feel they have been bullied/harassed by a colleague

	%	equivalent figure showing grounds of manager B&H
Age	13.2	13.1
Disability	5.2	9.0
Ethnicity	20.1	15.0
Sex	8.7	6.4
Sexual orientation	1.9	1.5
Religion or belief	3.8	2.6
Work performance	27.1	26.2
Other	60.0	64.6

BME staff are 1.6 times more likely than White staff to report experiencing bullying/harassment from a colleague (30.8% of BME survey respondents report experiencing this at least once in the previous 24 months, compared with 19.1% of White staff). In contrast, disabled staff are 1.4 times more likely than non-disabled staff to say they have experienced bullying/harassment from a colleague. Disaggregating data by gender does not reveal significant disparities. Fig 12 below shows the proportion of each band grouping who have experienced bullying/harassment from a colleague on at least one occasion. As can be seen, a third of doctors (31.4%) report experiencing this: a much higher rate than their colleagues on other bands. As such, doctors are 1.4 times more likely to report experiencing bullying/harassment from a colleague than the Trust average (22.0%).

Fig 12: % of respondents experiencing bullying/harassment from a colleague by band grouping

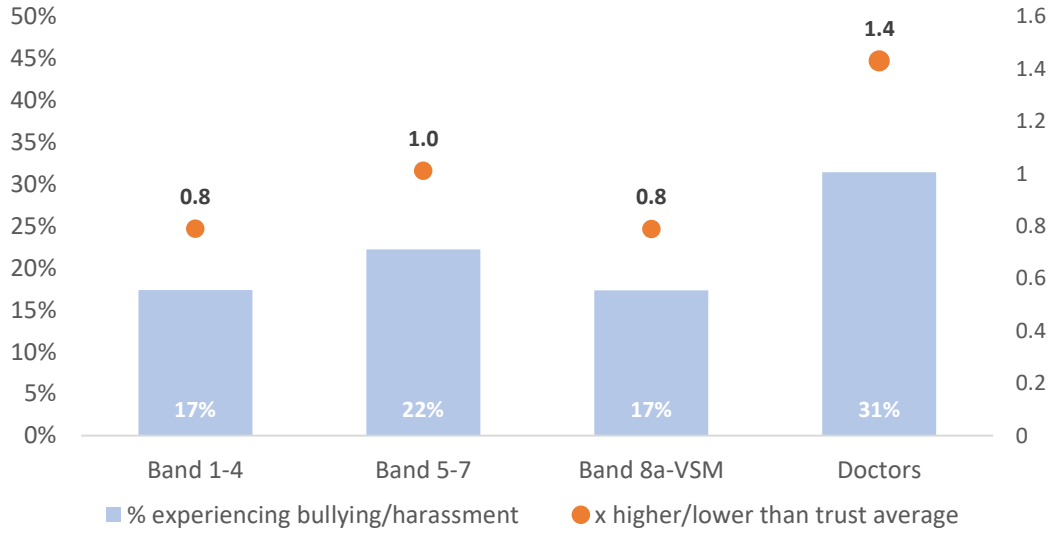
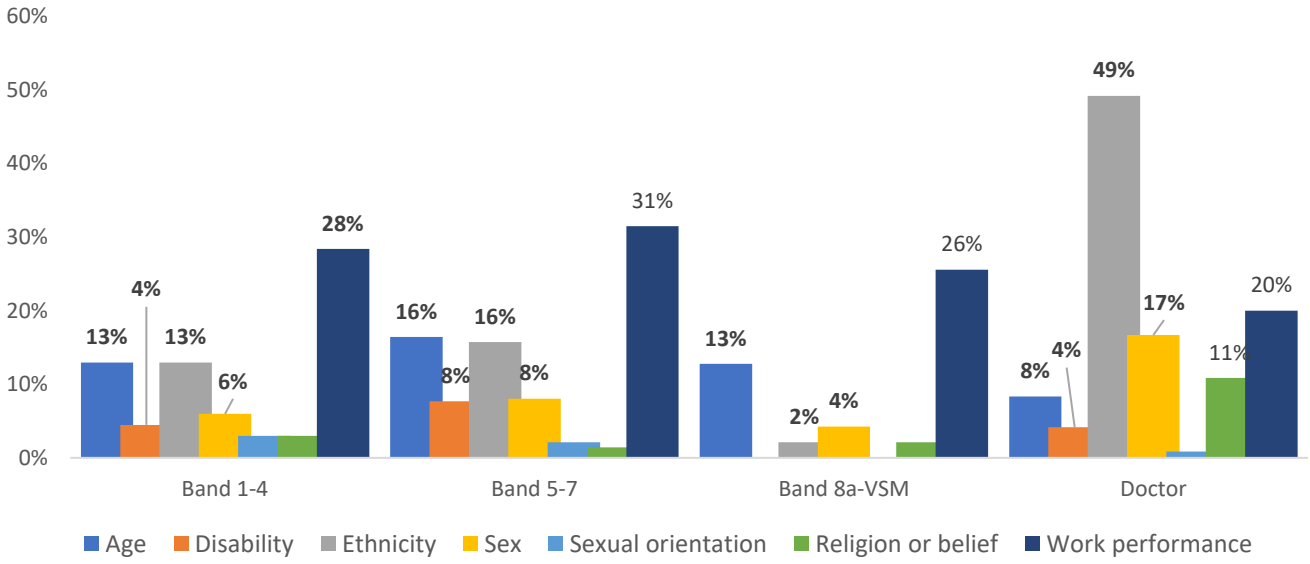


Fig 13 below shows the grounds upon which people feel they have been bullied/harassed by a colleague by band grouping. As can be seen – similar to responses around management bullying – doctors are more likely to cite their ethnicity as a factor leading to their experiences.

Fig 13: grounds upon which respondents feel they have been bullied/harassed by a colleague (excluding 'Other'), by band grouping



Respondents experiencing bullying/harassment from a colleague felt much more able to report the experience than did people experiencing issues from managers (46% of people reported harassment from a colleague compared with 28% of people experiencing it from a manager (see section 3.2.1)). As table 8 below shows, however, this figure covers a range of responses: 57% of staff of band 8a and over felt able to report their concerns compared with only 33% of doctors. The reasons staff feel unable to report issues are discussed in depth in section 3.2.1. However, it is worth noting feedback from interviews suggesting many doctors feel they have endured poor behaviour – talking over people during meetings, criticising work in public, aggressive questioning – for years, and have simply become inured to it. A perception that successive team and directorate managers have failed to tackle the issue has further led many to believe raising concerns is futile.

Table 8: 'Did you feel able to report bullying/harassment from a colleague?' by band grouping

	Band 1-4	Band 5-7	Band 8a-VSM	Doctors
Yes (%)	48.4	48.0	56.7	32.6
No (%)	51.5	52.0	43.3	67.3

3.2.3 FROM PATIENTS

Six per cent of survey respondents have experienced bullying/harassment from a patient/ visitor in the last 24 months on at least one occasion; eight per cent on two or three occasions; and five per cent on more than three occasions.

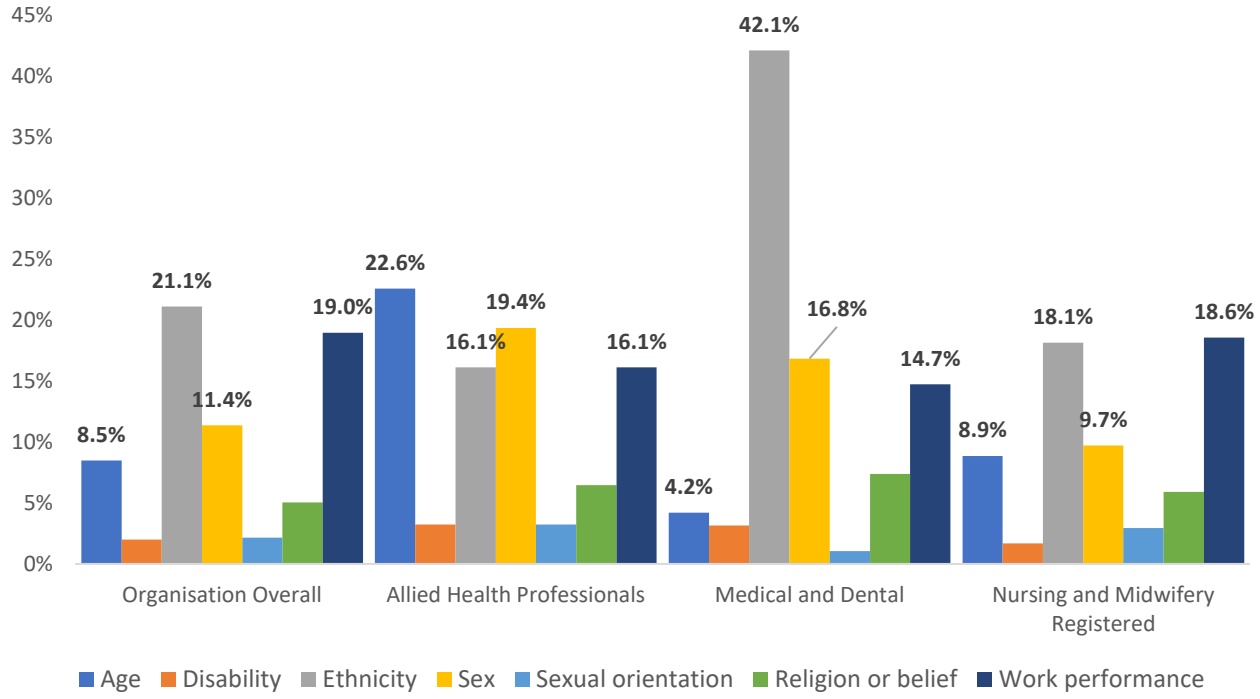
Of course, these incidents are not evenly spread across all staff groups: patient-facing roles are significantly more likely to report harassment from the public. As table 9 shows, one in 10 (11.3%) medical and dental staff have experienced bullying/harassment from a patient/visitor on two or three occasions in the last two years. This falls to 4.8% for more frequent complaints. This is consistent with interview feedback from doctors suggesting some form of frustration or rudeness is inevitable when dealing with often stressed and scared people. Most suggested they take it in their stride as part of their roles. However, it is important to note that while medical/dental staff find harassment from the public to be infrequent, 10.7% of nurses and midwives report experiencing this on three or more occasions.

Table 9: 'Have you experienced bullying or harassment in the last 24 months from patients or visitors?' by staff group

	Yes, on one occasion	Yes, on two or three occasions	Yes, on more than three occasions
Add Prof Scientific/Technic	3.4%	4.0%	1.3%
Additional Clinical Services	4.7%	6.0%	3.4%
Administrative and Clerical	2.6%	4.0%	3.9%
Allied Health Professionals	5.8%	13.3%	1.7%
Estates and Ancillary	1.7%	0.8%	2.5%
Healthcare Scientists	2.5%	4.3%	0.6%
Medical and Dental	9.4%	11.3%	4.8%
Nursing and Midwifery Registered	9.5%	11.8%	10.7%

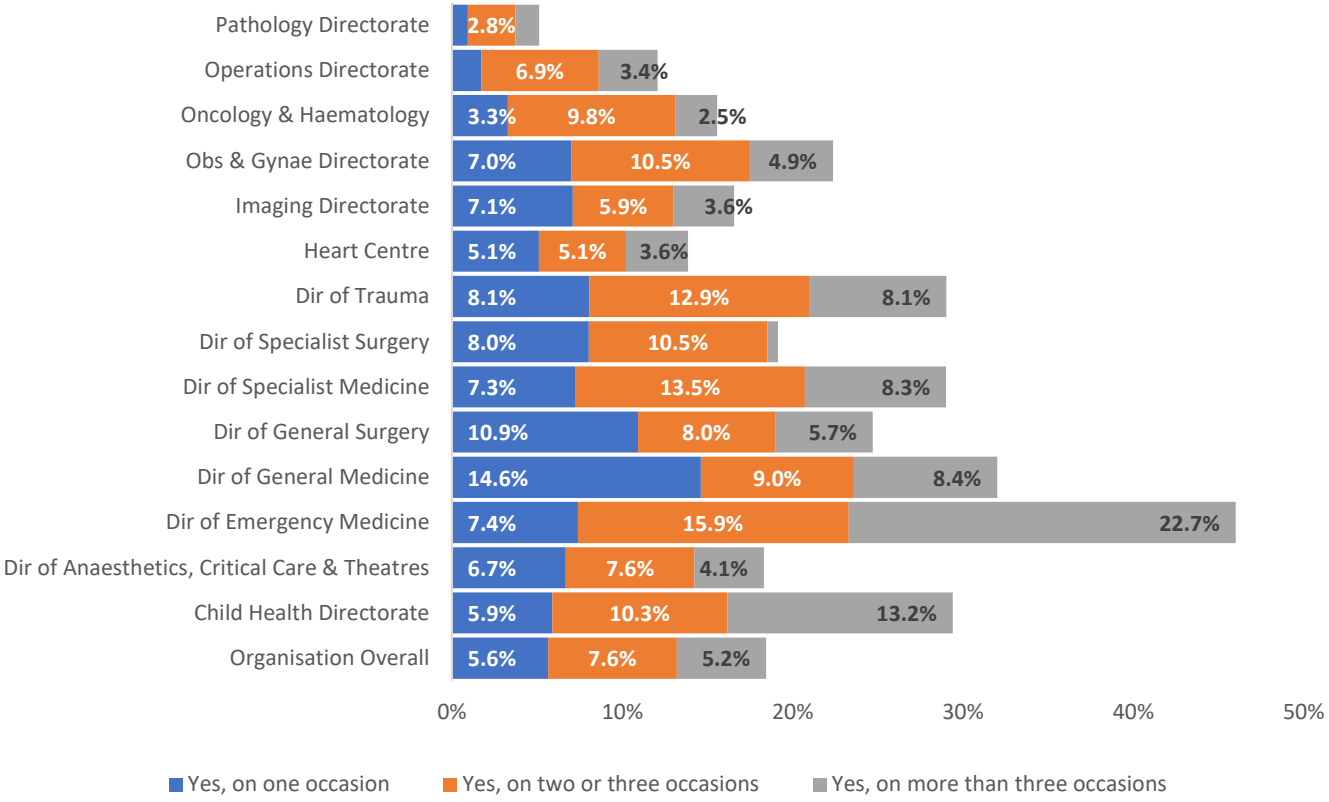
Fig 14 below shows the grounds upon which staff feel they have been bullied/harassed by patients/visitors. Only some staff groups are shown, based on the frequency of harassment shown in table 9 and the sample sizes involved. As can be seen 42.1% of medical and dental staff who have experienced harassment from the public attribute this to their ethnicity, double the rate for the Trust as a whole. Age-based bullying/harassment is also relatively prominent in the list of factors people have identified. This is primarily a reflection of younger people being told they are 'not old enough to do the job' and patients asking to speak to someone 'older and more senior'.

Fig 14: grounds upon which respondents feel they have been bullied/harassed by a patient/visitor by staff group



Finally, for reference, fig 15 shows the proportion of staff experiencing bullying/harassment from patients or visitors by directorate (where n ≥ 100). Colleagues working in General Medicine are most likely to experience one-off incidents. Those working in Emergency Medicine are most likely to experience bullying/harassment, and do so frequently. It is also worth noting the prevalence of bullying/harassment in Child Health: this was not something that was particularly discussed during interviews.

Fig 15: Have you experienced bullying or harassment in the last 24 months from patients or visitors?' by directorate



Two thirds (63%) of people who had experienced bullying/harassment from a member of the public reported the issue to a manager or other appropriate person at the Trust. This reporting is much higher than that identified for bullying/harassment from a manager (28%) or colleague (46%). Again, however, the figure masks a range of experiences, with 67% of nursing and midwifery staff reporting incidents with the public compared to only 37% of medical and dental staff.

The reasons for this are complex. In part, the low reporting rate from medical and dental staff may reflect the seriousness of the behaviours they face: comments from the survey and interviews suggest this may be the occasional exasperated outburst from stressed patients or family members (it is worth remembering that nurses and midwives are much more likely than dental and medical staff to experience bullying/harassment from the public on multiple occasions). On the other hand, however, many doctors report experiencing comments about their ethnicity or culture (examples are outlined in section 3.3.3, but often include references to people's accents or occasional requests for a White doctor). As noted in the previous sections, many doctors do not feel these issues are taken seriously and refrain from reporting them.

The most common reason for not reporting bullying/harassment from patients or visitors is a feeling that working in healthcare will inevitably involve some kind of abuse from the public. We understand from staff feedback the Trust has undertaken work in recent years to reassure colleagues this is not the case and they should not resign themselves to rudeness

or harassment. Interviewee responses and the fact that 63% of survey respondents are reporting incidents suggests these messages are having an impact (although there is obviously still work to do).

3.3 THE NATURE OF BULLYING AND HARASSMENT

In this section we outline some of the current behaviours leading people to feel bullied or harassed. Of course, many people feel their experiences are historic in nature so where necessary we also outline some of the longer term practices and actions that contextualise people's concerns.

3.3.1 BULLYING AND HARASSMENT FROM MANAGERS

There was a great deal of alignment between the kinds of behaviour participants claimed to have experienced. Most fall under three broad themes.

Firstly, many participants relayed being subject to one-off experiences, such as being spoken to rudely in meetings or being shouted at for not having completed a task. When context was provided, most people attributed this to managers being 'stressed' or 'pressured' due to excessive workloads generated by Covid-19 or winter crises. It is not entirely clear, but it appears most people subject to this kind of one-off behaviour naturally resolve the issue with their manager or put it down to the occasional tensions that tend to arise in the workplace. Nevertheless, many still feel sufficiently hurt by the experience to label it as 'bullying' or 'harassment'. Indeed, one consultant who was shouted at by a senior leader in their division in 2018 recalled how the incident had affected them and continues to affect them to this day. Although it was a one-off for them, the aggression and content of the tirade has led them to 'withdraw' (they no longer seek leadership positions, for example). It is difficult to discuss the incident without betraying confidences, but part of the impact may be that the leader in question was never tackled about their behaviour.

Secondly, and most commonly, participants talked about particular individuals treating them with a lack of dignity and respect over a period of time. Many people identified behaviours we have listed elsewhere as common poor practice in the NHS. These include:

- using patronising and demeaning language;
- shouting or talking aggressively to people;
- unacceptable demeanour in meetings – actively looking disengaged and dismissive;
- being overly critical of work, often in front of other colleagues;
- not being listened to;
- being rude and abrupt when direct reports ask questions: some participants talked about managers rolling their eyes when they asked a question;
- not being provided support to complete work; and
- being given a lot of work to complete within unreasonable timescales.

Doctors are more likely to raise these complaints than other members of staff. In particular, three 'sites' of harassment emerged:

- emails – participants relay being sent a large number of abrupt, impersonal emails 'telling' them what to do. As one participant put it, the emails suggest a 'command and control mentality' amongst leaders in particular directorates. 'There used to be a human element in the way managers spoke to you,' claimed another, 'Not anymore'. Participants often suggested that managers themselves are under a lot of pressure to deliver results and targets and this explained why they sent 'orders'. As part of this review, we spoke to managers within some directorates and divisions to understand where this pressure comes from. It was not entirely clear, however, that leaders feel under particular pressure or that the Trust is especially target driven. Having said this, it appears that managers/clinical leads in Imaging in the past few years have felt that consultants' working practices have needed to change and have sent emails that have been described as 'diktats'. We were not provided copies of these specific emails and understand that they would have been sent prior to 2020. Nevertheless, they form part of the narrative staff tell about the Trust;
- team meetings – it is, we understand, widely recognised that team meetings within some departments can be acrimonious and un-collegiate. Participants raising this concern were wary of naming their team, but it appears Trauma and Orthopaedics may be a particular area of concern. The issue is not just that particular 'big personalities' are confrontational and will talk over or dismiss colleagues. Participants are frustrated that managers have glossed over their concerns (suggesting, for example, 'that doctors should be able to cope with pressure'); and
- multidisciplinary meetings – there is some suggestion that senior consultants can 'interrogate' and belittle their more junior colleagues in these meetings. It is often dismissed as older colleagues being 'grumpy', but it can be quite intimidating for staff on the receiving end. It appears there is more scope for these meetings to be educational rather than punitive.

It is worth noting that some BME staff talked about being victims of 'micro-aggressions' (apparently slight or trivial actions, the culmination of which can marginalise or isolate the individual involved). In this respect, they were comparing the extent to which they are included in decisions, listened to, etc with their White colleagues.

In the list of behaviours identified above, the last two points relate to specific managers changing objectives or expected outcomes for specific individuals. More widely, people raised a third set of concerns relating to being harassed through punitive management practices, such as being given excessive workloads or not having adequate resources to complete tasks. One survey respondent described their experience in this way: 'given winter pressures, we have a huge work load, unrealistic expectations, insufficient staff in the work place, and [a] lack of equipment. There's just a sense of apathy in management'. The comment is indicative in suggesting the (lack of) management response constitutes bullying/harassment as staff suffering is ignored.

In addition to these three broad themes, participants also raised other issues, albeit less frequently. Obviously, there is some overlap with the concerns raised above, but participants often mentioned them without reference to other issues. They include the following:

Lack of development/progression

BME (in particular Asian) staff raised a number of concerns about the promotion and appointments process in the Trust. Many people – both White and BME – pointed to the lack of diversity in the executive team, but also talked about leadership in the Trust more generally and how this is disproportionately White. (For reference, the trust does not have any BME staff in band 8d or 9 positions. 5.9% of staff in band 8a-c roles are BME.)

More practically, respondents also talked about a lack of transparency around recruitment, promotion, and secondment processes. Some BME survey and interview respondents claimed they were working with people who had been appointed without the post being properly advertised. People who were unsuccessful in obtaining promotion opportunities talked about vague feedback explaining why they had not been appointed. BME participants in particular expressed frustration at being told they had 'just missed out' or that the successful candidate had 'just scored one point more' as they felt this level of vagueness may hide biases on the part of recruiters and was of little use for them to learn from for the future.

Coupled with this, BME participants talked about a lack of access to training and development opportunities. As one participant put it, 'they [managers] fast track White people's training – I asked a White colleague why he was being trained on this bit of equipment. I told him I had asked for training loads of times. He said you don't get anything if you don't ask, but I did ask and was told 'you're always moaning''.

As noted in section 2, WRES data shows White staff are only 1.1 times more likely than BME staff to access non-mandatory training and continuous professional development. However, White applicants are 1.4 times more likely than BME applicants to be appointed to roles following shortlisting. Staff survey data also shows BME staff are almost twice as likely as White staff to not believe there are equal opportunities for career progression or promotion.

When raised with managers and leaders, respondents reported that most dismissed these concerns, claiming recruitment followed the Trust's policies. Most felt this was a guarantor of fairness. Awareness of issues around unconscious bias and how this could affect recruitment outcomes was minimal.

Referrals to the GMC

Some doctors claimed they have been 'threatened' with referral to the GMC or not having their validation renewed. Most suggested this was in retaliation for questioning changes to working practices. It is not clear if anyone has actually been referred or had their validation withheld.

From what we can ascertain the Professional Standards Committee acts as a check and balance to the Responsible Officer's power in relation to managing doctors under MHPS or referring them to the GMC. However, it appears there are occasions when the Responsible Officer has had to act without reference to the committee, and in these cases has discussed cases with the Director of HR and Medical Director to double check his stance.

Management practices

A small number of people raised concerns around management practices. Two issues in particular arose.

First, when asked for examples of bullying or harassment, some people talked about being pressured or 'told' to come to work during the pandemic. One survey respondent had a particularly bad experience: "I was 'managed' into situations that I was destined to fail, despite telling my manager and consultants how I felt…I was unsupported during Covid. I didn't sleep properly for weeks and worked 35 days straight (most unpaid weekends). Senior management suggested that as this person was retiring soon not to pursue".

Second, a handful of doctors have raised concerns around issues such as job planning. In particular, there are concerns around the value placed on clinical (as opposed to non-clinical) activities, how the use of time is evidenced, and the extent to which consultants are required to justify the use of their time ('every minute', claimed one participant). When interview participants were pressed on why they felt this constituted bullying/harassment, most said it was indicative of how 'high handed' Trust leaders can be, how little they valued the consultant role, and how they ignored the emotional impact their decisions can have on staff.

A lack of compassion/empathy

Participants relayed a number of examples of managers responding to issues with a lack of empathy or concern. Some participants with underlying conditions felt their managers were dismissive of their fears around Covid-19. Some participants talked about coming back off sick leave and being 'interrogated' about their time off or feeling the Trust unthinkingly applied its sickness absence policy. One participant said they were called 'stupid' by their manager after catching Covid-19 from a family member. Another who took time off to attend their child's medical appointment said they were 'emotionally blackmailed' into not attending others. A colleague returning to work after they had taken an overdose recalled how little concern managers expressed in their wellbeing. 'One manager sent me an email,' they said, 'talking about work. When I said what had happened they emailed back, 'Sorry you've been a bit poorly''.

Other clinical respondents discussed how complaints have been raised against them by patients and other staff. Regardless of the nature of the complaint, many suggested Trust managers failed to act in an empathetic way. For example, some participants claimed they were informed via email about complaints made against them, that managers did not offer them opportunities to share stresses or worries, or that the Trust's approach suggested they were guilty until they could prove their innocence. For some this was particularly galling given their years of unblemished service to the Trust.

Conversely, a small number of people relayed raising concerns/potential grievances with HR and being told to simply submit their complaints in writing so they could be progressed under the Trust's Grievance Policy. "That was it," recalled one participant, "there was no expression of sympathy for what I was going through. I remember wondering if I was being a burden on [the HR contact] because she was just about getting it in writing. No chat over a cup of tea".

There was widespread agreement amongst all interview participants that the Trust seeks to formalise grievances too quickly. Leadership were clear that they expected managers to act with compassion, although few had examples of how they had actively supported people to behave in this way.

3.3.2 BULLYING AND HARASSMENT FROM COLLEAGUES

Again, the kinds of behaviour respondents tended to cite as examples of bullying/ harassment tended to be incivility (people being ignored, talked over, etc). However, a small number of participants relayed examples of people making inappropriate remarks or 'jokes'. One participant claimed he was subject to "constant 'jokes' about my age, and how this is funny". Another claimed one of her colleagues "makes jokes about how much additional medication I need to take". During the course of this review, we have heard of Chinese people being referred to as "slitted-eyed blokes" or "Mrs Ching-chang-chong", Asian people being called "dog eaters", and travellers being referred to as "dirty gypos". Most of these incidents have occurred in the last three/four years, although it is not entirely clear precisely when.

A small number of participants separately expressed some concern regarding their colleagues' attitudes towards prejudice and racism in particular. Participants raised some concern around dismissive attitudes towards things like Black Lives Matters or suggested their colleagues are suspicious of EDI programmes (and see them as 'political correctness'). Participants generally did not see this as bullying/harassment per se, but were nevertheless concerned by what they heard.

3.3.3 BULLYING AND HARASSMENT FROM PATIENTS OR VISITORS

The types of issues staff face from patients and visitors are well-known. Typically, survey respondents talked in general terms about "aggressive behaviour", "verbal abuse", and "rudeness" from patients and their families. When people were specific about the abuse they faced, it tended to fall into three categories:

Qualifications/seniority

A few nurses relayed being hurt or frustrated by demands from patients to see "a proper doctor" or "someone senior".

Appearance

A small number of survey respondents have been taunted about their weight.

Racism

Staff in Emergency Medicine and General Medicine relayed a range of experiences including:

- on two occasions patients have asked me where I am from, just to make negative comments about my country of origin;
- patients asking to see a White doctor;

- racist remarks from patients (I work in ED). Often religious stereotype is based on my appearance;
- some patients not happy to see dark skin people. They said they were British and did not want other ethnicities to touch them and do anything for them; and
- I was called a nigger and the patient swore.

3.4 CAUSES OF BULLYING AND HARASSMENT

We identified the following factors as potential reasons bullying or harassment persist within the Trust.

Workload pressures

In their 2013 study into the prevalence of workplace bullying Carter et al suggest that 'often the people doing the bullying are actually stressed' and 'under more pressure', resulting in aggression 'in how they approach and manage people'.[7] This was echoed to some degree in this review: survey respondents often mentioned not reporting incidents because they felt their manager's actions were simply a reflection of how stressed they are. It does not appear leaders within the Trust view working pressures as a particular issue facing UHNM. Many people also reported feeling supported to perform their roles (although obviously most would welcome extra resources).

'Big personalities'/'weak management'

As noted in section 3.2, the most common reason people cited for bullying/harassment they experienced was the personality, attitude, and disposition of their managers and colleagues. It is clear a narrative has developed amongst doctors that some teams have "big personalities" who will challenge – aggressively and unsupportively – their colleagues and working practices at the Trust. This is cited as a primary reason why team meetings can be so hostile. In addition, it is felt senior clinical leaders have, in the past, failed to tackle these "big personalities" for a variety of reasons: in recognition of their reputation and/or expertise, not feeling their behaviour constituted bullying/harassment, and – more vaguely – just feeling it is too big a problem to tackle. For example, a number of years ago, doctors within a particular directorate were encouraged, by senior leaders, to call out negative behaviour. "But some of the clinical leaders then didn't," recalled one doctor, "so people didn't feel they had the backing and support to call out behaviour". Where we have been able to speak to clinical leads, many have talked about the frustrations they felt trying to model appropriate behaviour but not feeling supported by others more senior.

Organisational culture

Research into the causes of workplace bullying have identified the importance of different aspects of organisational culture, such as 'poor job design', 'work intensification' and 'job stress'.[8] This was not a topic we were able to explore fully during the course of this review, but it is worth noting the following:

[7] Carter et al (2013) op cit

8 See, for example, Evesson, J. and Oxenbridge, S. (Employment Research Australia) & Taylor, D (Acas) (2015), 'Seeking better solutions: Tackling bullying and ill-treatment in Britain's workplaces'

- the exec team have a clear understanding of the need to promote an inclusive culture and change those aspects that may be acting as barriers to clear, collegiate communication. There was less clarity on the levers available to affect this change, however. Other senior leaders below Trust level clearly feel the most important tool they have to affect change is to model professional behaviour. This reflects their analysis that bullying/harassment most commonly takes the form of incivility and rudeness;
- the Trust's work promoting its values has landed. Most people knew the four values, people generally liked the idea of obtaining badges, and a couple of people were genuinely moved to have had their commitment to compassion recognised by colleagues and senior leaders. It is not clear to us, however, the extent to which the Trust recruits to its values. This is may be particularly relevant when appointing people to leadership positions within clinical teams; and
- the primary means by which senior leaders claimed to know whether there was/would be an issue with bullying/harassment was staff raising this with them when they walk the floor. The increased visibility of the exec team has been noticed and is appreciated by staff in the Trust. However, we did not see clear evidence the team had reflected on the power they have as (the most) senior staff and how this can impact on the conversations they have with people. From our conversations, it appears there may be an issue with staff feeling they can talk openly and honestly with senior leaders, not least because there is a natural desire to self-censor and defer to leaders' opinions.

Racism

Those experiencing racism claimed knowledge and understanding of race equality across the Trust was poor. Our conversations suggest knowledge is mixed. One of the key complaints raised by people were micro-aggressions[9]. While some people had heard of the term, few understood precisely what they are, how they could be exhibiting them, or what their impact can be. In addition, few people showed an understanding of how race equality could help them manage diverse staff teams.

Some White British colleagues suggested "the Trust is scared of talking about race" and felt this explained why the behaviour of some BME individual colleagues has been allowed to persist. Senior leaders "won't say anything because they're afraid of being called racist", as one participant put it.

Hierarchy

While the exec team have done much to reduce the effects of professional hierarchies, there is still more to be done, especially in clinical settings. "We are still a bandist organisation", said one participant, "I used to work in Surgery and you see a lot of deference to what the doctors want".

[9] Micro-aggressions are defined by Washington et al as "incidents in which someone accidentally (or purposely) makes an offensive statement or asks an insensitive question….[they are] verbal, behavioural, and environmental indignities that communicate hostile, derogatory, or negative racial slights and insults to the target person or group". See Washington, E; Hall Birch, A; and Morgan Roberts, L (2020) 'When and How to Respond to Microaggressions' in *Harvard Business Review*

It is also apparent there are some senior leaders (below board level) who do not view issues around incivility or rudeness as particularly important. We noted on page 17, for example, a participant who claimed a benefit of the "chain of command" was that only "important" issues reached senior management (that is, clinical and strategic issues, rather than concerns around staff relationships). Some senior leaders were unclear that improving the work experience of clinical staff would in turn improve patient care and safety.[10]

Festering tensions

Most readers of this report will be aware that some of the grievances people hold go back years. It was widely said that people hold on to issues for a long time because "managers feel they have resolved issues, but they haven't". This reflects a lack of conflict resolution skills (clinical) leaders have had historically. It also reflects the tendency in the Trust to 'formalise' complaints and only progress them under the auspices of the Grievance Policy.[11] This stifles the freedom managers feel they have to resolve issues. Equally, because staff do not want to progress issues formally, it means underlying behaviours and attitudes persist, with the consequence that tensions and resentments linger.

3.5 EXISTING INTERVENTIONS

3.5.1 CURRENT INTERVENTIONS

As part of this review, we reviewed the Trust's existing interventions around bullying and harassment. These included:

Training packages

A number of programmes offered by the Trust touch on issues relevant to this review. The Trust's induction modules have specific slides on bullying and harassment covering what it looks like, the effects and impact it can have, and common reasons people do not complain. Modules on conflict minimisation and managers' roles in promoting dignity at work also clearly explain what forms unprofessional behaviour may take and how leaders should respond.

As far as we have been able to ascertain, feedback on the training packages has been positive and participants have relayed finding them useful. Perhaps the biggest barrier to the implementation of their contents, however, is a prevailing culture within the Trust that formalises complaints. As noted above, many interview participants expressed frustration when liaising with HR about issues in their teams and being told to get complaints in writing. The training packages also imply leaders will have the support – both practical and moral – of their managers when dealing with workplace conflict. As noted, many people managing doctors have not felt this to be the case.

The Trust also provides training on issues around unconscious bias and micro-aggressions.

[10] For more on the link between the two, see, for example, BMA (2017) *Workplace bullying and harassment of doctors: A review of recent research* or, indeed the Francis Inquiry Report

[11] HR colleagues fed back that the first steps outlined in the Trust's Grievance Policy are informal resolution, and this is generally the approach they would aim to take.

Again recognising the positive feedback from participants, we would note from our own experience the resistance many people have to the idea they may be acting in ways that perpetuate inequality. Strong facilitation is required to help people grapple with some of the ideas – and emotions – in play. In addition, it is important once training has been provided that participants have the autonomy and 'permission' to act on the learning in their workplace, and be supported openly in doing so. It is not entirely clear that the prevailing culture within the Trust provides people with this freedom.

Finally, it is worth noting that not all these packages are mandatory. It is recognised that some of the people most in need of development will not make use of training provided. And while the packages should help develop a new cohort of leaders with the skills to tackle inappropriate behaviour, it is not clear that more established managers in the Trust refresh their knowledge of these topics.

Reverse/reciprocal mentoring
This is a comprehensive programme. One programme participant we spoke to found the process "invaluable". We would only note here some of the common concerns often made about co-mentoring programmes, namely: they inevitably only touch a small handful of people, they encourage senior staff to understand the concerns of the particular person they are liaising with (rather than cultural/structural issues facing all members of that group); and there is evidence to suggest the senior party ends up only supporting their partner with one-off support, rather than affecting wide-scale change in their department. So while this type of intervention might be useful, the research evidence on its effectiveness is mixed.

Awareness raising campaigns
The Trust has undertaken a couple of awareness raising campaigns recently which make explicit that bullying and harassment take different forms and that staff should not be wary of reporting unprofessional behaviour they have seen or experienced.

Whilst there are few robust evaluations of this sort of intervention, a review of interventions to address bullying/harassment for ACAS identified the limited effectiveness of approaches that rely on formal anti-bullying policies and procedures.[12] Formal policies and general awareness raising campaigns are insufficient in getting people to formally report problems (especially when surveys and research show they are unwilling to). These sorts of intervention are also quite often ineffective as they lead to a reliance on formal complaints mechanisms which can prevent early resolution.

A full list of interventions is outlined in Appendix 4.

3.5.2 RESOURCING

It is worth noting that there was appetite amongst HR business partners, Guardians, and others to pursue this agenda much more aggressively. It was common for people to question the quantity (rather than quality) of work the Trust is doing on this agenda. Most felt work on this topic is under-resourced, with staff delivering it in addition to other responsibilities. As

[12] Evesson, J. and Oxenbridge, S. (op cit)

such, there was a suggestion that some of the activities outlined in past action plans had slipped, or the scope to roll things out more widely was constrained.

3.5.3 CIVILITY

As mentioned, some of the training packages provided to staff touch on issues around incivility. Given the prominence it had in this review, however, it should perhaps have a higher profile with regards to the work the Trust is undertaking. Indeed, the impact of incivility on staff and on patient care is often under-estimated despite research showing its considerable impact.

3.5.4 LONGER TERM ISSUES

We did not undertake this review with the intention of reaching conclusions about existing bullying complaints. However, respondents kindly shared important data with us, in some cases in detail. A number of these cases had been subjected to drawn-out formal processes which do not seem to have addressed the root causes or provided satisfactory outcomes. In at least some cases they seem to have neither assisted resolution of concerns raised nor addressed underlying or wider causes. Some seem to have caused very significant stress for those who raised the concerns – and in some cases for those who were the subject of complaints.

Feedback from managers suggests formal mediation is a common tool used to resolve issues. Where this has failed, it is suggested that some of the parties have become intransigent in their views and are unwilling to concede on any issues (which is, of course, a prerequisite for mediation to work). We saw little evidence, however, of reflection on *why* particular individuals have become entrenched in their positions.

It is outside the scope of our remit to resolve individual cases but the Trust would benefit from reflecting on whether outstanding cases can be addressed through a different lens rather than the existing focus on formal processes. The new Medical Director and relevant clinical leads are attempting to resolve these issues through a more ‘human’ approach: regular check-ins with the individuals concerned, for example. This is to be welcomed. However, unless their conversations are accompanied by an understanding of some the issues these individuals have faced over many years, there is a danger this will have limited impact. Part of this understanding is an understanding of how racism plays out in the modern workplace.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

4.1.1 SCOPE AND PREVALENCE

Whilst this does not make the Trust an outlier, one in five respondents feel there is a culture of bullying within their team. This is a significant number and higher than we expect the Trust would wish. Similarly, NHS staff survey data, whilst not showing the Trust as an outlier shows overall levels of bullying higher than the Trust would wish to have.

Furthermore, there are clear hotspots of concern, most notably Anaesthetics, Critical Care and Theatres (with 36% of staff feeling there is a bullying culture there), Obstetrics and Gynaecology (34%), and Trauma (31%).

Survey data is consistent with a narrative arising from staff interviews: namely, that the Trust historically had an issue with inappropriate behaviour, but this has greatly improved in recent years for most people except doctors. The proportion of nurses currently reporting experiencing bullying or harassment, for example, is about one in 10: consistent with national staff survey data (although, again, undoubtedly higher than the Trust would wish). However, 18.7% of doctors are currently experiencing bullying or harassment, while 31% doctors report experiencing this from a colleague in the previous 24 months. This incident rate is 1.4 times higher than the Trust average. 49% of doctors attribute the bullying/harassment to their ethnicity.

Experiences of bullying/harassment from patients/visitors in the past two years for medical/dental staff and nurses and midwives may be particularly high. 26% of medical and dental staff have experienced this from a patient/visitor on at least one occasion in the past 24 months. 32% per cent of nurses and midwives have on one or more occasions.

Forty two per cent of medical/dental staff attribute bullying/harassment from the public to their ethnicity. This is high and should be a priority for the Trust to address.

4.1.2 NATURE AND TYPE OF BEHAVIOURS

The most common form bullying and harassment takes is incivility, rudeness, and a lack of kindness. BME staff are likely to talk about encountering micro-aggressions.

Doctors are more likely to raise these complaints than other members of staff. In particular, three ‘sites’ of harassment are apparent:

- emails;
- team meetings (“doctors should be able to cope with pressure”); and
- multidisciplinary meetings.

BME (in particular Asian) staff raised a number of concerns about the promotion and appointments process in the Trust. Many people pointed to the lack of diversity in the executive team, but also talked about leadership in the Trust more generally and how this is disproportionately White.

Participants relayed a number of examples of managers responding to issues with a lack of empathy or concern.

4.1.3 FACTORS THAT MAY PERPETUATE BULLYING/HARASSMENT

There is a perception that senior leaders in the Trust have failed to tackle inappropriate and unprofessional behaviour amongst some doctors in the past. It is not clear why this is, but a range of factors present themselves, including leaders being conflict averse, placing too much regard on expertise and status, and lacking the confidence to talk about race and racism. As a consequence of not being able to address unprofessional behaviours amongst those who are most senior, the power of these roles becomes amplified – which in turn makes some people in the organisation 'bullet proof'.

A lack of leadership at higher levels has left local, directorate managers feeling unsupported.

4.1.4 RESPONSES

Many of the interventions the Trust employs are necessary but not sufficient to tackle the issues outlined above. In particular, some aspects of organisational culture will blunt their effectiveness. Conflict-averse management approaches are particularly key here.

An overreliance on policies and processes means that energy is tied up in following processes, which in and of themselves do very little to change or challenge behaviours. The Trust is too slow to resolve issues informally. The prevailing tendency is to only progress complaints under the auspices of the Grievance Policy. The nature of many complaints – incivility and rudeness – mean victims are wary of doing so.

It is not clear to what extent the executive team and other senior leaders are aware of the scale of bullying and harassment. In part this is because staff are reluctant to report incidents. Many fear repercussions, are not convinced the Trust takes this issue seriously, and are worried they cannot meet the evidential standards the Trust demands under its Grievance Policy.

In addition, many senior leaders gauge the seriousness/scale of the problem by what they hear when walking the floor. However, their status and power mean staff (particularly lower banded staff) will not always raise with them concerns and worries they may have.

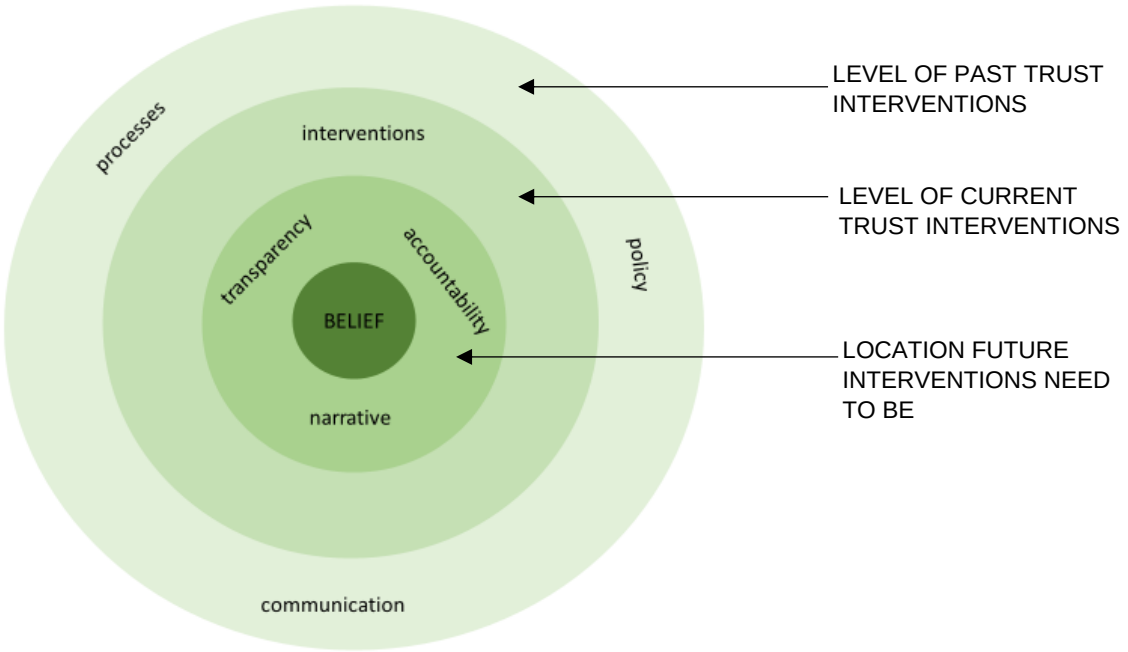
4.2 RECOMMENDATIONS

Vision and commitment

Most immediately, we would suggest the Trust needs a big, long-term plan to 're-humanise' the organisation. The Trust's existing culture has permitted, and continues to permit infringements in behaviour. While this is not condoned by senior leaders in the trust, the lack of a plan to proactively tackle a legacy of overlooking poor behaviours has allowed them to persist. This needs to be acknowledged, and the desire to create a more inclusive and equitable culture placed firmly on the table and reiterated frequently (so that it is believed).

As part of this plan, trust leadership will need to articulate a clear vision of the types of behaviours it expects to see, the activities it will undertake to promote these, and a rationale as to why this is important. The vision should explain how promoting more collegiate behaviours can help promote the trust's mission, values, and strategic objectives. In doing so it will make explicit the link between promoting more professional behaviour, staff experience, and the positive impact this will have on the issues staff care about the most – patient care and safety.

The diagram below outlines some of the factors required to affect behavioural change in organisations. In the past, we understand most of the Trust's work has focused at the outer level, on changes to policy, processes, and on awareness raising. Current efforts involve developing the kinds of interventions outlined in Appendix 4. Future work, we are suggesting, should aim to develop a clear narrative around this agenda and devise measures that will allow senior leaders to be held accountable on their ability to affect change. It is important to note, however, that ***all*** this is needed. There is an opportunity, for example, to issue a clear policy on patient choice: pointing out that patients do not have the right to discriminate (by asking for a white doctor, for example).



The Trust's existing culture surveys provide a range of useful measures of workplace experience. The Trust should work with staff to identify other measures of civility and compassion it can collect. Data relating to these measures should be presented to the Board, disaggregated by band, directorate, and ethnicity (as a minimum). Responsibility for improving reporting against these measures should lie with the Chief Executive.[13]

NHSi have recently issued a toolkit (which Roger Kline contributed to/wrote) on promoting cultures of civility and respect, which contains a useful framework and practical resources on how to progress this.[14] In addition to this, we would suggest focusing on the following six themes.

(i) Early intervention

The importance of early, informal intervention to resolve workplace issues has been widely noted.[15] As stated above, it is not entirely clear why HR colleagues formalise issues in the first instance. However, in other trusts, this often stems from a fear of pushback or challenge by the alleged perpetrator (particularly when the alleged perpetrator is a doctor). Being able to say policies are being followed and referring to the 'evidence' provided by the complainant are natural defence mechanisms. If this is the case, having a strong narrative around tackling unprofessional behaviour will help staff when dealing with pushback.

In 'lowering the waterline' HRBPs and managers will require backing from the Trust if they are to address unprofessional and inappropriate behaviour informally. As we have noted, though, there is appetite amongst HRBPs to work this way, and this enthusiasm needs to be leveraged.

HR colleagues may need support to work more informally. They will need to be able to recognise covert discriminatory behaviours and address deftly concerns people have about the *intent* behind their colleagues' behaviours and not just their *impact.* This type of work involves being able to hold 'braver' conversations to adequately interrupt poor behaviours before they escalate. Any new development process should enable HR colleagues to recognise micro-aggressions and micro-inequities and be more competent in talking about these and the impact of them in relationships between staff. An informal process to lessen micro-aggressions could be a specific target adopted by the Trust.

(ii) Support and development for leaders

Many of the interventions the Trust has employed are not directed at those who need them the most. Furthermore, at a fundamental level, there is a lack of awareness of how power is used or not used and the impact that this has on the organisation. We would highly recommend the Trust explore the use of the Diamond Power Index (DPI). The DPI is an individually employed 360º tool that is specifically designed to assess how leaders use their power. It works on how people 'experience' leadership: whether leaders are fair, empowering, and approachable, for example. These dimensions are central to some of the

[13] There is a wealth of evidence highlighting the importance of leaders and managers setting expectations for standards of behaviour within an organisation and ensuring these are maintained and monitored. See for example, BAPIO (2022) *Dignity at Work Standards*

[14] www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/civility-and-respect.

[15] For a recent example, see BAPIO (2022) op cit

existing leadership dilemmas within the Trust. Feedback to leaders on how they are experienced can be used in one-to-one coaching.

Furthermore, and in relation to those areas of the Trust where there are greater concerns, a team profile can be produced, using the individual feedback scores (see point (iii) on divisional/department specific work). The team profile is still confidential, but presents a holistic view of how leaders in the area are experienced and what the leadership team needs to do to take action.

The Trust may find it useful to create a managers peer support network to support managers to learn from best practice from those more experienced or working in some of the better-performing teams. This can function in both formal and informal ways.

All newly appointed clinical leads and directors without adequate managerial experience should receive a mentor for the first 12 months of their tenure. To ensure the relationship is beneficial, this should be built into both the mentor's and mentee's appraisal procedures.

Training packages should recognise head on barriers to implementation: in particular, how racism and respecting professional hierarchies can hinder the implementation of some of the course content. Given the distress poor behaviours create, the Trust should review the resources they offer to support staff and how these are deployed.

(iii) Division/department-specific work

There are some areas within the Trust – Anaesthetics, Critical Care and Theatres; Obstetrics and Gynaecology; Trauma – which would benefit from intack team leadership development. By this we mean that leaders of these teams should be given the opportunity to both individually and collectively appraise their leadership styles and approach. (The Diamond Power Index can also be used for this purpose.) There may also be opportunities for some of these departments to learn from other parts of the trust where bullying and harassment is less pervasive (see page 12).

The proportion of staff experiencing race-based harassment or abuse from patients/visitors is higher than we would expect and clearly unacceptable. The BMA has just this month issued useful guidance on this topic that addresses some practicalities involved in responding to patient discrimination.[16] We would recommend the Trust review this guide.

(iv) Management of meetings

Multidisciplinary meetings should be reviewed to ensure they take an educational, supportive approach. All teams could adopt a similar process and this could be embedded by a number of 'meeting gurus' whose role is to support teams to adopt similar standards.

(v) Recruitment and talent management

A key form of bullying and harassment identified by BME colleagues is a lack of fairness in the promotions and appointments process. As such, it may be useful to audit the Trust's

[16] https://www.bma.org.uk/media/5144/bma-guidance-on-how-to-deal-with-discrimination-from-patients-march-2022.pdf

recruitment and promotion processes against existing best practice. We have outlined what this looks like here[17], and distilled the lessons into a toolkit here[18].

(vi) Dealing with longer term grievances

There is a need to work intensively with particular individuals who have grievances going back a number of years. We have suggested the Trust's past approaches have failed to tackle the root causes of their concerns. The approach adopted by the new Medical Director and clinical leads is to be welcomed. However, to surface these individuals' underlying issues and deal with them in an emotionally competent way will require time and expertise. It may be beneficial to provide particular individuals with an (external) coach who can support them with their development.

[17] www.england.nhs.uk/east-of-england/nhs-east-of-england-equality-diversity-and-inclusion/publications-and-practical-resources/

[18] www.england.nhs.uk/east-of-england/wp-content/uploads/sites/47/2021/10/NHS-Practitioners-Guide-If-Your-Face-Fits_FINAL-2.pdf

APPENDIX 1: COMPARISONS OF UHNM STAFF SURVEY DATA

National Staff Survey theme results compared to benchmark trusts are over page.

Divisional outliers on the national staff survey themes: the NHS national staff survey reports a number of divisions were significant outliers on each of these themes (>0.5 difference). Nursing was significantly above average across all 10 themes. See next page.

THEME RESULTS COMPARED TO BENCHMARK TRUSTS

	EDI	Health + wellbeing	Immediate managers	Morale	Quality of care	Bullying + harassment	Violence	Safety culture	Engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1.	8.7	9.8	7.4	7.6	7.1
UHNM	9.1	5.9	6.5	6.0	7.5	8.0	9.4	6.7	6.9	6.1
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5.
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Change compared to (2016-20)average	0.1	0.1	0.0	0.0	0.1	0.1	(0.1)	0.0	0.0	0.0

DIVISIONAL OUTLIERS ON THE NATIONAL STAFF SURVEY THEMES

	EDI	Health + wellbeing	Immediate managers	Morale	Quality of care	Bullying + harassment	Violence	Safety culture	Engagement	Team working
Directorate 1										
Medicine Division						**0.6**				
Estates etc		**0.8**								
Directorate 2										
Anaesthetics etc		**0.6**								
Em Med	**0.5**					**1.3**	**0.9**			
Finance etc					**0.7**					
Spec Med						**0.5**				
Trauma						**0.6**				
Heart										**0.5**
Imaging		**0.8**	**0.6**							**0.9**
Nursing		**0.9**	**1.3**	**0.7**					**0.7**	**1.0**
ICT					**0.7**	**O.6**				**0.8**
Gen Med							**1.0**			
Obs + gyna					**0.7**					
Other		**1.1**	**0.7**			**0.8**				
Pathology			**0.6**							**0.8**
Soft FM			**0.5**							**0.6**

Spec Div m/ment		**0.7**								**0.8**
Surg Div mment		**0.6**								

Note.

1. Red figures are where the core is more than 0.5 worse than the Trust average
2. Green figures are where the score is more than 0.5 better than the Trust average

APPENDIX 2: RAG TABLES BY DIVISION

This tables below show positive scores for each question. The positive score is the percentage of respondents to whom the question applies, who gave a favourable response to each question. Only questions that can be positively scored have been included.

100.0%
>3 ppt above
<3 ppt below
In between

Description	Comparator (Organisation Overall)	Central Functions	Children's, Women's & Diagnostics	Estates, Facilities and PFI Division	Medicine Division	Specialised Division	Surgical Division
	n = 3506	n = 633	n = 917	n = 180	n = 664	n = 388	n = 724
1. Are you currently suffering bullying or harassment?	88.5%	94.6%	87.5%	92.1%	84.7%	88.4%	86.8%
2. Have you suffered bullying or harassment within the last two years that has stopped?	79.4%	82.8%	79.7%	88.4%	76.4%	80.4%	75.9%
3. Did you suffer bullying or harassment more than two years ago, but which has now stopped?	77.5%	79.8%	77.4%	87.4%	75.4%	77.5%	74.7%
5. Have you experienced bullying or harassment in the last 24 months from a MANAGER?	79.2%	83.3%	79.5%	84.6%	76.9%	78.4%	76.3%
8a. Did you feel that you were able to report the problem/issue?	27.7%	24.7%	26.6%	36.0%	30.4%	27.0%	27.2%
9. Have you experienced bullying or harassment in the	78.0%	85.3%	78.6%	90.3%	71.3%	77.4%	74.1%

last 24 months from a COLLEAGUE?							
12a. Did you feel that you were able to report the problem/issue?	45.7%	51.9%	45.3%	50.0%	45.2%	47.5%	42.5%
13. Have you experienced bullying or harassment in the last 24 months from PATIENTS OR VISITORS?	81.6%	93.5%	84.0%	95.5%	66.6%	77.9%	79.9%
16a. Did you feel that you were able to report the problem/issue?	62.7%	75.8%	65.6%	60.0%	63.1%	61.1%	55.3%
18. Do you feel there is a culture of bullying in your department?	73.1%	83.3%	68.8%	83.9%	72.8%	74.5%	65.8%
20a. Do you think levels of bullying/harassment are higher in some parts of the Trust compared to others?	14.9%	12.6%	11.6%	32.9%	14.5%	18.1%	15.0%

APPENDIX 3: RAG TABLES BY ETHNICITY

This tables below show positive scores for each question. The positive score is the percentage of respondents to whom the question applies, who gave a favourable response to each question. Only questions that can be positively scored have been included.

100.0%
>3 ppt above
<3 ppt below
In between

	Comparator (Organisation Overall)	BAME	White
Description	**n = 3506**	**n = 541**	**n = 2608**
1. Are you currently suffering bullying or harassment?	88.5%	79.5%	90.7%
2. Have you suffered bullying or harassment within the last two years that has stopped?	79.4%	77.4%	82.3%
3. Did you suffer bullying or harassment more than two years ago, but which has now stopped?	77.5%	80.9%	79.0%
5. Have you experienced bullying or harassment in the last 24 months from a MANAGER?	79.2%	77.8%	81.4%
8a. Did you feel that you were able to report the problem/issue?	27.7%	20.8%	30.0%
9. Have you experienced bullying or harassment in the last 24 months from a COLLEAGUE?	78.0%	69.2%	80.9%
12a. Did you feel that you were able to report the problem/issue?	45.7%	37.8%	48.7%

13. Have you experienced bullying or harassment in the last 24 months from PATIENTS OR VISITORS?	81.6%	78.6%	83.0%
16a. Did you feel that you were able to report the problem/issue?	62.7%	49.4%	67.9%
18. Do you feel there is a culture of bullying in your department?	73.1%	61.9%	75.2%
20a. Do you think levels of bullying/harassment are higher in some parts of the Trust compared to others?	14.9%	18.3%	13.6%

APPENDIX 4: TRUST B AND H INTERVENTIONS

INTERVENTION	IS THE INTERVENTION SHAREABLE? (Y/N)	IS FEEDBACK ON THE INTERVENTION SHAREABLE? (Y/N)
Civility and Respect work – task and finish group		
Cut it out campaign	Y	N
Comfortable Being Uncomfortable About Race sessions	Y	Y
Induction – mandatory inclusion and Dignity at Work session	Y	N
Induction – mandatory session on speaking up	N	Not yet
Reciprocal mentoring	Y	Y
Various staff networks	Y	N
Work in Confidence [understand this has been paused]		-
Masterclass on Taking the Heat Out of Conflict	Y	Not Yet
Masterclass on Belonging in the NHS	Y	Y
Connect leadership programme [sessions on role modelling behaviours]	Y	Y (for all of Gateway to Management)
Dignity at Work policy and related complaints procedure/mechanism	Y	
Holding up the mirror piece with estates and facilities department	Y	Y

APPENDIX 5: DATA TABLES

Fig 1: 'Are you currently suffering bullying or harassment?' by staff group

	Organisation Overall	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Yes	365	15	31	83	17	12	17	86	104
No	2805	137	339	924	150	93	140	321	701
Not sure	284	9	32	83	13	12	18	34	83
Total Responses	3454	161	402	1090	180	117	175	441	888

Fig 2: 'Have you suffered bullying or harassment within the last two years that has stopped?' by staff group

	Organisation Overall	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Yes	661	37	64	190	35	12	26	107	190
No	2552	116	312	844	135	94	140	291	620
Not sure	233	8	24	57	10	8	9	44	73
Total Responses	3446	161	400	1091	180	114	175	442	883

Fig 3: 'Are you currently suffering bullying or harassment?' by band grouping

	Organisation Overall	Band 1-4	Band 5-7	Band 8a-VSM	Doctor in Post-Graduate training, staff grade, associate specialist and specialty Doctor, consultant, others
Yes	365	89	131	26	74
No	2805	935	1096	255	296
Not sure	284	78	98	16	25
Total Responses	3454	1102	1325	297	395

Fig 4: 'Are you currently suffering bullying or harassment?' by directorate

	Organisation Overall	Child Health Directorate	Clinical Technology Directorate	Dir of Anaesthetics, Critical Care & Theatres	Dir of Emergency Medicine	Dir of Finance and Performance	Dir of General Medicine	Dir of General Surgery	Dir of ICT	Dir of Neurosciences	Dir of Quality & Safety Compliance
Yes	365	16	1	52	31	5	25	21	3	3	2
No	2805	121	25	277	141	69	149	141	99	57	15
Not sure	284	3	2	33	18	7	18	18	4	8	0
Total Responses	3454	140	28	362	190	81	192	180	106	68	17
	Dir of Specialist Medicine	Dir of Specialist Surgery	Dir of Trauma	EF&PFI Division Management	Estates	Heart Centre	Human Resources	Imaging Directorate	Med Div/Dir Management	Nursing	Obs & Gynae Directorate
Yes	33	13	20	0	4	10	1	31	2	3	18
No	160	147	91	24	30	122	50	134	54	83	121
Not sure	17	9	17	0	3	9	4	18	7	9	13
Total Responses	210	169	128	24	37	141	55	183	63	95	152
	Oncology & Haematology	Operations Directorate	Pathology Directorate	Performance Directorate	Pharmacy Directorate	Research Directorate	Soft FM	Specialised Division Management	Trust Offices		
Yes	10	10	26	2	3	3	8	6	3		
No	107	105	176	61	69	31	73	27	29		
Not sure	10	6	27	2	3	6	7	4	2		
Total Responses	127	121	229	65	75	40	88	37	34		

Fig 5: 'Have you suffered bullying or harassment within the last two years that has stopped?' by directorate

	Organisation Overall	Child Health Directorate	Clinical Technology Directorate	Dir of Anaesthetics, Critical Care & Theatres	Dir of Emergency Medicine	Dir of Finance and Performance	Dir of General Medicine	Dir of General Surgery	Dir of ICT	Dir of Neurosciences	Dir of Quality & Safety Compliance
Yes	661	22	7	99	41	6	45	34	17	7	2
No	2552	112	20	237	131	68	129	123	84	52	15
Not sure	233	7	1	23	19	7	17	23	5	8	0
Total Responses	3446	141	28	359	191	81	191	180	106	67	17

	Dir of Specialist Medicine	Dir of Specialist Surgery	Dir of Trauma	EF&PFI Division Management	Estates	Heart Centre	Human Resources	Imaging Directorate	Med Div/Dir Management	Nursing	Obs & Gynae Directorate
Yes	42	24	33	3	1	20	10	43	12	16	36
No	147	135	83	20	31	117	43	134	47	75	106
Not sure	19	10	13	1	5	6	2	5	4	4	9
Total Responses	208	169	129	24	37	143	55	182	63	95	151
	Oncology & Haematology	Operations Directorate	Pathology Directorate	Performance Directorate	Pharmacy Directorate	Research Directorate	Soft FM	Specialised Division Management	Trust Offices		
Yes	18	23	42	11	13	12	8	7	2		
No	99	93	172	53	60	26	74	23	31		
Not sure	10	5	14	1	2	2	3	7	1		
Total Responses	127	121	228	65	75	40	85	37	34		

Fig 6: 'Do you feel there is a culture of bullying in your department?' by directorate

	Organisation Overall	Child Health Directorate	Clinical Technology Directorate	Dir of Anaesthetics, Critical Care & Theatres	Dir of Emergency Medicine	Dir of Finance and Performance	Dir of General Medicine	Dir of General Surgery	Dir of ICT	Dir of Neurosciences	Dir of Quality & Safety Compliance
Yes	694	23	4	120	51	9	39	31	16	7	4
No	1889	90	22	133	91	51	109	101	60	43	10
Not sure	616	18	1	84	33	15	25	41	20	10	3
Total Responses	3199	131	27	337	175	75	173	173	96	60	17
	Dir of Specialist Medicine	Dir of Specialist Surgery	Dir of Trauma	EF&PFI Division Management	Estates	Heart Centre	Human Resources	Imaging Directorate	Med Div/Dir Management	Nursing	Obs & Gynae Directorate
Yes	41	26	36	3	3	21	10	38	4	8	47
No	122	106	65	17	26	89	30	85	40	67	59
Not sure	31	24	15	3	11	26	10	39	15	12	33
Total Responses	194	156	116	23	40	136	50	162	59	87	139
	Oncology & Haematology	Operations Directorate	Pathology Directorate	Performance Directorate	Pharmacy Directorate	Research Directorate	Soft FM	Specialised Division Management	Trust Offices		

Yes	23	16	62	4	12	9	14	10	2
No	76	74	104	47	39	14	60	19	27
Not sure	22	24	47	11	13	11	11	5	1
Total Responses	121	114	213	62	64	34	85	34	30

Fig 7: 'Have you experienced bullying or harassment in the last 24 months from a manager?' by division

	Organisation Overall	Central Functions	Children's, Women's & Diagnostics	Estates, Facilities and PFI Division	Medicine Division	Specialised Division	Surgical Division
Yes, on one occasion	210	31	56	5	43	24	51
Yes, on two or three occasions	235	36	60	14	39	27	59
Yes, on more than three occasions	261	36	65	8	65	30	57
No	2686	513	703	148	490	294	538
Total Responses	3392	616	884	175	637	375	705

Fig 8: 'Have you experienced bullying or harassment in the last 24 months from a MANAGER?' by directorate

	Organisation Overall	Child Health Directorate	Clinical Technology Directorate	Dir of Anaesthetics, Critical Care & Theatres	Dir of Emergency Medicine	Dir of Finance and Performance	Dir of General Medicine	Dir of General Surgery	Dir of ICT	Dir of Neurosciences	Dir of Quality & Safety Compliance
Yes, on one occasion	210	5	1	27	8	6	19	15	8	5	1
Yes, on two or three occasions	235	5	2	39	16	3	15	10	6	2	0
Yes, on more than three occasions	261	7	1	39	27	7	15	14	1	3	0
No	2686	123	23	253	137	64	139	143	86	54	16
Total Responses	3392	140	27	358	188	80	188	182	101	64	17
	Dir of Specialist Medicine	Dir of Specialist Surgery	Dir of Trauma	EF&PFI Division Management	Estates	Heart Centre	Human Resources	Imaging Directorate	Med Div/Dir Management	Nursing	Obs & Gynae Directorate
Yes, on one occasion	13	9	11	0	1	8	4	9	3	2	15
Yes, on two or three occasions	7	10	11	2	3	9	3	22	1	7	12

Yes, on more than three occasions	19	4	16	0	3	5	2	18	4	7	11
No	160	142	91	22	33	123	44	129	54	77	111
Total Responses	199	165	129	24	40	145	53	178	62	93	149

	Oncology & Haematology	Operations Directorate	Pathology Directorate	Performance Directorate	Pharmacy Directorate	Research Directorate	Soft FM	Specialised Division Management	Trust Offices
Yes, on one occasion	5	6	16	0	6	3	3	0	1
Yes, on two or three occasions	7	7	10	6	4	3	7	5	0
Yes, on more than three occasions	12	7	15	3	2	3	4	6	3
No	102	100	181	56	57	28	70	26	30
Total Responses	126	120	222	65	69	37	84	37	34

Fig 9: Grounds upon which people feel they have been bullied or harassed by a manager in the previous 24 months by band grouping

	Organisation Overall	Band 1-4	Band 5-7	Band 8a-VSM	Doctor in Post-Graduate training, staff grade, associate specialist and specialty Doctor, consultant, others
Age	87	27	40	5	7
Disability	60	24	30	2	3
Ethnicity	100	20	25	1	44
Sex	43	7	16	2	14
Sexual orientation	10	3	5	0	1
Religion or belief	17	2	3	1	11
Work performance	174	46	78	19	16
Other	428	119	181	45	51
Total Responses	663	187	274	58	93

Fig 10: 'Have you experienced bullying or harassment in the last 24 months from a COLLEAGUE?' by division

	Organisation Overall	Central Functions	Children's, Women's & Diagnostics	Estates, Facilities and PFI Division	Medicine Division	Specialised Division	Surgical Division
Yes, on one occasion	188	29	39	3	44	23	50
Yes, on two or three occasions	254	22	65	6	64	31	66
Yes, on more than three occasions	273	36	77	8	68	27	57
No	2538	505	665	158	438	278	494
Total Responses	3253	592	846	175	614	359	667

Fig 11: 'Have you experienced bullying or harassment in the last 24 months from a COLLEAGUE?' by division

	Organisation Overall	Child Health Directorate	Clinical Technology Directorate	Dir of Anaesthetics, Critical Care & Theatres	Dir of Emergency Medicine	Dir of Finance and Performance	Dir of General Medicine	Dir of General Surgery	Dir of ICT	Dir of Neurosciences	Dir of Quality & Safety Compliance
Yes, on one occasion	188	2	0	28	12	3	17	13	5	0	0
Yes, on two or three occasions	254	7	2	40	29	2	14	19	3	5	2
Yes, on more than three occasions	273	16	2	34	19	1	18	13	1	2	0
No	2538	110	22	236	116	67	130	127	89	56	15
Total Responses	3253	135	26	338	176	73	179	172	98	63	17
	Dir of Specialist Medicine	Dir of Specialist Surgery	Dir of Trauma	EF&PFI Division Management	Estates	Heart Centre	Human Resources	Imaging Directorate	Med Div/Dir Management	Nursing	Obs & Gynae Directorate
Yes, on one occasion	10	9	12	1	0	9	5	7	5	4	7
Yes, on two or three occasions	17	7	15	0	2	9	2	11	4	5	18
Yes, on more than three occasions	28	10	15	1	1	7	3	20	3	10	14
No	143	131	82	21	36	112	42	127	49	71	104
Total Responses	198	157	124	23	39	137	52	165	61	90	143

	Oncology & Haematology	Operations Directorate	Pathology Directorate	Performance Directorate	Pharmacy Directorate	Research Directorate	Soft FM	Specialised Division Management	Trust Offices
Yes, on one occasion	6	9	15	0	2	1	2	2	2
Yes, on two or three occasions	8	5	18	3	3	0	2	2	0
Yes, on more than three occasions	7	11	17	1	3	6	4	3	1
No	101	91	166	59	57	28	79	28	29
Total Responses	122	116	216	63	65	35	87	35	32

Fig 12: Have you experienced bullying or harassment in the last 24 months from a COLLEAGUE?' by band grouping

	Organisation Overall	Band 1-4	Band 5-7	Band 8a-VSM	Doctor in Post-Graduate training, staff grade, associate specialist and specialty Doctor, consultant, others
Yes, on one occasion	188	52	78	16	28
Yes, on two or three occasions	254	58	107	15	49
Yes, on more than three occasions	273	79	108	21	45
No	2538	900	1026	248	266
Total Responses	3253	1089	1319	300	388

Fig 13: 'grounds upon which respondents feel they have been bullied/harassed by a colleague' by band grouping

	Organisation Overall	Band 1-4	Band 5-7	Band 8a-VSM	Doctor in Post-Graduate training, staff grade, associate specialist and specialty Doctor, consultant, others
Age	91	26	47	6	10
Disability	36	9	22	0	5
Ethnicity	139	26	45	1	59
Sex	60	12	23	2	20
Sexual orientation	13	6	6	0	1
Religion or belief	26	6	4	1	13
Work performance	187	57	90	12	24
Other	413	125	172	37	56

Total Responses	690	201	286	47	120

Fig 14: grounds upon which respondents feel they have been bullied/harassed by a patient/visitor by staff group

	Organisation Overall	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Age	47	1	7	4	7	1	2	4	21
Disability	11	0	1	1	1	1	0	3	4
Ethnicity	117	2	19	4	5	3	1	40	43
Sex	63	2	7	5	6	1	3	16	23
Sexual orientation	12	0	2	1	1	0	0	1	7
Religion or belief	28	1	1	3	2	0	0	7	14
Work performance	105	1	12	27	5	1	1	14	44
Other	328	7	24	73	18	7	8	45	146
Total Responses	554	11	56	101	31	10	13	95	237

Fig 15: Have you experienced bullying or harassment in the last 24 months from patients or visitors?' by directorate

	Organisation Overall	Child Health Directorate	Clinical Technology Directorate	Dir of Anaesthetics, Critical Care & Theatres	Dir of Emergency Medicine	Dir of Finance and Performance	Dir of General Medicine	Dir of General Surgery	Dir of ICT	Dir of Neurosciences	Dir of Quality & Safety Compliance
Yes, on one occasion	184	8	0	23	13	0	26	19	0	5	0
Yes, on two or three occasions	246	14	0	26	28	0	16	14	1	6	0
Yes, on more than three occasions	171	18	0	14	40	2	15	10	1	6	0
No	2657	96	27	281	95	74	121	131	95	45	17
Total Responses	3258	136	27	344	176	76	178	174	97	62	17
	Dir of Specialist Medicine	Dir of Specialist Surgery	Dir of Trauma	EF&PFI Division Management	Estates	Heart Centre	Human Resources	Imaging Directorate	Med Div/Dir Management	Nursing	Obs & Gynae Directorate
Yes, on one occasion	14	13	10	1	2	7	0	12	2	2	10
Yes, on two or three occasions	26	17	16	0	1	7	0	10	4	7	15

Yes, on more than three occasions	16	1	10	0	0	5	0	6	3	5	7
No	137	131	88	22	37	118	51	141	51	73	111
Total Responses	193	162	124	23	40	137	51	169	60	87	143

	Oncology & Haematology	Operations Directorate	Pathology Directorate	Performance Directorate	Pharmacy Directorate	Research Directorate	Soft FM	Specialised Division Management	Trust Offices
Yes, on one occasion	4	2	2	0	3	0	1	2	1
Yes, on two or three occasions	12	8	6	1	3	0	2	5	1
Yes, on more than three occasions	3	4	3	0	0	0	1	0	0
No	103	102	204	62	60	33	83	27	28
Total Responses	122	116	215	63	66	33	87	34	30