BULLYING AND HARASSMENT AT THE LEWISHAM AND GREENWICH NHS TRUST

An Independent Inquiry Report

This document contains the report of the Investigating Officer in pursuance of the Terms of Reference set by
Ben Travis, CEO, Lewisham and Greenwich NHS Trust

Ashfold CONSULTING

Andrew Gent
Director

Preface

Since I joined the Trust, it has been clear that we need to do more to make sure that all staff feel respected, valued and supported. Whilst I've met many staff who have a great experience of working here, I've also spoken to a number of people who have told me about their experiences of bullying and harassment.

Bullying and harassment is recognised as an issue across the NHS as a whole. It's a real concern that our staff survey showed that 29 per cent of staff at this Trust reported problems with bullying and harassment, against a national average of 24 per cent. So I commissioned this independent assessment to find out more from people who have experienced problems and from those involved in handling these issues.

I wanted to give a voice to those who feel that the system has let them down. That's why we have spoken to people who have reported concerns, and I'd like to thank everyone who has shared their experiences for this report. Whilst the report does not represent the views of everyone who works here, it does show the experiences of many members of staff. We need to make this a great place to work for everyone, and understanding the views of those who've not had great experiences is essential for this.

When we commissioned this assessment, we knew that it would make difficult reading. We are sharing this with you as we need to be open and transparent. It's clear that there have been many cases of bullying and harassment in the Trust and, as a leadership team, we've not done enough to tackle this. This includes improving how we investigate cases and supporting anyone who reports concerns.

I want to assure you of my personal commitment to addressing these issues. Our next step is to develop a full action plan to tackle bullying and harassment, in line with the recommendations of this report. We've set up open staff meetings for the next two years to report to you on progress and we will be publicising the dates widely in our Staff Updates and on the intranet. In addition, we will appoint a group to hold us to account on this work. This will be led by an independent chair and will include staff representatives. We will be working closely with our staff-side (the unions in the Trust) and the equality and diversity network on all this.

I want to apologise to anyone in the Trust who has experienced bullying and harassment. This is a watershed moment for the Trust and we need to be clear: bullying and harassment will not be tolerated in any part of the organisation. We recognise that people are working under pressure. However, this doesn't excuse bullying, and we need to do more to become an organisation that supports all our staff. The important thing is that we learn so that we can make the changes that are needed to do this. We need to come together and have the confidence to live our values and challenge others to do so.

Ben Travis
Chief Executive

Message from Mike Davey, Staff Side Chair

We have been fully involved throughout the process of the neutral assessment and very much welcome the publication of this report and the recommendations contained within it. For us the subject of bullying and harassment has been a long standing agenda item, both within the Trust and the wider NHS itself, and so again we very much welcome the strong commitment from the CEO and the Trust Executive to tackling these issues here at Lewisham and Greenwich NHS Trust. This includes inviting external scrutiny to hold the organisation to account and to ensure the Trust makes genuine and tangible improvements for staff. As always, we will continue to support our members who are affected by bullying and harassment, while working in close partnership with the Trust to ensure that it delivers on its action plan to address the fundamental problem.

Message from Manisha Patel, Chair of Equality and Diversity Inclusion Network

The Equality and Diversity Inclusion (EDI) network was set up by the Trust for staff who want to support the organisation in becoming more accessible and inclusive for everyone. We have been fully involved in the neutral assessment into bullying and harassment and it was great to see so many people attending the staff workshops to discuss the recommendations. There is a strong commitment from the very top to addressing the issues in the report, making the Trust a great place to work for everyone. We will be working closely with the Trust and with staff to deliver the recommendations and to support this work.

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Executive Summary

This report is the outcome of a three-month inquiry into bullying and harassment (B&H) at Lewisham and Greenwich NHS Trust (LGT). It is important to emphasise that this inquiry takes the form of a neutral evaluation, and is not a study or an investigation into any individual allegations. I have no jurisdiction other to report on what I have found, providing advice and identifying necessary actions.

Using a study of key internal documents and data, over 50, mainly one-to-one, interviews involving over 75 people and conducting six workshops, the report provides an assessment of the levels, handling and culture affecting B&H in the Trust. To ensure appropriate context, reference has been made to relevant published studies and reports on the subject. This report is a commissioned inquiry conducted by Andrew Gent of Ashfold Consulting Limited for the Chief Executive Officer (CEO)of LGT.

Principal Key Findings

- Whilst bullying in the Trust is not described as institutionalised, it is however widespread in that it is evident across all sites, in all divisions, at all levels and perpetrated by managerial, non-managerial and clinical staff. To this extent, it is embedded in the culture of the organisation.

- The prevalence of overt bullying, both witnessed and reported, particularly at the most senior levels, coupled not only with a lack of visible action to address it, but a *laissez faire* attitude which appears to condone it, can be interpreted as a lack of willingness to recognise and tackle bullying behaviour. This apparent inaction has damaged the reputation and credibility of the executive leadership, as it existed at that time, both at a collective and, in some cases, individual level.

- The level of complaints and evidence of poor case timeliness, together with negative descriptions of processes and policies lead me to the conclusion that case management is sub-standard. Whilst the creation of the Employee Relations (ER) team and the introduction of a new case management software are welcome changes, these need to be built upon to drive change and place the ER Team at the centre of a credible, reliable and trusted ER case management process. This is a key priority.

- There are, within the Trust, teams and individuals whose behaviour and performance remain a concern. It is a relatively straight forward exercise to conduct a level of analysis with the current data sets and apply a forensic and justifiable approach to identifying and tackling these problems. This issue should be addressed as a matter of priority.

Principal Recommendations

- The past failures of the senior team are publicly acknowledged, and the CEO now develops the senior leadership team in a way that gives confidence to the workforce that change will be effected, and that the team understand the expectations of staff in this regard.

- The Trust builds upon the recent changes to the Employee Relations (ER) Team to enhance its recording, case management, investigative and the decision-making capacity including providing a level of investigative capability and developing case management Key Performance Indicators (KPIs).

- That a Behavioural Standards Policy or Framework is created which clarifies the expected standards of behaviour of all staff and is drawn from the Trust values, professional codes of conduct and bullying and harassment negative behaviours.

- A strategy is devised to identify and appropriately tackle those staff subject of or making repeated complaints and this is acted upon as a matter of priority.

- A strategy is devised to identify those teams where behaviour or performance presents as problematic with a view to making appropriate interventions to address the issues.

Main Context

- The problems of bullying and harassment in the workplace have been well documented and understood for decades. The health, social care and wider public sector are 'hotspots' for bullying and harassment (B&H), which is recognised as a major issue in the NHS.

- Bullying and harassment have unfavourable consequences for effective organisational performance, specifically through increased sickness absence, reduced productivity, higher levels of employee turnover and directly impacting the potential for new entrants into the NHS labour market.

- Negative behaviours, a lack of challenge to such behaviours, organisational change, hierarchy and power, destructive management and leadership styles, and a broad range of stressors around a lack of job autonomy, insufficient resources, ineffective and poor levels of employee and management support are all potential contributory factors for bullying and ill-treatment.

- The culture of an organisation is defined by the role modelling of its leadership as employees closely and carefully monitor leader and manager behaviours.

- The 2017 NHS Staff Survey identified that the Trust had a 5% higher score for 'B&H from other staff' compared to the average score for similar trusts (29% versus 24%).

Other Key Findings

- The number of reported cases reflects a significant level of under reporting in comparison to the staff survey, exit interviews and other indicative data. A position exacerbated by an unwillingness to report B&H issues due to complex and poorly understood reporting channels, a significant level of mistrust of the process, and a resignation that little will happen in any event.

- Effective data collection and analysis is extremely limited masking the true picture, impacts and costs. The inability to maximise valuable data sources, particularly exit interviews and ER case data, deprives the Trust of an early warning system from which it can take appropriate action. In this regard the Trust is "*data rich but intelligence poor.*"

- The role of Workforce and Education in this context is one of advice, oversight and governance, therefore drawing the ER resources together as one team with a new Head of ER post is a welcome step forward, as is the acquisition of new case management software. However, the strength of feeling and views expressed about the service received and the Workforce role should not be underestimated or disregarded, as they are real and represent a challenge to rebuilding trust in the system. Moreover, there is unlikely to be fundamental change until a full overhaul of the policies and procedures has taken place.

- The foundation to any performance or people management process is a recognition that the role of the supervisor or manager is to provide a level of day to day advice and direction, making interventions when appropriate, challenging negative behaviour or performance where necessary and acknowledging positive performance. However, many managers, particularly those in 'first time' people management roles, do not have the skills or confidence to manage difficult conversations. As a consequence, much behaviour goes unchallenged and escalates to a point where formal procedures are engaged.

- There is a clear deficit of available skilled workplace investigators, the demand for which will depend on the investigation model Trust choses to use. This model needs

to be determined quickly and a training regime implemented to provide quality investigation training.

- The ER suite of policies lack synergy, are too lengthy, too complex and in need of overhaul to streamline processes, bring them up to date and make them more user friendly.

- Key to addressing B&H is top level leadership. Although there have been a number of recent changes at Board level, there remain questions over their commitment to change, a position influenced by the recent past. Additionally, senior clinicians and general managers below the executive must recognise their role in an organisational culture that has left many staff feeling unhappy, anxious and unsupported. Whilst a new CEO has recently been appointed, it is critical that he now develops the senior leadership team in a way that gives confidence to the wider workforce that change will be affected.

- There is no real referencing between the Trust values, B&H behaviours and the professional codes of conduct. The positive reverse of B&H behaviours have much in common with the values of the Trust and those behavioural expectations of the various professional codes and NHS Constitution. There is a real benefit to concentrating the behaviours expected to be demonstrated, and those that are not, into one accessible and recognised behavioural document.

- The use of Performance and Development Reviews (PDRs) as a powerful and appropriate tool for holding individuals to account in relation to values and behaviour is readily accepted by many staff. It is acknowledged that the PDR process is transitioning from paper to an electronic system, none the less the process is regarded by many staff as ineffective and a 'tick box' exercise.

- A holistic suite of KPIs relating to key ER issues is absent. The lack of a published 'balanced score card' deprives the Trust of a tool to hold managers to account. Moreover, managers are unable to determine performance and therefore what needs to be addressed and staff will not have the opportunity to understand and discuss solutions.

- The Workforce and Education Department is regarded as the creator and guardian of the policies, overseer of the accompanying procedures and 'flag bearer' for the principles underpinning those policies. The wider staff have a right to expect those responsibilities will be applied fairly, impartially and, where it is obvious that processes or the principles are not being adhered to, that there is appropriate challenge and intervention. Unfortunately, in too many instances this has not been

the case and the image of the department in this area has, in the eyes of many, been damaged. In pursuing the new Workforce strategy there must be heavy emphasis on meeting the expectations of staff, re-establishing trust and restoring confidence given their critical role in tackling many ER issues including B&H.

- All staff, but particularly managers and consultants, need a heightened awareness of negative behaviours and poor leadership/management behaviours that lead to perceptions of B&H, or are not in keeping with Trust values.

Key recommendations

It is recommended that:

- The mechanisms for reporting wrong doing are reviewed to produce clear and accessible reporting channels including the introduction of an independent confidential reporting line.

- An Information Management Strategy is devised with a view to the collation, analysis and publication of key data sets to provide for a greater understanding of the issues and target interventions.

- The Trust reviews the structure, training and use of workplace investigators.

- Relevant policies are reviewed and revised to ensure they are fit for the effective management of behavioural issues of all members of staff including; the introduction of a management action file note procedure and publishing all formal disciplinary hearing outcomes.

- The content, use and training of PDRs is reviewed to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus and a positive emphasis on individual development needs.

- An appropriate KPI regime is introduced which recognises the key indices upon which to measure B&H performance and hold managers to account at a Trust, Divisional and Team level.

- An education programme should be put in place for all staff to heighten awareness of B&H negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how staff should respond when they are recipients of such behaviour.

- All managers, particularly those in foundation management role or new to post should receive appropriate training for managers to provide the skills and confidence to challenge poor behaviour by managing difficult conversions or difficult people.

Underpinning all the recommendations in this report is the need for broad cultural change and the need to restore the trust and confidence of the staff in the leadership, processes and systems through which poor behaviour is managed. Delivering such change will require a genuine and demonstrable commitment on the part of the Board and senior leadership, including recognition that it will be difficult to build confidence that there will be fundamental change, particularly if some of those expected to be the levers of change are regarded as part of the change that is needed.

There is now a responsibility to act and I am confident that the new CEO will ensure a swift and appropriate response to this inquiry. The findings in this report and the recommendations made will, I hope, be of real assistance in that task. I recognise that some recommendations, and the actions required to make them effective, may challenge thinking around workforce policies and practices that have been shaped by years of NHS HR tradition or culture. Such is the scale of the bullying and harassment problem, both within the Trust and wider NHS, I believe the current situation presents an opportunity for the Trust to take a more enterprising, if not radical, approach to effect sustainable and long-term change.

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Introduction

Investigator Qualifications

I am an Investigator with over 40 years investigative experience, ten years of which as Head of Investigations in the Professional Standards Department of two police forces. I am nationally accredited across a broad range of investigative disciplines including serious incidents, public complaints, counter corruption, workplace grievances and misconduct matters. I am an ILM Qualified Workplace Investigator, a member of the Association of Workplace Investigators and an OCN Accredited Mediator. I have 20 years senior management experience in a number of public sector organisations and have conducted a number of inquiries with a wide-ranging organisational scope.

I bring to this inquiry what I regard as valuable experience, an extensive background in investigating and managing difficult employee relations issues and many years' experience of representing, advising and training both employers and employees on bullying and harassment in the workplace. I also have a clear understanding of the policies, procedures and skills required to address these issues effectively. I have drawn on this experience in considering all the information provided to this inquiry and in making recommendations about what needs to be done.

Background

This inquiry arose as a result of concerns raised with the CEO regarding a number of responses received from staff during the Leadership Capacity Review, conducted by the Trust in late spring of this year. Whilst these concerns related to potential bullying behaviour at the highest levels in the Trust, the CEO was aware of underlying concerns of wider spread bullying and harassment throughout the organisation, which appeared to be reflected in the Staff Surveys, Exit Interviews and emails sent to him personally.

A decision was made to appoint an external, independent investigator to conduct an inquiry into the extent of bullying and harassment within Lewisham and Greenwich NHS Trust (LGT). The Terms of Reference (ToR) were constructed accordingly and on 1st August I was formally commissioned to conduct the inquiry on a 'neutral evaluation' basis and to report by 1st November 2018.

Confidentiality Caveat

This report has been written to fulfil the Terms of Reference (ToR) and as such contains information and observations designed to openly inform both the Trust Board and wider staff of the findings of the inquiry. However, given the nature of the inquiry, the ToR and the methodology adopted, it is inevitable that details of cases, allegations of bullying, potential perpetrators and targets would be disclosed or discovered.

Clearly the open publication of such confidential information is both inappropriate and unnecessary. As mentioned below, any details received, which in my view, pointed to a significant and immediate intervention being required would be passed to senior Workforce personnel to facilitate an intervention.

Terms of Reference

1. *Carry out a neutral evaluation of the levels, handling and cultural issues affecting instances of bullying and harassment across the Trust over the last 3 years*

The Consultant will be provided with a bundle of documents in order to be able to carry out this evaluation, including but not restricted to:

1. *Trust policies on disciplinary, grievance, bullying & harassment, performance and mediation*
2. *Staff Surveys for last 3 years*
3. *Medical Engagement Scale Reports for 3 years*
4. *CQC Reports*
5. *Grievance, conduct, performance statistics and analysis for last 3 years*
6. *Numbers of ER cases relating to harassment and bullying which have resulted in ET, dismissal for SOSR or settlement agreement*
7. *The recent consultant's report on the "Leadership Capacity Review"*
8. *Summary of exit interviews for the last three years*
9. *Trusts vision and values statement or program*
10. *Outline of Leadership Training or other training provided to managers relating to B&H and / or managing difficult situations or people*

The consultant may also conduct interviews with:

1. *Staff Associations*
2. *Freedom to Speak Up Guardians*
3. *HR ER team*
4. *Operational Teams*
5. *Other Internal or external stakeholders as directed*

2. *Report to the CEO on the findings of the above enquiries including any recommendations for action as part of a plan to improve the Trusts approach to harassment and bullying issues.*

Inquiry Scope, Caveats and Terminology

The Inquiry has invited Trust staff and others with relevant perspectives (including staff representatives) to offer in person or in writing their experiences of perceived bullying and harassment. All contributions will be treated in strict confidence and will not be published or liable to release. Any references to such information in this or any report arising from the Inquiry will be anonymised and quotes will not be attributable.

It is not the purpose of the inquiry to reopen past complaints of bullying or harassment or to investigate new ones against particular individuals. It is hoped that the opportunity offered to Trust staff to present their experiences to an independent third party, in confidence, may help them to achieve closure, where appropriate.

Neither was there any intention of inquiring into the specific workings of any department or division. That said, like most inquiries of this nature, it will touch on the construct, application and effect of relevant policies and procedures. In this context it is inevitable that a light will be shone on parts of Workforce and Education (WED), not only as organisational owners of the key policies and procedures but as stewards of the entire system and guardians of the standards and principles underpinning them. In this context I use the word 'system' to mean the entirety of the policy, procedure and related processes.

Throughout the report I reference levels of management and leadership, and in a similar vein clinical and operational functional teams. Given the wide range of roles and bandings, together with a complex and changing organisational structure, I have made some assumptions or interpretations based on my understanding and I apologise if this understanding or nomenclature is not wholly correct.

Board – means the executive directors and non-executive directors of the Trust
Executive or **Executive Team** - means the executives
Senior Team / Senior Leadership Team – means the executives and senior management strata directly below the executives, the Trust Management Executive. (TME)
Senior Managers – means those fulfilling a management role mainly at band eight or nine
Leadership – means those fulfilling any role managing people or any other role that has influence or power, including in a clinical context e.g. doctors, particularly consultants
Divisions -means Clinical and Corporate Divisions
Teams – means clinical specialties and wards in a clinical setting or other operational teams in a corporate context
Workforce – means Workforce and Education Department (WED)
HR – means Human Resources and has been used in different contexts. It has been used to mean the wider accepted Human Resources functions and is how WED has been described by many staff.

The inquiry aimed to present preliminary findings to the CEO before the end of October, depending on the numbers of people who come forward, and a Final Report as soon as reasonably practicable thereafter.

However, the large number of people who wished to contribute to the inquiry, the sheer volume of information they provided including workshop feedback was such that the information gathering phase of the inquiry continued until the beginning of December. It was therefore not possible to present the findings in the timescales originally agreed.

Inquiry Methodology

The basic methodology of all inquiries is the examination of key documents, data sets and the obtaining of witness accounts. Although this inquiry is not a study, as many of the recently published reports on bullying and harassment have been, I felt it appropriate to consider the findings of those reports. This has been particularly so given their relevance to the subject, the nature of the recommendations and their applicability to this inquiry. Accordingly, I have referenced key reports and, where appropriate, relevant research that underpins or explains my findings and conclusions. Below I outline the key documents upon which I relied, a full list is contained in Appendix A.

Data

- Staff Survey 2017;
- Sickness Absence;
- Vacancy Rates;
- Temporary and Agency Staffing Levels;
- Exit Interviews Summaries;
- Complaints and PALs data; and
- ER Case Data

Documents

- Exit Interview Reports and Summaries;
- PDR content and the Online Appraisal manual; and
- Various emails and documented submissions.

Policies

- Grievance and Disciplinary;
- Capability;
- Dignity at Work -Bullying and Harassment;
- Sickness absence;
- Speak Up – Whistleblowing; and
- MHPS Policy

Other Key Reports and Research

- The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings – A study by University of Bradford (2010);
- Bullying & Harassment at the South East Coast Ambulance NHS Foundation Trust: An Independent Report (2017);
- Bullying and harassment: how to address it and create a supportive and inclusive culture -BMA (2018);

- The Bullying and Harassment of House Of Commons Staff: An Independent Inquiry Report (2018);
- Workplace Culture at Whittington Health NHS Trust: An Independent Report (2018); and
- The price of fear: estimating the financial cost of bullying and harassment to the NHS in England (2018)

Interviews

The interviews carried out fell into three discrete sets:

- Staff who, by virtue of job role, would provide key evidence;
- Staff who were suggested to me by Workforce or other interviewees or those identified by myself; and
- Staff who came forward wishing to contribute.

The fact that the inquiry was being conducted was publicised to the wider workforce, together with an invitation to contribute to the interviews. The selection of other staff to be interviewed was contained in the terms of reference (ToR) or directed by the senior leadership of Workforce, whose administrative support organised the interview schedule. The reason for an interviewee being scheduled was, in most cases, was unknown to me until I began the interview. I did identify some candidates for interview based on their role or having been named by other interviewee's, but these were minimal. Towards the end of the interviewing process it was evident I was seeing people who had elected to speak with me as the level of confidence in the inquiry grew.

As this was not a in depth study, the range of interviews was restricted, in the main, to those identified by the Trust and volunteers. The contributors involved staff from all sites, representing most divisions, occupational groups, managerial and non-managerial roles. I am satisfied that I have seen more than sufficient to fulfil my terms of reference. Whilst retaining confidentiality, and to provide a broad overview of the range of interviewees included, I highlight the following:

- Board members;
- WED staff;
- TME members (clinical and corporate);
- Other senior managers (clinical and corporate);
- Chairs of a number of representative groups;
- Individuals involved in past or current cases;
- Staff Side, EDI and Freedom to Speak Up Guardians; and
- Other volunteers

In order to provide a consistent and structured interview, I utilised a guide at the outset of the interview process and has been attached at Appendix A. However, this approach became less critical when interviewing a number of interviewees who wished to provide accounts of their own experiences.

There has been significant engagement with this inquiry from both current and former members of staff and I have received information from over 75 people. The reliving of traumatic experiences can be painful and distressing, and I am extremely grateful to everyone who came forward and provided such helpful information and observations.

The contributions therefore contained information from across the Trust, from staff working at all levels, as to the prevailing culture in the Trust, incidents of alleged bullying and harassment, the level of support for those subjected to such treatment, the adequacy of procedures and views about necessary changes.

The accounts describe behaviour of managers, colleagues and include medical staff. None of those descriptions were based on hearsay. The accounts given related to incidents in which the interviewees had themselves been directly involved, or that they had witnessed happening to others. The number and breadth of the contributions have provided a deal of information and some invaluable insights. They also revealed some clear patterns and themes. In accordance with the assurance as to confidentiality, there is nothing in this report which could lead directly or indirectly to the identification of any contributor.

The giving of information in confidence in this way can be criticised as providing a platform for disgruntled employees. The compelling counter argument however, as is now well understood, is that people who have been bullied or harassed, or who have seen this happen to others, are generally reluctant to come forward and report it. Less than 15% of the people contributing by way of interviews and submissions referred to formal cases in which they were either alleged perpetrators or targets. In addition to these, nearly 50% been subject to or witnessed bullying behaviour and either did not report it or act formally upon it. As an aside, this in itself is a little concerning given the substantial cohort of senior managers and senior leadership who made up the interview process and may be an issue that needs attention from the Board. Therefore, the interviews are far from being the observations of a discontented few, but rather they provide, in my view, a sound basis for the findings and recommendations set out in this report.

Throughout this report, I have included a number of direct quotes from interviewees, which are italicised. These put into words the depth of feeling and the genuine concerns of Trust staff. Each quote is generally representative of views that many others also expressed.

Overall, the information given to the inquiry has been detailed, thoughtful and measured. In my view, there was a general lack of exaggeration and a willingness to acknowledge personal failings, which indicated some careful reflection. Everyone who attended meetings spoke freely and frankly. People welcomed the opportunity to speak about matters and were fully cooperative. Much of what they had to say reflected the pride that members of staff have in working for the NHS, but that generally served to emphasise the level of resentment and unhappiness about their experience of working in the Trust.

Staff Workshops

As the Inquiry developed it was felt appropriate to expose some key findings and associated recommendations to workshops, with a view to validating some of my findings and testing the practicality of the emerging recommendations. The workshops were made up of staff expressing an interest in assisting the process following advertising of the workshops to all staff.

The workshops were held over two days and were attended by 115 people, two thirds of whom I had not previously met. The range of attendees was fairly broad in relation to ethnicity, managerial, non-managerial, clinical and medical staff. These workshops were extremely useful and reflected a significant level of support for the findings and recommendations together with some practical considerations which, where appropriate, have been included in this report. A copy of the recommendations placed before the workshops is included in Appendix B.

During and post these workshop events there remained a desire by staff to come forward and add their experiences to my inquiry. The general tenor of the wider discussions underlined my assessment of the cultural and leadership dimensions to the B&H problems in the Trust and reinforced the expectation that positive action will be taken following the completion of this report.

Context

Workplace Bullying and Harassment

The problems of bullying and harassment in the workplace have been well documented and understood for decades, as observed by Lewis (2018):

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

Research shows that larger, complex organizations, which are equipped with policies and practices designed to tackle bullying, were more likely to experience the phenomenon (Fevre et al., 2012). That research demonstrated that managers and supervisors are often cited as the perpetrators of the behaviours many employees label as 'bullying', but that co-workers, clients/patients and families of patients can also be perpetrators (Fevre et al., 2011).

Research evidence shows that effective leadership and management, along with a range of employee support such as occupational health and counselling services, buffers the effects of bullying whilst their absence exacerbates it (Lewis et al., 2016).

Workplace Bullying and Harassment in the NHS

The 2013 Francis Report into the Mid Staffordshire NHS Foundation Trust reported how a culture of bullying can harm an NHS organization. Bullying can affect the ability of staff to undertake everyday tasks, which ultimately impacts patients. It should therefore come as no surprise that bullying and harassment have unfavourable consequences for effective organisational performance, specifically through increased sickness absence, reduced productivity, higher levels of employee turnover, directly impacting the potential for new entrants into the NHS labour market, excessive litigation costs, damaged organisational reputation and of course patient experiences (Francis, 2013).

It has been reported how health and social care, and the public sector more generally in Britain were hotspots for bullying and mistreatment.

Within a British health and social care context, Fevre et al., (2012) reported that negative behaviours associated with incivility and disrespect were the most prevalent, but also that

behaviours associated with unreasonable management in the form of demands and expectations also helped explain how employees feel ill-treated at work.

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

The Meaning of Bullying and Harassment

The terms "bullying" and "harassment" can mean different things to different people and it is important to understand what they mean in this context, and what I mean in using these terms. I have not sought to deal with the legalities or the legal liabilities of individuals or the Trust other than to say that harassment on the basis of a protected characteristic may be considered discriminatory under the Equality Act 2010. Also relevant is the employer's duty under the Health and Safety at Work Act 1974 to protect employees from work related violence, which includes acts of bullying and harassment.

ACAS have described bullying and harassment together as "*offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious, or it may be insidious. It may be persistent or an isolated incident. It can also occur in written communications, by phone or through email, not just face to face. Whatever form it takes, it is unwarranted and unwelcome to the individual.*"

The important question is whether the actions or words are viewed as detrimental and unacceptable to the target. It is the deed itself and its impact on the target that matters, not the intention of the perpetrator.

Such behaviour can take the form of easily noticed, physically threatening or intimidating conduct with immediate impact, or it can take place behind closed doors, or be much more subtle or camouflaged and difficult to identify.

Some bullies lack insight into their behaviour and are unaware of how others perceive it. Others know exactly what they are doing and will continue to bully if they feel they are unlikely to be challenged. Bullying and harassment can sometimes be overlooked, as a result of common euphemisms being used by way of explanation or justification, referring to someone as "that's the way they are" for example. The information provided to this inquiry has demonstrated all these different features.

It is also important to recognise that the key differential for a good proportionate of bullying situations is that a power or authority differential between individuals. This may normally be

seen as a supervisor / manager and subordinate; however, this can frequently include professional standing such as exists in the medical or academic professions. It can also be a perceived power differential borne of cliques, friendships or knowledge, all of which cannot be overlooked. In the context of this report the managers and medical staff, especially consultants, have very much the same emphasis in that they have, in my view, an absolute leadership responsibility insofar as their behaviour is concerned.

Types of Bullying and Harassment

Understanding bullying in the NHS limited to the NHS employee survey, which, by design, does not ask the level of questions to understand the problem in more depth. There is a growing argument that these need to be expanded to reflect exposure to the 21 negative behaviours, as described by Ferve, *et al* (2011), which form the cornerstone of the British Workplace Behaviour Survey (BWBS) and the frequency to which that occurs. This approach has been adopted in recent studies into B&H in the NHS by Lewis (2018). An example of the behaviours is contained in Appendix C.

These questions break the behaviours into three clusters:

- Violence and Injury as a result of Violence;
- Unreasonable Management Behaviours; and
- Incivility and Disrespect Behaviours

These more granular questions, including frequency of exposure, provide a much more informative data set upon which to understand the issues and identify root causes.

Costs of Bullying and Harassment

Whilst not a specific part of the ToR, the recently published paper by Kline and Lewis (2018) on the financial cost of bullying and harassment to the NHS in England provided a timely opportunity to contextualise the Trusts' position in this regard. This is particularly pertinent as in considering a business case for any recommendation and actions required and it provides a process from which the cost effectiveness of such actions can be measured.

The paper conservatively estimates the costs to the NHS in England as £2.281 billion per annum. Whilst it is accepted that these costs are both real and opportunity costs, they none the less amount to a significant amount, which on a pro rata basis will apply to the Trust. There is clearly much overlap with other key workforce indicators such as turnover, vacancies, sickness and the use of agency and bank staff and therefore concerted attention to bullying will inevitably impact on those indicators.

However, as Kline and Lewis (2018) observe;

"*Bullying and harassment are everyday features of many UK workplaces, with health and social care being the most prominent employment sector bedevilled by workplace ill-treatment…….. With the massive budgetary pressures facing the NHS, it is more relevant than ever to address the real costs of bullying, both moral and financial.*"

Levels of Bullying and Harassment

Findings

Employee Engagement Overall

Data obtained from the 2016 and 2017 NHS Staff Survey was examined to establish some baseline indicators. Staff engagement scores were compared with other combined acute and community NHS trusts and were classified as 'below average', with an average but decreased score for staff ability to contribute towards improvements at work. This is consistent with a general overall and noticeable decline in performance across the survey since 2015. Of greater concern however is the significant decline in the responses for the Friends and Family questions *"I would recommend my organisation as a place to work"* from 60% to 52% compared to an NHS average of 59% and *"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"* from 62% to 54% with an NHS average of 69%. Such a decline is a real cause for concern, which the Trust has recognised. It almost amounts to a collapse in trust and confidence of the staff over a short period, which I cannot attribute to any operational or organisational event. The Trust has indicated that the 2017 responses have changed significantly, returning to previous or better levels, the 2018 Staff Survey will provide more clarity in that regard.

In terms of bullying and harassment and attendant issues, the Trust had a 5% higher score for B&H from other staff compared to the 2017 average for similar trusts (29% versus 24%) with above average scores for work-related stress (43% versus 38%). LGT also reported higher than average experiences of discrimination (18% versus 10%) up from 14% in 2016. 17% of racial minorities reporting discrimination from a manager/team leader compared to only 8% of white respondents. Survey evidence from 2017 also showed that racial minorities reported higher levels of bullying and harassment in LGT from other staff compared to white colleagues (30% versus 29%) with a margin that has closed since the 2016 survey.

The 2017 NHS survey also provided insights into the occupational groups most likely to report bullying. Given that the more problematic bullying is that perpetrated by other staff, the focus here is on interpersonal relations between staff at LGT. The 2017 NHS data for LGT showed general management (44%) and maintenance (42%) reported the highest levels of bullying and harassment from other staff with nursing, nursing/healthcare assistants and medical the next highest levels. Reporting the most recent experiences of bullying/harassment/abuse amongst these occupational groups was 56% or less, with medical reporting at 35%, thus suggesting a potential for under-reporting. That said, the 2017 survey showed an improved but slightly below average score for reporting B&H at LGT compared to other similarly structured trusts.

The 2017 results were slightly surprising in relation to general management and maintenance occupational groups were concerned. A comparison with the 2016 results reveal an increase

from 31% to 44% for general management and 8% to 42% for maintenance. This was accompanied by a drop in reporting from 56% to 44% for general management and a 0% reporting for maintenance. This tends to indicate a significant uplift in bullying in the general management occupational group and a decline in willingness to report. This data supports the general level of incidents and unrest in the managerial roles in relation to the poor behaviour exhibited at higher levels, raised during interviews and covered later in this report.

I am surprised that this issue does not appear to have been identified and givens me some concern regarding the level of analysis of the survey results, particularly in the light of other emerging information relevant to this issue.

Staff Survey

As mentioned above 29% of staff completing the survey reported bullying from managers or colleagues with 46% reporting those events. Based on a 32% completion rate for the staff survey this would indicate that 265 events of bullying were reported by staff during 2017. Accepting that the reporting question also covers bullying events from the public which staff may be more willing to report, this still leaves a significant difference from the formal cases per year recorded by the Employee Relations Team (ER). Accepting that some cases will be dealt with without referral to ER, this is still indicating a potentially significant level of under reporting.

The frequency of this survey, its lack of detail and the low levels of completion make it a poor source of really understanding the nature of bullying and the impact of any change or progress in tacking it. A focused but expanded survey, run on a more frequent basis, say quarterly, is a much-needed tool.

Exit Interviews

Towards the end of 2017 and in response to a 6% take up rate and the need to reduce staff turnover levels, an initiative was launched in Workforce to drive up the number of completed exit interviews. This was principally conducted by personal interviews with a project manager from Workforce, following a reach out to leavers who had not been previously interviewed.

For the period December 2017 to May 2018 the interview rate was driven up to 48%. Although the subsequent report indicates that main reasons for departure or moving was promotion prospects, work life balance and health and well-being, it did report a significant level of discontent encapsulated in the conclusions:

"This project has produced some very rich anecdotal evidence that the culture within the Trust is not as it should be. People are not very nice to each other and staff that have been in the same posts for a long time are resistant to change and are bullying peers and managers in some areas. This is apparent in many areas around the Trust, in all divisions"

A more detailed examination of some of the feedback reveals a significant level of comments relating to treatment in the workplace which would be considered as bullying and harassment, below are a few examples:

"I've witnessed a lot of bullying in the Trust. Matrons scream in the faces of ward managers and others"

"A year ago, there was lots of bullying – it nearly broke me, but one of the instigators went on long term sick and left and the other went on maternity leave so it was ok afterwards. I did inform managers of the problems, but nothing happened."

*"**Very bullying culture in this Trust – finger pointing at meetings, GM shouting at people**"*

The interviews were able to identify individuals and teams where, for whatever reason, bullying was prevalent and problematic and the same perpetrator names were raised on many occasions. This included most divisions and at all levels up to and including senior leadership. In my view there were instances that demanded an intervention and some undoubtedly, if investigated, could have led to disciplinary proceedings. It is of no surprise that many of the names and locations were subsequently raised during my later interviews with existing staff.

So concerning were the emerging findings, several examples were raised immediately with the leadership in Workforce and although summary reports of the findings were sent to the respective divisions it is not clear what has happened to them. Furthermore, there were instances where a number of staff left two different teams in a short space of time. They were subject of further interview which provided detailed and quite graphical accounts of extremely poor treatment leading directly to their departure. These interviews were reported, but again, there is no clear indication of what interventions followed. During my interviews it was evident there was a feeling of ***"so what, what's going to happen about them"*** and the overwhelming view was nothing tangible has occurred. This needs to change. There should be a strong expectation that the exit interviews are properly collated, analysed and used to inform managers as to issues that may require attention and hold them to account for doing so.

The exit interviews are, and remain, a rich source of information as to the underlying 'health' of the workforce and organisation. The reliance on managers to conduct this process is all well and good but when, in many instances, they are part of the problem appropriate alternative avenues to provide feedback are necessary. The completion of a form either in writing or via a download is not using technology to best effect to encourage completion.

There is little incentive for managers to encourage departing staff to complete the process and they are not held accountable in this regard. It feels that these interviews have been overlooked by managers and not pursued by Workforce until the commendable initiative in December 2017. Accepting that reports may have been placed before Board or Committees it is difficult to identify what meaningful activity or actions have arisen which impact on the collation, analysis and use of exit interviews, which seems a relaxed approach by the Trust considering the workforce issues being faced in relation to retention and turnover.

The exit interview form itself does not reflect that bullying and harassment may be a feature of someone's exit and so, even if completed, does not provide for proper feedback. It would be useful if the form reflected more the 21 bullying negative behaviours and sought to explore answers to the key issues facing the workforce and engagement dilemma's in the Trust.

It appears to me that the whole process needs to be revisited, revised and re energised to provide reliable exit data, capable of analysis with other data sets to identify emerging issues or problems and inform the Workforce Strategy.

ER Data

Accepting that the ER function has recently been consolidated and new case management software introduced, the regular production of data relating to ER cases is inadequate and could be significantly improved. The fact that this function operated previously in divisional silo's demanded that at least the same record keeping process and standards should have been enforced. This was not the case and a as consequence the data appertaining to these independent operations could not be effectively collated, analysed or published. Consequently, no meaningful data around case management was published on a Trust wide basis. It is difficult to understand why the absence of this key information seems not to have been pursued by the senior leadership of Workforce until recently and, equally, up to that point, its absence accepted by the Board.

Whilst the new case management software is having current open cases and all cases from April uploaded onto it, in my view this hinders proper year on year analysis, the identification of repeat perpetrators and targets, and comparative investigation performance data. It should not be that onerous to take existing data from spreadsheets, clean and import key datasets from the last few years into the software by way of file transfer. Many managers, particularly those in clinical settings, also observed that they would like a greater amount of performance data particularly complaints data, so the issue appears to be one of relevant information not just ER data.

The data provided shows ER cases from October 2016 to October 2018 as follows:

ER Cases	Number of Cases
Disciplinary	95
Bullying & Harassment	35
Grievance	36
Capability	18
Sickness	444
Total Number of ER cases	628

I am unable to comment on comparative data with similar trusts as I do not have that information and it is an area of bench marking for the ER team. Although I do not have accurate year on year data, my feeling is that the levels may be high, and this observation has been made to me by the ER team. I add to this that in the same period there have been 11 Employment Tribunals (ET) and a number of settlements. Whilst accepting there may be various different reasons for those ET claims, not necessarily B&H, they would still relate to how an employee feels they have been treated by or in the Trust. Indeed, the observation was made that a number of the claims had featured opportunities for early intervention which may have prevented as escalation to formal proceedings and the subsequent ET.

However, it is the inability to readily produce and publish key data which is of concern. This lack of information raises questions in some minds as to the commitment of Trust to understand and tackle this issue in a transparent way, as the below observation indicates.
"If you're not collecting or publishing data it raises a suspicion as to why and questions the Trusts' commitment to deliver against its ambition"

Other Workforce Data

Other workforce data is readily available including sickness, vacancy, turnover, temporary staffing and PDRs. Whilst this data is published, like most organisations it is difficult to digest, and frequently is produced in demand to other drivers. The need to 'overlay' such information with other key dataset to provide for the identification of trends, hotspots and target specific interventions is very clear and greatly desired by managers.

Whilst some steps are being taken to tackle this, these need real impetus and a clear understanding of what the managers need to effect change. The view of many managers is that they receive little useful combined data and analysis which they can easily understand and share with their teams to start addressing a range of workforce issues.

"I only get staff survey results. Nothing else is there to engage with, it would be really useful to have greater information to allow me to raise issues with my team"

Other Data Sets

The Trust, like most other NHS bodies collects significant levels of data which are subject to examination in their own right and primary for the purpose collected. For example, public complaints, Datix, Serious Incidents, Maintaining High Professional Standards, Speak Up, Student feedback and Health Education England but to name a few. Whilst it is outside my brief to examine these, it is evident that many of these deal with the performance of staff in different arenas.

Many of the causes of poor or adverse performance across these indices lay in attitudes and behaviours of the staff. This is supported by national complaints data which identifies highest causation of complaint being communications and behavioural issues. Indeed, this was a significant matter for the Trust in the CQC inspection of 2017 where the levels and handing of public complaints was criticised and required immediate attention.

There are examples elsewhere in the NHS and certainly in other industries where such data is overlaid with core workforce data to provide a more holistic picture, not only of the emerging problems, teams and people but where there appears to be few problems and good practice. This approach would help to resolve many workforce and operational problems not just bullying and harassment, and requires a clear strategy for Management Information and Information Management.

Reporting Channels

It is evident that what constitutes bullying and harassment is not well understood by many staff. Equally, it is also important to distinguish between bullying behaviour and reasonable management responses to actual or perceived misconduct, or to poor performance by an employee. A few interviewees described instances when managers who had instigated appropriate conduct or performance management proceedings found themselves on the receiving end of a grievance accusing them of bullying. This is an issue I address later in the report; however, such a lack of understanding limits the challenging and reporting of poor behaviour.

The complex issues of concerns as to what will happen, trust in the system and reprisals arose frequently during the interviews and are addressed in more detail later. However, there is a significant loss of trust by the staff and in these circumstances the use of overt reporting channels diminishes and the need for other reporting avenues grow

There is also confusion with as to the roles of the EDI Network and Freedom to Speak Up Guardians (FSUG), neither body having clear terms of reference at the time of being interviewed. This needs to be addressed particularly as the Network is not intended as a reporting line.

The Freedom to Speak Up Guardians do have reporting in their remit although their role and how it operates is not fully understood by staff and is not contained in the Whistleblowing Policy. Observations and concerns were made regarding the FSUG which related to their original purpose, make up and selection. In essence, the view that they were created to allow confidential reporting of clinical practice and patient safety and not B&H is noticeable, albeit it is recognised that many models exist in the NHS, and they could be used for B&H issues. However, the FSUG were made up of ex members of the trust and that the EDI profile of the team does not reflect the workforce was felt by many to undermine their position as a reporting mechanism for reporting behavioural or conduct wrongdoing. The Trust may need to review this going forward.

The report into the refresh of Trust values also noted staff views pertinent to this area:
"Staff would like to see a mechanism put in place where they can raise any concerns about other staff behaviour in a safe and confidential way. Where their concerns will be acted on appropriately and where they receive feedback on what has been done about it."

The need for a clearly independent reporting line, particularly in the short term, was recognised and is considered an appropriate step to allow confidential reporting including anonymous reporting. The development of anonymous complaints mechanisms for harassment, regarding it as a valuable tool in addressing harassment in larger organisations and in the regulated professions. Such mechanisms enable employers both to facilitate safe reporting and to develop a picture of a person's pattern of behaviour. Anonymous complainants can be informed in cases where there have been multiple complaints and asked whether they wish to make a formal complaint alongside others. There are many organisations that provide an experienced and efficient service for reporting wrongdoing for many public sector industries.

The Whistleblowing policy describes a plethora of avenues for reporting wrongdoing of all kinds. The most efficient and effective systems are those that are limited, simple and well understood, this is not the case in either the NHS or Trust and this needs urgent attention.

Support for Staff

The support networks for staff from the seeking of advice, right through any process are not as clear as they could be. The referral to the Employee Assistance Programme (EAP) and Occupational Health are well understood by managers, less so by staff and the experience of EAP is variable.

More importantly the availability of trusted sources of advice and guidance is limited. Whilst approaching colleagues, Workforce or staff side are recognised avenues, the level of trust in those avenues is very low for a variety of reasons. There is the need for a network of suitable volunteers, selected and training to act as trusted sources of advice and support on how to

deal with many concerns, particularly bullying and harassment. This approach has been used in many other organisations and does much to provide confidential and neutral advice, prevent unnecessary escalation of minor issues and is another source of identifying emerging trends.

Conclusions

Understanding the true levels of B&H in the Trust is difficult as the main tool for this the annual staff survey and this has its limitations. But even so the reported levels are high by comparison to other similar Trusts and may potentially be higher. The number of reported cases reflects a significant level of under reporting in comparison to the staff survey, exit interviews and other indicative data.

The current position is exacerbated by a real level of unwillingness to report B&H issues due to complex and poorly understood reporting channels, both overt and confidential, a significant level of mistrust of the process and a resignation that little will happen in any event.

Even given recent change, the inability to maximise valuable data sources particularly exit interviews and ER case data deprives the Trust of an early warning system from which it can take appropriate action.

Effective data collection and analysis is extremely limited masking the true picture, impacts and costs. The Trust has many workforce and other pertinent data sets, which if appropriately collected, collated and analysed would provide the basis for a real understanding of the problems, proper comparisons between teams or even other trusts and allow for appropriate interventions. This would be true of a number of areas of the Trust's business not just ER issues. In essence the Trust is *data rich but intelligence poor*.

Recommendations

1. The mechanisms for reporting wrong doing are reviewed to produce clear and accessible reporting channels including:
    a. Clarification of the roles of the EDI network and Freedom to Speak Up Guardians;
    b. The introduction of an independent confidential reporting line; and
    c. An overhaul of the Whistleblowing Policy

2. The Trust considers the introduction of a network of Resolution Advisors;

3. The exit interview process is urgently reviewed, revised and re energised; and

4. An Information Management Strategy is developed with a view to the collation, analysis and publication of key data sets to provide for a greater understanding of the issues and target interventions.

Handling of B&H Cases

Findings

Context

In considering my findings in this area recent changes in the Employee Relations function of Workforce and Education must be acknowledged. I should also acknowledge that much of the performance around the handling of any ER case rests with the managers responsible for the investigation or similar and not with the ER team. The difficulties with skills, experience and availability of those managers are highlighted on later in this report. The previous structure had the ER and some other HR functions working within Divisional silos with a HRBP lead for each. This approach has been recognised in the NHS as not being the most efficient and effective use of resources but also the "silo" nature of the functioning of different divisions, each team / division being "sovereign to itself" was likely to conceal some of what is happening. The signs are usually there to be discovered and there needed to be a much higher level of awareness and monitoring which may not have existed.

The system as it stood previously and to a larger extent, in procedural terms, still exists is that when a B&H issue arises the local manager determines whether a matter should be investigated, who investigates, and at the end of the process, what happens or whether a case proceeds to disciplinary hearing. If it does, this will normally be heard by other managers in the division as will any appeal. It does not take much to see how this can be problematic in a number of area's particularly in B&H cases where the alleged perpetrator is a manager in that division. As one complainant observed:

" when the investigation was complete and I had returned to work, I was called to see xxxx about my grievances. We spoke about the outcome and he told me there was no point appealing as he would hear it anyway. A member of HR was present during this discussion…"

The evidence provided to me clearly shows this to have been the case with the HR function seemingly, if not actually, being inappropriately persuaded or overly influenced by divisional management in relation to many complaints, investigations or outcomes. As one manager observed;

"…. They are supposed to be neutral and not protect the managers, which is what I saw in my case. I was the one complained about and I didn't need protecting!"

The role of WED in the existing system is one of advice, oversight and governance, therefore drawing the ER resources together as one team with a new Head of ER post is a welcome step forward, as is the acquisition of new case management software. My findings almost exclusively detail what has occurred prior to these changes and as such many of the observations should be seen in this context. That said the strength of feeling and views

expressed about the service received and the role WED play in the system should not be underestimated or disregarded as they are real and represent a challenge to rebuilding trust in the system. More over there is unlikely to be fundamental change until a full overhaul of the system has taken place. In this context I use the word 'system' to mean the entirety of the policy, procedure and related processes. The below observation of the system from a senior and experienced member of staff is typical in this regard;

"…in respect of Employee Relations here, it is one of the worst I have seen. If you take the handling of grievances; the time it takes, the way we treat people raising grievances and the feedback they get, in particular…"

I was struck by the willingness of the ER Team to recognise the ills of the system and take advantage of the potential for change, including having a more central role in the recording and handling of all ER cases. This represents a real opportunity to improve key areas of the ER process which are subject of real concern and criticism.

Use of Informal Procedures

The foundation to any performance or people management process is a recognition that the role of the supervisor or manager is to provide a level of day to day advice and direction, making interventions when appropriate, challenging negative behaviour or performance where necessary and acknowledging positive performance.

"Managers should really be attending courses on managing difficult conversations and bullying and harassment, it is part of their daily job and its 'nipping some of these things in the bud' before it escalates"

" … for me what is more important, if we can, we should 'nip it in the bud' before it becomes anything more formal"

These sentiments were expressed all too frequently and represents the overwhelming view that many managers, particularly those in 'first time' people management roles, do not have the skills or confidence to manage difficult conversations. As a consequence, much behaviour goes unchallenged and escalates to a point where formal procedures are engaged. I address this issue in more detail later in the report.

The observation ***"…some managers are really challenged by the whole process especially if it involves race"*** reflects the research by Archibong and Daar (2010) which shows that in the NHS and a number of other public sector industries, part of this reluctance to engaged is the fear of being accused of bullying, particularly if the member of staff is BME. The concern is best replayed in a quote ***"I do not want to be accused of racism, so I will play this by the book"***. Such an approach may not have discrimination at its heart but certainly deprives BME staff of the more informal methods of managing behaviour or performance. I do not suggest there are not instances of discriminatory behaviour as there probably are in some cases.

However, this issue is important in understand the Workforce Race Equality Standard (WRES) data which reflects a disproportionate level of BME staff entering formal proceedings.

There is also a willingness in policy and practice to allow those raising the issue to dictate how it should be resolved. Whilst a complainant's views are relevant the process cannot be dictated on that basis. Most early B&H matters can be resolved by managed discussion without entering a formal investigation. All ER policies that have behavioural or grievance issues at their heart should be able to mandate an informal or mediated approach before investigation, where this is appropriate.

It is also accepted by many managers, and recognised in other organisations, that from time to time the day to day guidance does not bring about the change required but the situation does not demand entering formal procedures. Experienced managers point to having conversations with staff and recording such, by way of a file note, to evidence intervention if there is no improvement or a further occurrence. This is a good practice and the use of those management action / advice notes in subsequent proceedings has been supported in recent employment tribunals decisions.

However, the Trust, like many others, does not have a policy or process which describes when and how these notes are made, how they are kept or any other governance around this common management practice. This exposes the managers, staff and organisation to real risk in my view. The practise should be acknowledged and enshrined in policy as a part of the processes for managing all ER processes as it would provide for a consistent, legitimate tool for behavioural change. In other organisations it is also used following investigations where there may not be the justification for formal proceedings, but suitable advice or direction needs to be given and documented. Whilst there were questions as to the storage, consistency and governance of the notes, there was overwhelming support of the principle from contributors, particularly at the workshops. ER would have a key role in the governance of this process, although the introduction such a policy will place a spotlight policy and procedure governing the use and maintenance of staff personal files.

Whilst the Trust has a mediation scheme and supports mediated solutions, these are all too frequently late and used in quite difficult circumstances. To facilitate a dialogue at an early stage is a preferred approach and does not require a full mediation session or highly trained mediator. This should be made clearer in policy and practice terms.

Initial Reporting and Recording

In general terms, accusing someone of bullying is a serious matter and such an accusation should not be made lightly. It is always right to consider whether the "perpetrator" was under acute pressure and just having a bad day, for example, and whether this was just an isolated outburst with no lasting effects and the behaviour was out of character, or whether such

incidents had happened before. Patterns of behaviour are extremely important in effectively tackling this and, I would argue, all ER issues. It is therefore important to maintain reliable records and to log reported incidents and their outcomes accurately, and to have processes in place to enable patterns to be picked up and their historical and systemic significance understood.

Many people were highly critical of poor record keeping and poor follow up in respect of such incidents, and of the consequent inability of those responsible for dealing with such allegations to do so fairly or effectively. While recognising the abilities, professionalism and the dedication of most individuals working in WED, the department was the subject of concerns and criticism in a number of respects. This in the main related to the maintaining of records, perceived breaches of confidentiality, conflicting advice being given by different WED personnel, and a general lack of follow up of reported incidents. The below was typical in this regard;

"The complaint was investigated and ultimately upheld but the way this was handled was appalling; It was 15 weeks before the official investigation began, there was no transparency and those that had complained were not kept informed. I sent repeated emails asking for updates with no response."

"I wanted to raise a grievance but was told by the XXXX that I would be wasting my time and would be better off leaving."

The system that exists at the moment relies very much on a manager 'notifying' ER but there is little mandatory requirement to do so, especially in a timely fashion. Neither is there a common referral form which allows standard information about any relevant matter to be passed on. What tends to happen is emails or telephone referrals are made to a variety of WED personnel and this gives rise to delays and inconsistency. It also does not provide for WED proper oversight of managerial activity in relation to ER issues. As described earlier, many contributors felt that WED were not sufficiently neutral and allowed commissioning managers to 'plough their own furrows'.

There will obviously be occasions when an allegation of bullying is wrongly or unfairly made, as a response to legitimate conduct or performance management. I identified a few instances amongst all the information provided where I considered that this was the most likely scenario. And I recognise that a manager on the receiving end of such an allegation will be justifiably upset and angry.

On the other side of the coin, however, is that grievance, performance management or disciplinary proceedings can sometimes be misused as a means of controlling or humiliating someone, or even in extreme circumstances to terminate their employment or cause them

to leave. There were a number of examples of referred to in the accounts provided to me where this was a possibility.

"I was investigated for a discipline matter, it took 16 months and at the end nothing was found against me. This was just the manager picking on me. I'm not the only one who has suffered from her behaviour"

The whole procedure for reporting ER cases, not just B&H cases, needs to reflect compulsory and timely referral to ER for assessment and recording. This will permit ER to ensure consistent and appropriate action is being proposed and provides an opportunity for appropriate advice to be given and this should be in a timely fashion. A greater mandatory role for ER at the initial and final stages will help reduce such instances and go some way to restoring trust in the process.

Investigation Procedures

Before considering my findings in detail it is worth commenting on the data relating to the timeliness of cases provided to me. It should be noted that these relate only to cases classified as bullying and harassment, but it is highly likely this will be common to other case types including disciplinary.

- Average time taken to complete B&H cases – four months;
- Number of B&H cases over 28 days old – 33; and
- Number of B&H cases open currently – eight

Of the cases closed in the last two years, 33 were over 28 days old with an average time to complete of four months. These included cases completed by external investigators, which were themselves over six months.

These figures lend support to the numerous complaints made regarding timescales, which some have experienced as over 12 months, 16 months in one discipline case. These timescales are unacceptable and are the major source of concern and discontent of those involved both alleged perpetrators and targets alike. Given that most lengthy cases feature staff become absent through sickness for long periods, the costs to them, their teams and the Trust is significant, and this position cannot be allowed to continue.

The process seems to be that the commissioning manager selects an Investigator, normally from their Divisional resources based on availability, workload, previous experience and perceived managerial skill, in that order. Whilst there is no doubt that there are a number of managers who have been trained and have experience in conducting work place investigations, there is no collective awareness as to exactly who is and to what level. Whether they have received appropriate training does not seem to feature in the considerations when appointing to an investigation. There is certainly no central Investigating

Officer list or pool. Indeed, by admission a number of managers have conducted investigations having not been trained, or trained some time previous and not had recent experience.

Those that have been trained reveal how variable in quality training can be with some trained in other trusts or the Local Authorities appearing better versed in the necessary understanding, skills and techniques. Such a lack of quality training and experience, coupled with the pressure of conducting investigation without protected time to do so, will inevitably impact on timeliness and quality. Many complaints and examples of unwarranted delay were accompanied with a lack of being kept informed and transparency around the process and outcomes. This is unacceptable, every person involved in an investigation particularly the principals, have the right to be provided with regular updates and most, if not all reports should be written in a way that permit disclosure to both parties at the conclusion of the inquiry.

There is a tension in the current model that centres on the use of resource's as described above or seeking an external investigator, which should be reserved for cases where internal investigation is not appropriate. The could, in part, be relieved by the ER team having a deployable, skilled investigative capability to take on cases that are more complex or involve line managers.

The Trust may need to consider what its model should be in relation to workplace investigations and the investigator resources needed. This will determine the training requirements in this regard. If it intends to retain a corpus of investigators amongst the wider staff, then an assessment should be made as to how many and at what level they sit. The view of staff is that there should be at least 30 at a variety of levels who are given particular training but that all managers should have at least half a day foundation training.

On a similar vein I note the CQC criticism of the complaints which, on the surface of it have some similarities with the issues I am finding. The Trust may wish to consider a wider review of all its case handling and investigation processes to identify if there are opportunities to establish common approaches.

The seriousness of any allegations and whether they involve the line manager of the complainant need to be taken into account when considering an appropriate investigator and a process for allocating independent investigators needs due consideration. These could be drawn from another division, ER or, in the most serious circumstances, externally. This may happen at the moment, but it is not structured, and a more defined investigation continuum should be devised where appropriately skilled investigators are appointed commensurate to the case seriousness and complexity. If external investigators are engaged then the Trust should be sure they are properly trained, preferably qualified, experienced and have the

capacity to deliver in a timescale commensurate with the seriousness and complexity of the case.

The management of all live cases, irrelevant of the investigator, is a responsibility of the ER team. The need to ensure timeliness and standards is, in my view, a part of the teams remit, and this should be expressed in policy and procedure. Disproportionate or incomplete investigations featured in some accounts provided to me and this process will go some way to managing this issue.

Policy gives licence to the movement of staff during investigations. This is a difficult issue to manage whilst being fair to all, particularly if one of the parties is a manager. The amount of times it has been referred to and criticised gives me concern as to how it may be used and may be a default to appropriate if somewhat difficult management. It should not be seen or expressed as a right, and only reserved for the most serious occasions. Policy may need to be reviewed in this regard.

Suspension

Suspension was raised by some contributors. Of concern was a validated example which appeared totally inappropriate and unnecessary, the consequence of which was the individual leaving the Trust. This arose due to the rather bullish approach of a senior manager and the inability of a member of Workforce to provide robust and appropriate advice or challenge the matter. Whilst I have not sought precise data, I am assured that numbers are low. That said this is another issue, which in my view requires central and high-level approval. The policy permits a level of managerial autonomy, which has no operational imperative and should be tightened up. Suggestions as to suspension should be included as part of the referral process and only approved when agreed by the Deputy Director or Director of Workforce and Education. Policy should reflect this and include an appropriate review regime whilst suspension is in operation.

Outcomes and Transparency

At the completion of the investigation the report should be forwarded to ER before any decision as to outcome are made or transmitted. The ER Manager can then consider, with advice if need be - particularly in disciplinary cases, whether the investigation has been thorough and fair, the report is of the correct quality, and the recommendations justified.

ER may also take a view, if the matter is to go to hearing, who may be best place to deal with it, and should oversee the disciplinary or hearing process.

Many complaints were made that the whole of the process lack transparency, with many citing that the outcomes were not known, no copy reports or redacted reports were provided.

Therefore, explanation for actions or inaction were missing, leaving participants feeling frustrated and aggrieved. As the below expresses:
"…there were a lot of witnesses and complaints, yet the investigation didn't uphold anything. Even someone in HR said that this was unusual…."

These issues arose on at a number of interviews and included very detailed explanations or documentation in support. Whilst not privy to the whole case I cannot help but feel that some investigations may have been weak, and others had questionable conclusions and outcomes.

It is important that through its processes and procedures the Trust can demonstrate that it will uphold its standards or undertaking, and that staff can see this is the case. The below observation was one frequently made:
"…people do not see any consequences to their behaviours, I've never heard of anybody being disciplined for bullying. You can have a policy but if you don't act on it then there is no deterrent"

I consider that suitably sanitised outcomes for all disciplinary cases, irrelevant of finding or 'offence' / breach should be published on the intranet. Given that many NHS professional regulating bodies make full disclosures in professional misconduct proceedings, the approach is already familiar. It should be noted that this approach was welcomed by most workshop attendees.

Role of ER Team

Much of the potential role of the ER team has been touched on in the above narrative but I feel it is worthwhile emphasising some points. The conduct of an investigation and the preparation of the subsequent report is the responsibility of the investigator. The practice of writing, completing or editing such reports in the ER team, is not appropriate. Accepting that this was to lend assistance to the investigator or correcting a substandard report, such activity not only is outside their remit but leaves ER open to legal challenge. However, the opportunity for ER to have an independent and properly skilled investigative capability is a consideration as part of the Trusts' approach to managing these issues.

The team should become the centre of excellence and knowledge for all parts of every ER process providing sound consistent advice, quality assuring referrals, investigations and outcomes. As overseers of the investigations processes, the team has a role to ensure timely and appropriate investigations take place. This requires them to have been trained to do so, which, as a team they have not.

ER should provide consistent and recognised check points for reporting, recording and investigations. This should include being a proper and considered gateway to disciplinary proceedings without causing undue delay or having bureaucratic processes.

However, they need to raise staff awareness of who they are and their role to engender staff confidence and trust. They should also be considerate of their role in the 24/7/365 operating environment of their customers and be responsive to that.

Most case management systems have some case reviewing process designed to dip check the standards of handling, investigations and outcomes. This would normally be from outside the organisation. In this case arrangements with a partner Trust would be a useful start. It should be a process which will enhance learning and validate quality.

Finally, the team will need to create and maintain a suitable suite of Key performance Indicators (KPIs) and Team Performance indicators to establish and monitor the performance of the processes and their contributions to it.

Existing Policy and Procedure

I have not forensically dissected the existing policies but make general observations given the amount of recommendations likely to affect them in any event. There is a lack of synergy between the relevant ER policies specifically Discipline, Grievance, Capability, Sickness and Whistleblowing and Bullying and Harassment. For example, naming and activities of stage one and informal stages, which should all be informal and expectations as to file notes mentioned in one but not others. More importantly, the opportunity to have one investigative process, common escalation stages and standard documents for all ER process is a feature I have seen within the best ER policies and procedures.

In general terms the policies, in common with other NHS policies, are unnecessarily lengthy, and complex, attracting a consistent level of complaint about being difficult to find and navigate. They are out of date in many areas and too frequently put decisions in the hands of those in the process as opposed to the organisation. For instance, the right of a witness not to provide an account or remain anonymous, or the consents required to record interviews. The opportunity to align many processes with identical stages, timescales, rights etc exists and they require significant update if they are to be of use in guiding change to more effective, fair and transparent processes.

The single biggest challenge is around the current B&H policy and how this aligns with the Trust values and various codes of conduct that appertain to different NHS professional groups. The reality is that B&H is a set of undesirable behaviours which are polar opposites to those articulated in the Trust values and a large number of the codes of conduct. Of particular concern is the Maintaining High Professional Standards (MHPS) procedure for doctors and dentists and its relationship with any bullying and harassment or behavioural policy. I address these policy issues in more detail later in the report from an accountability and governance perspective.

The tenor of many policies is started in their title, for instance 'Grievance', which would be better off as 'Resolution', with greater emphasis on resolving matters at the earliest stage. I chose grievance in this instance, but this could be applied across the board and the principle is about reflecting a mind-set that steers to openly raising issues, early resolution and using formal process only when appropriate and necessary, irrespective of the policy subject.

Conclusions

How cases are managed shapes the views of those involved whether that be as 'perpetrators', complainants or witnesses. This is true of any case management system whether it be criminal, civil or workplace. Good case management systems have key features of accessibility, responsiveness, professional competence, fairness, timeliness and transparency which engenders trust and confidence in the system, even when expected outcomes are not met. Conversely, when these are absent, trust and confidence is eroded and complaints abound.

The level of complaints and evidence of poor case timeliness, together with negative descriptions of processes and policies lead me to the conclusion that case management is sub-standard. Evidence presented to me indicates a lack of consistent advice, poor record keeping, inordinately long investigations of questionable quality - some with inconsistent or inexplicable outcomes, and a noticeable lack of transparency throughout the process. Whilst the creation of the ER team and the introduction of a new case management software are welcome changes, these need to be built upon to drive change, and in order to place the ER Team at the centre of a credible, reliable and trusted ER case management process. This is, in my view, a key priority for the Trust.

There are some significant cases which are worthy of review and it would be appropriate to evaluate the handling of some cases containing specific features or allegations, or a random sample from the last three years. This should include disciplinary cases and may include cases resulting in ETs, if this has not already been done. The review should seek to identify, amongst other things, appropriate use of policy and procedure, identify if early intervention opportunities were missed, if the investigation standards were met and resultant outcomes were appropriate.

There is a clear deficit of available skilled workplace investigators, the demand for which will depend on the investigation model Trust choses to use. This model needs to be determined quickly and a training regime implemented to provide quality investigation training.

The ER suite of policies lack synergy, are too lengthy, too complex and in need of overhaul to streamline processes, bring them up to date and make them more user friendly. Such a process will inevitably involve the introduction of either new policies or procedures.

Recommendations

5. The Trust builds upon the recent changes to the ER Team to enhance its recording, case management, investigative and the decision-making capacity including:
    a. Mandating the timing and format of the reporting and recording of all ER issues;
    b. Augment of the ER Manager role in relation to decisions to investigate and decisions to enter formal proceedings;
    c. Providing suitable level of investigative capability and capacity; and
    d. Develop relevant case management KPIs to inform the Trust and Team Performance Indicators (TPI's) to inform the team.

6. All or a significant sample of key cases from the last three years is reviewed to ensure that, given the nature of the allegation, the handling, investigation and outcomes are appropriate.

7. The Trust reviews the structure, training and use of workplace investigators to establish the Trusts' preferred model for managing workplace investigations

8. Relevant policies are reviewed and revised to ensure they are fit for the effective management of behavioural issues of all members of staff including:
    a. Introducing a structured management action/advice file note process;
    b. Introduce appropriate links to engage the MHPS procedures; and
    c. Publish all formal disciplinary hearing outcomes.

Culture

Findings

"I have worked at this Trust for the past 18 years. Throughout this time, I have experienced quite a bit of rollercoaster rides but for the past 4-5 years I have encountered varying levels of unfavourable treatments that really challenged my outlook on the culture of the present working environment."

"I probably won't be here much longer, I had couple of interview invitations already, but I hope things can change at this Trust, so people here don't have be anxious about coming to their workplace"

" if you have a culture where people are living in fear you will never a have full staffing, better sickness or meet your financial targets"

"This place has just become unkind, people don't speak to each other nicely and much respect has gone.."

"There has been a culture, definitely over the last three years, from a lot of senior managers in the organisation, that has filtered down. You can see that, and it does go unchallenged"

The above comments represent but a small proportion of the range of feelings and views provided by contributors during my inquiry, which included some harrowing views and thoughts including past considerations of self-harm. Even though some of the interviewees had received no personal instance of bullying, it was difficult to identify many people who did not think that bullying and harassment was prevalent in the Trust to the extent that it appeared part of the culture. In understanding the extent of the problem, it is pertinent to reflect on the recent history of the Trust and the impact this may have had on the current position.

Context

The 2013 merger between the University Hospital Lewisham (UHL) and the Queen Elizabeth Hospital Woolwich (QEH) was always likely to be problematic. The QEH had previously been through a number of merger processes and was seen as a struggling trust and UHL was the opposite. The merger does not appear to have been welcomed by staff of either trust and, inevitably differences remain that appear not to have been resolved. This was always going to provide a significant organisational design and development challenge which, in development terms, would be ongoing for some time.

"…Lewisham saw itself as high performing and didn't know how to fail, QE was extremely challenging and didn't know what good looked like"

Many examples were given by staff from each site and, more importantly, staff who had worked on both sites as to the general differences between the two hospitals. However, one of the most telling observations relative to this inquiry arises from the 2017 CQC inspection when cultural differences were observed in particular;
"…small number of health professionals were more aligned to one hospital …"

"A lack of cohesive working amongst consultant grades across various specialities could lend itself to missed opportunities in terms of developing centres of excellence"

The evidence provided to me from some staff working on patient care and clinical outcome initiatives, approved across the Trust, have been subject to public belittling of their work and open criticism of other medical colleagues by some consultants. In one case this appears to have resulted in the potential collapse of the initiative due to the clinical staff delivering the project being belittled and bullied to the extent that they moved on or left. The below being a typical example:
"I was in a meeting providing an update on the programme to doctors when DR xxxx came into the room, late, and immediate started commenting that what I was saying was "rubbish" it was embarrassing and hurtful"

It is evident that the cultural differences across the Trust requires continued attention from an organisational development perspective. This issue will not be unique to the Trust and there are examples of mergers between trusts with similar difficulties and where cultural differences have been successfully overcome.

Leadership and Management

"Poor behaviour should not be tolerated from any member of staff, no matter what their position in the organisation and consistent, appropriate action should be taken. Staff felt that the Board and senior management should lead by example in this. This was the priority action for staff."

The above excerpt from the report into the Values Refresh captures the essence of the matters at the heart of this inquiry. I take the view that most organisational issues start and end with the leadership, as this dictates the culture and management of the organisation. In this context I include the Board and those senior in operational and medical teams.

This inquiry was founded over concerns of poor behaviour at senior level, which, as it unfolded reveal some of most the disturbing examples of bullying at senior leadership level. What was equally concerning was an obvious lack of visible intervention or challenge.

"..in my first week in role at the eight o'clock huddle I was shouted at in real anger, it was made *to feel very personal, all of the execs were there and nobody intervened.."*

"... it wasn't just one person at executive level or senior level, there were and remain a number of people who behave like this..."

Many examples were given of members of the senior leadership team demonstrating a leadership style that at best was described as 'menacing, threatening and heavy handed'. These behaviours were regarded as part of the day to day persona of the individuals concerned often excused as ***"Oh well that's how they are"*** or ***"they are really, really stressed"*** seemingly legitimising the behaviour, which became an accepted part of life for those more junior.

Many contributors understood the need for accountability but felt that many meetings from corporate level down to ward level had become arena's in which they were inappropriately challenged and castigated publicly. The picture painted was one of repeated poor behaviour which, in the worst cases, resulted in shouting at or putting down and belittling junior staff during meetings where other executives or senior managers were present. These were not one-off instances, and left many recipients' shocked, extremely hurt and frequently visibly upset.

A clear feature of these episodes was the absence of any form of visible challenge or attempt to defuse the situation by any other member executive or senior leadership team. Such a lack of intervention was not just wholly unacceptable but set the foundation of a laissez faire norm, from which the perpetrator and observers could regard the behaviour as being acceptable. It is understood, and recognised elsewhere in this report, that challenging poor behaviour is naturally uncomfortable and sometimes takes courage, confidence and skill, particularly when the behaviour is so openly displayed. But when that intervention is expected of junior managers it is expected that it is demonstrated by those more senior. The below sentiment was expressed to me not just frequently but in the majority of interviews throughout the inquiry;
"Everybody knew about it, colleagues and XXX. Why wasn't it tackle at that point?. Was it because tacitly it was acceptable and tolerate? Therefore, the organisation is saying that its ok even if we don't like it, so what does that say?"

There was a clear expectation amongst the contributors, whether they were targets or observers to such behaviour, that interventions would and should be made by other executive or senior team members, particularly the senior leaders of the executive. The strength of feeling regarding the lack of challenge or visible support has done much to shape the views of many contributors, including middle to senior managers, as to the collective and individual commitment of the executive to the Trust values or to effect any real change.

As some members of staff see that senior staff can bully people and not be held to account, they feel able to bully others in turn, without fear of adverse consequences, or feel that this is the best way to achieve results, and the problem soon becomes embedded.

Inevitably this behaviour, publicly displayed and unchallenged set a tone which became adopted by more junior staff exposed to it. I have received many examples and accounts which highlight this 'learned behaviour' has percolated across and through the strata of managers, particularly within the general manager occupational group, and has brought with it much concern, anxiety and distress for many junior managerial and non-managerial staff. These accounts are supported by the exit interview feedback and staff survey analysis.

The development of a culture which believes that to fit in, avoid criticism or 'get on' managers had to behave in a way that mirrored that of their more senior colleagues, was in my view evident in the accounts provided to me. This made for a very toxic, corrosive and fearful environment where blame featured more than support and understanding. Such is the level of concern regarding the behaviour of some managers that the impending structural changes to the divisions was causing real anxiety amongst some staff as to who will be managing them. I must highlight this is not inferring that all managers in the general management group behave this way, far from it most do not, however there is a corpus whose behaviour is unacceptable and must be tackled.
"..some people are destroying their teams and people, not necessarily their direct reports. They are seen as successful and are moved on or up where the resultant behaviour continues with further complaints and upset.."

Contributors identified many examples of instances where concerns were raised about a range of bullying incidents, either with the senior members of the Executive Team or senior managers in Workforce and nothing was seen to be done, which merely reinforced the views that such behaviour was accepted. I acknowledge that there may well have been actions which contributors were not privy to but, if there was, appropriate feedback was missing. There was also clear evidence that the targets of much of this poor behaviour were reluctant to instigate formal, action on the basis of fear of retribution and the belief that nothing would be done. Those who did make a formal report frequently ran into the handling issues well documented earlier in this report.

The impacts of such behaviour were in keeping with that described in research and reports with many targets feeling abused, humiliated, angry and very anxious. The descriptions below are indicative of some of the many feelings described:
"....I became so stressed that I was going home and taking it out on my family. What sort of mother does that?"

"the final straw was that I was physically sick on my way to work at the thought of going in and facing her.."

" I have said that I won't work for her again, I would rather leave the Trust"

The moving of both 'perpetrators' and targets of bullying allegations arose reasonably frequently with in interviews. Accepting that the full circumstances were not always clear, there were some obvious cases of concern. Whether it is real or perceived there appears to be a practise of moving either party both before and after the investigation. Whilst policy describes this process there is a real danger, in my view, as it being perceived as a right by those making allegations. Furthermore, the effect of such a process on one or both of the parties may be significant especially if the rational for such a move is not clear, with one or either feeling further bullied as a result. In my experience this is a 'tactical option' in the management of only the most difficult and serious cases of B&H or disciplinary investigations. In many cases the movement becomes 'permanent' and this, coupled with a lack of transparency, is viewed as rewarding either party or avoiding taking appropriate action.

The moving of those involved, particularly perpetrators, is a feature of many difficult ER situations, including bullying and this is recognised in numerous studies and reports. This is particularly so for perpetrators who are senior and are moved rather than appropriately dealt with.

"My view of this situation is there was a clear case in terms of bullying but there was not a risk appetite on behalf of the executive to actually deal with it and address it. This seems to be thematic"

Unfortunately, it appears to me, that this way of resolving some situations is common and occasionally receiving support at the highest levels, including from bodies which have regulatory oversight. As one contributor observed:

"the challenge is they move to another organisation where the bad behaviour is repeated.."

What is equally concerning, and I was presented with some evidence to support this, is that some individuals move from Trust to Trust when they have antecedents of such behaviour, in many cases avoiding investigation or proceedings in the process.

Medical and Clinical Staff

The instances of bullying mentioned above, and the attendant circumstances, are not confined to non-clinical managers. There are ample examples of overt poor behaviour from senior nursing managers and consultants and an equal lack of willingness to address poor behaviour. These include outbursts and 'temper tantrums' in theatre and the abrupt and public dismissal of the views of more junior clinical staff even though they have expertise in

the field. Even to a lay person, many of these accounts seem reflect incidents that jeopardise patient safety in a way, which if correct, may amount to professional misconduct.

"In 30 years of nursing I have never been in an organisation where medicine has so little respect for nursing as a profession, resulting in nursing being intimidated by the profession of medicine."

"I have witnessed Consultants regular shouting and swearing at staff and they have been getting away with it for years"

"I have dealt with many bullying allegations, it's just frustrating that I don't get support when tackling the medical side around their conduct towards nurses"

"after one incident the nurses raised the issue with xxxx stating 'we want something done, we shouldn't be shouted at in theatre or have instruments thrown around or made to feel like this'….. nothing was done"

That is not to say that when firm reports of poor behaviour are formally made, they are not investigated where appropriate. But it is fair to say that I was given examples where concerns were raised, and this did not happen and the same fears about repercussions or lack of action exists insofar as consultants are concerned.

In those areas where contributors reported bullying as prevalent, a number of other adverse indicators are evident such as complaints, turnover and vacancies. As a consequence, problematic wards and departments can be readily identified. Similarly, examples were given of areas of good practice which warrant examination on that basis. It was disappointing to be given some accounts of individual manager having the courage and ability to turn around a problematic team, only to receive little or no recognition but then being subject to bullying behaviour as a consequence. This was one of a few examples offered by interviewees, which were consistent in highlighting those clinical and operational teams which were considered 'good', unfortunately there was little evidence put for as 'good' in so far as any identified or related practice. Most of the 'good' was felt to be bound to the quality of the team managers.

Despite some of these wards and teams being known to senior managers, and in some cases being tackled, there remain some areas where bullying and the related performance issues continue to exist, and key protagonists remain unchallenged.

Wider bullying

"… I have seen bullying by managers, bullying by peers and bully by staff against managers…"

I need to emphasise that the bullying I have found is not just the obvious, overt incivility and disrespect behaviours from leadership roles. Like most other studies, there is an undercurrent of more subtle behaviours that abound, as the contributors below indicate:

"I'm sure the supervisor's hypercritical attitude of people not included in the clique and general unfriendly environment is the reason for the high number of new staff leaving but also I don't know what do about it. If I go to the manager and say ''they're not talking to me" I would feel like a five-year-old. Also, I have experienced this in another workplace on a smaller scale and not until all the ''old-timers'' had left or retired, did it become a lovely place to work."

".. when I returned to work I sought more flexible hours, but this was refused even though somebody else had been granted similar."

"…was refused compassionate leave and had to take annual leave when a relative was dying.."

".. you were either in the gang or left out of conversations, not invited to things or not told things.."

There were accounts of related cliques, cronyism, favouritism and, in some case, nepotistic behaviour some of which resulted in promotions, jobs being obtained, or not as the case maybe, and a general feeling of unfairness. These accounts tended to arise in many of the same operational area as the more overt bullying but are more widespread.

Many contributors raised the use of email as a medium used for a variety of bullying behaviours.

"A lot of the problem was around the tone of the emails and how that was perceived…"

" in the email what I had done was described as "shit" and this was sent to all. I didn't even get an apology afterwards"

From direct incivility and rudeness, through threats and demands to the more subtle unreasonable manager behaviours of constant requiring updates, demands as to timescales and exclusion from circulation. This was considered a significant problem for many, particularly in high pressure scenarios with managers who were equally under pressure.

These behaviours are not confined to managers. Evidence of bullying in peer groups was also common but, again, was more prevalent where it had been allowed to flourish. Indeed, examples of junior staff practising incivility and unreasonable behaviours on more senior staff were capture in this example:

"..an new band seven nurse started from another hospital. Soon the other nurses started a petition to raise a grievance against her because she was good and trying to change things. She ended up going back to her old job in another Trust"

It is also important to distinguish between bullying behaviour and reasonable management responses to actual or perceived misconduct or to poor performance. A few contributors described instances when managers who had taken appropriate steps to manage conduct or performance issues found themselves on the receiving end of a grievance accusing them of bullying. Not only did this bring an end to the management activity but caused a great deal of stress to the managers accused resulting in sickness absence and eventual movement to other roles.

" I came here to do a job, I was asked to help with a difficult team, as a result I am now I am in a job I didn't want and have no choice but to leave the Trust"

Whilst I came across examples of bullying and harassment that clearly had an element of race involved, the majority of contributors who had been subject to bullying stated that the primary reason for being targeted for such behaviour was not because of a personal characteristic, but because of the disposition of the other party or the prevailing culture in their workplace.

Where bullying problems arise as an emerging problem for an organisation, there is a reasonable expectation that the leadership acknowledge this, and develop a strategy for scoping, analysis and tackling the issue. The staff survey and allied data sets point to a problem that has existed for a number of years and, in staff survey terms, has been getting worse. Couple this with staff accounts and, what appears to be, a growing number of issues raised at senior level, the need for such a strategy seems clear. Where such a strategy is not visible, this adds to the view that the leadership do not recognise B&H as a problem, nor do they wish to tackle it. The recently produced Workforce Strategy, which I address later in this report, appears overdue in this regard.

Blogs, staff meetings and Board discussions have been suggested as evidencing the awareness and previous activity of the Board in relation to B&H issues. Whilst I have no doubt that B&H issues were recognised and discussed, including collective and individual acknowledgements that such behaviour is not acceptable, these activities appear unsupported by meaningful visible action that has impact. Worse, in my view, that such acknowledgements become meaningless if overt bullying is allowed to happen in the way that it has been evidenced in this report. As the below observations indicate:

" The Trust says that there is zero tolerance on bullying but they don't mean it…" and

" they say one thing then do the other"

In the absence of proper problem identification, a clear plan to deal with it and a process of accountability, I take the view that it is reasonable that both the staff and an independent observer deduce that the Board has lacked a willingness to recognise and tackle such behaviour.

The views of most staff I met reflect the observations within the Refreshing Values report. Far from a fatalistic or overly cynical view of the future, there was a great deal of positivity that things at the Trust would change for the better. I received many comments highlighting the apparent commitment of the newer members of the Board to making enduring change and were optimistic that action will follow.

Conclusions

5 years on from merger, there remain cultural differences between the Greenwich and Lewisham sites which not only affect the quality of service provided to patients but directly impacts on issues of bullying of the staff.

Whilst I would not describe bullying in the Trust as institutionalised, it is however widespread in that it is evident across all sites, in all divisions, at all levels and perpetrated by managerial, non-managerial and clinical staff. To this extent it is embedded in the culture of the organisation.

The prevalence of overt bullying both witnessed and reported, particularly at the most senior levels, coupled not only with lack of visible action to address it, but a *laissez faire* attitude which appears to condone it, can be interpreted as a lack of willingness to recognise and tackle bullying behaviour.

This apparent inaction has damaged the reputation and credibility of the executive, as it existed at that time, both at a collective and, in some cases, individual level. This reputational harm, particularly as it appertains tackling bullying and harassment, may well have been irreparable in the absence of changes to the Board that have occurred.

Key to addressing B&H is top level leadership. Although there have been a number of recent changes at Board level, there remain questions over their commitment to change, a position influenced by the recent past. Additionally, senior clinicians and general managers below the executive must recognise their role in an organisational culture that has left many staff feeling unhappy, anxious and unsupported. Whilst a new CEO has recently been appointed, it is critical that he now develops the senior leadership team in a way that gives confidence to the wider workforce that change will be affected.

Accepting that the Workforce Strategy has recently been produced, initiatives to tackle bullying and harassment has been undermined by a lack of a clear strategy supported by proper analysis, interventions and monitoring. The importance of such an overt, well informed, realistic and measurable statement of intent cannot be overstated as the first sign of a programme to tackle bullying and this needs to be built upon.

There are, within the Trust, teams and individuals whose behaviour and performance remain a concern. It is a relatively straightforward exercise to conduct a level of analysis with the current data sets, and apply a forensic and justifiable approach to identifying and tackling these problems. Identifying members of staff who have attracted repeated complaints to understand why and make appropriate interventions is an obvious step to take. However, there is also a need to understand the concerns of those who have felt it necessary to make repeated complaints and provide any necessary support. This issue should be addressed as a matter of priority.

Recommendations

9. The past failures of the senior team are publicly acknowledged, and the CEO now develops the senior leadership team in a way that gives confidence to the workforce that change will be affected, and that the team understand the expectations of staff in this regard.

10. A strategy is devised to identify and appropriately tackle those staff subject of or making repeated complaints and this is acted upon as a matter of priority.

11. A strategy is devised to identify those teams where behaviour or performance presents as problematic with a view to making appropriate interventions to address the issues.

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Accountability and Governance

Findings

Trust Values and Bullying & Harassment

" …..the problem with the values, bullying and harassment and the different codes of conduct is how do you know what is in operation and where do you find them?.."

As detailed earlier in the report, much commentary has been expressed about the need to reinforce the standards of behaviour expected in the Trust, building on the recent exercise to refresh the Trust Values. That process involved a significant level of staff involvement in shaping what they felt staff should commit to. The values arrived at were:

- We treat everyone with respect and compassion;
- We work as a team to improve quality;
- We take responsibility for our actions;
- We work together for patients and colleagues; and
- We learn, develop and share knowledge

The report makes it clear that the behaviours causing staff most concern and deemed unacceptable were those expressed in the 21 negative behaviours which constitute B&H. There was also a clear desire to ensure all staff, irrelevant of role, actively demonstrate positive behaviour that reflects the Trust values and should be held accountable when they do not.

As detailed earlier in the report, this remains a serious issue for staff which demands positive and effective action, and which is not negotiable. All too frequently contributors observed that in relation to its values, particularly those appertaining to behaviour and B&H that ***'it says one thing and does another'***. There was a significant level of frustration and much resignation that little is ever challenged or dealt with.

"The new values are great, but we need to see evidence from the top down that people are living and breathing them. We can't expect a HCA who works nights on the wards to give a stuff about the values unless they see the Matrons, Doctors, Finance Director, Head of Workforce and the CEO living them.."

"..behavioural standards and values need to be role modelled by all staff particularly those in leadership roles.."

The above observations are some examples of a strong contributor view which captures the essence if the issue; if progress is to be made then all staff need to be held to account for their behaviour. The question is how is this best achieved? I am strongly of the view that this

be approached on a policy, personal and organisational level in a way which can be measured and has proper oversight and governance commensurate with its strategic importance.

Policy

There is a real mandate and basis for enshrining the Trust values in a policy statement and linking them to the 21 negative behaviours of B&H and the relevant elements of the various professional codes of practice and the NHS Constitution. Such a 'Behavioural Standards' or Framework policy would make clear the behaviours expected of all staff and the procedure that would be adopted if they are not met. It would allow for such standards and expectations to be held in one place and provide an opportunity to slim down the discipline and B&H policies and provide for a common procedure for all staff.

There is, in my view, nothing in this approach that conflicts with the expectations of Maintaining High Professional Standards (MHPS). It is more a case of how, in clear terms, poor behaviour of medical staff is dealt with, in common with all other staff, before the MHPS process is engaged. There are examples from other trust as to how this works, and this could be spelt out in policy and procedure in this Trust. I am not making any observation as to the workings of the MHPS process as there is nothing to indicate that it is not working as it should. The issue is, as pointed out above, being clear as to when MHPS is engaged, preferable on the same basis as a potential disciplinary process for any other member of staff, if the poor behaviour is found to warrant it.

Whilst I acknowledge this may have a few challenges and would require development in consultation with professional bodies and staff, it would be a simplified expression of what behaviour expected and what is not and in which the Trust values are intrinsic. This approach received almost unanimous support when tested at workshop.

PDRs

"….. I question the value of the PDRs, we seem more interested in completion rates than the content and as a consequence it becomes a tick box exercise…."

"..trying to get them done is sometimes difficult. With no protected time they become rushed and the quality goes down.."

It is understood that the Performance and Development Review (PDR) system is itself going through transition from a paper to electronic process (Online Appraisal system), however, the above views represent the groundswell of feeling about the PDR process. Clearly, as the process was transitioning many observations were made on the basis of the paper system. That said, the below comments reflect the cultural hurdles that the roll out will face:

"The new system is complicated with no time to really learn it"

"It get 'pinged' back and forward, removing face to face contact and making the process complicated. I won't use it anymore I've gone back to paper"

Having examined documentation, I could not ascertain how the objectives were entered into the e-system and I have to say it did appear complex. Whilst not directly related to my inquiry, I make the observation that the PDRs should include a section clearly dedicated to staff development in which realistic development issues were articulated and commented on. It appears that this can happen in the e system, but clarity is important especially in relation to promotion or preparedness for other roles. This issue has a direct bearing on the WRES data regarding the success of BME staff in job/promotion processes.

Whilst the PDR had objectives and values, it was felt that the Trust values and behaviours should be made explicit and not just scored but subjected to an evidence-based entry to articulated how the appraisee has demonstrated them. Observations suggest that PDRs were an appropriate and powerful tool for holding all staff to account for their performance, but they were not used well.

The view that managers at all levels should be held to account for the performance of their teams in relation to the ER KPIs identified below and this should be contained with the PDR, was strongly supported in both interviews and workshops.

The fact is, despite staff surveys indicating it was valued by staff, it is considered a tick box exercise driven by a completion KPI rather than the quality of the content. There was much other feedback and observations around protected time, it not a replacement for face to face meetings, and the PDR being a positive focus for staff development and not system driven.

Again the 'top down' theme of leadership commitment was evident in much of the feedback and questions raised as to how this would work for clinicians and medical staff. Whilst the medical staff do have a separate appraisal system directed on a national basis, again I see no conflict between Trust values and the equivalent elements of this process and I would advocate this is examined so as to make the expectation as to what is being assessed very clear. The use of 360 appraisal, as use by medical staff, was felt worthy of introduction for all managers and I note the ambition for this in the Workforce Strategy. However, for these to work well the contributors to the appraisal should contain a substantial proportion of direct reports and staff who have daily contact with the appraisee and not just staff nominated by them.

Whilst the use of the PDR as an appropriate tool to ensure accountability it has a number of significant hurdles to overcome, some real and some perspective driven, to ensure it is a fully functioning and well used system and those responsible in Workforce will need to address this. However, this should not prevent steps being taken to use amend its use accordingly.

KPIs

Current arrangements do not provide for any real key performance indicators around B&H issues, or arguable pertinent related issues such as complaints. The need for the Board, managers and all staff to understand Trust, division and team performance is an absolute requirement if poor behaviour or performance is to be identified with an expectation that it is acted on. Furthermore, these indicators are not just about identifying poor but understanding where it is good, understanding why it is so and recognising the efforts of all staff in making it that way.

These indicators are common place in many other organisations, particularly outside of the NHS and, at the highest level, for open comparison between organisations. The need for KPIs that are relevant and published as a suite or balanced score card as a method of accountability at Trust, Division and Team level was given considerable support by contributors and workshops.

Workforce Strategy

A Workforce Strategy is critical to delivering a number of key strategic workforce objectives which are at the very heart of the Trusts performance, service delivery and ambition to improve. This is true of any business whose operational delivery relies heavily on people, especially if the service is complex and requires a variety of skills. In my experience such strategies, aligning Workforce activity in clear support of operational strategy and need, have existed in other public sector organisations for a number of years, in some cases well over a decade. The very recent production of such a strategy in the Trust is therefore to be applauded as it clearly focusses on a number of issues related to B&H either directly or indirectly.

Unsurprising, as it has been produced during the time of this inquiry, many of the goals and initial actions it contains reflect the findings and likely recommendations that were emerging from the inquiry. It will however require amending to take account of the full findings and recommendations contained in this report and this fact is acknowledged in the document. On that basis, I will make a few observations as to the content of it. These should be seen for what they are; the views of an independent observer and not a denigration of the document or any contributor.

Whilst it is right that the document contains targets and that those targets 'stretch' the Trust, I would suggest that some are overly ambitious for the timescales set or are not focused on measuring the right activity or indices. For example;

The goal to reduce the number of staff reporting experiences of bullying and harassment by other staff will reduce year on year, and by at least half by April 2021 (29% in 2017)

Whilst striving for a year on year reduction is appropriate and achievable, to suggest a halving by April 2021 is, in my view, unrealistic. In effect this means that by time of the staff survey in two years' the Trust will not only better the existing average (24%) and the best performing similar Trust (20%) but aims to achieve 14.5%, a score that is in the domain of the best Community Trusts. The goal should reflect the *'percentage of staff'* as opposed to '*number of staff'* as the Trust is seeking to drive up survey completion rates so the actual numbers will increase.

It is not appropriate for this report to critique the content of the strategy document particularly, as mentioned above, it will need revision. That said, in general terms there should be acknowledgement that the some of the goals mean tackling culture, which will take time and there is a degree of work that needs to be undertaken to understand some of the problems and set baselines from which to measure progress. These are imperatives for setting realistic targets and workstreams with appropriate timescales for delivery.

Role of Workforce and Education (WED)

It is important that the WED function is confident, well informed and well equipped to deal with the workforce challenges faced by the Trust, particularly as they appertain to ER matters including B&H. Whilst recognising the commitment, professionalism and personal values held by the WED staff, and that they are not responsible for the poor behaviour of others in the organisation, the negative views of many I have interviewed or spoken with cannot be ignored.

The Workforce and Education Department is regarded as the creator and guardian of the policies, overseer of the accompanying procedures and 'flag bearer' for the principles underpinning those policies. The wider staff have a right to expect those responsibilities will be applied fairly, impartially and, where it is obvious that processes or the principles are not being adhered to, that there is appropriate challenge and intervention. Unfortunately, in too many instances this has not been the case and the image of the department in this area has, in the eyes of many, been damaged.

In pursuing the Workforce strategy, it is critical, in my view, the talent and commitment of those in WED is harnessed in pursuit of the strategic objectives. Not only understanding how they contribute to success, both individually and as a team, but recognising that how they do so is equally important in the eyes of the rest of the Trust. There must be emphasis on meeting the expectations of staff, re-establishing trust and restoring confidence given the critical role of WED in tackling many issues including B&H.

Role of TME, WEC and Board

The role of senior management, committees and board groups are relatively clear in relation to most governance scenarios. In this particular instance much of the responsibilities are

about attitude, the need to demonstrate positive behaviour and the Trust values. I believe this is well understood given that it has been subject of so much staff feedback in the Values Refresh.

If progress is to be made in relation to B&H issues, however, the somewhat unpalatable findings of this report should be accepted and the relevant required actions, including some that may be uncomfortable, need to be supported. Any KPIs that are developed need to remain in the 'eye line' and a regime of robust accountability should endure, this responsibility should rest with an identified non – executive director and the Board.

I have no doubt that the CEO and Chair of the Board will champion this process, but members of the Board and executive should be in no doubt as to the expectations of staff that they unify in support of the drive to tackle bullying and harassment.

Conclusions

There is no real referencing between the Trust values, B&H behaviours and the professional codes of conduct. The positive reverse of B&H behaviours have much in common with the values of the Trust and those behavioural expectations of the various professional codes and NHS Constitution. However, these expectations are contained in disparate areas and not linked in a common format. There is a real benefit to concentrating the behaviours expected to be demonstrated and those that are not into one accessible and recognised behavioural document.

The use of PDRs as a powerful and appropriate tool for holding individuals to account in relation to values and behaviour is readily accepted by many staff. It is acknowledged that the PDR process is transitioning from paper to an electronic system, none the less the process is regarded by many staff as ineffective and a 'tick box' exercise. Whilst the new system may facilitate assessment of behaviour, demonstrating Trust values and a more structured approach to personal development there is still some work required to embed this.

Whilst there exists a variety of workforce related performance indicators, these in the main, reflect organisational performance around issues such as turnover, vacancies and sickness. The results of the staff survey are also circulated with a suitable level of drill down. However, a more holistic suite of KPIs relation to key ER issues is absent. The lack of a published 'balanced score card' deprives the Trust of a tool to hold managers to account. Moreover, managers are unable to determine performance and therefore what needs to be addressed and staff will not have the opportunity to understand and discuss solutions.

Whilst detailed commentary is made above about the role of Workforce and Education it is right and proper that the conclusions reflect the vital role they will play in tackling B&H and

the responsibilities placed upon them, in particular their senior leadership, in this regard. The expectations of the wider staff have been expressed and in pursuing the new Workforce strategy there must be emphasis on meeting the expectations of staff and restoring confidence in the policy, procedures and system designed to tackle many ER issues including B&H.

Recommendations

12. That a Behavioural Standards Policy or Framework is created which clarifies the expected standards of behaviour and is drawn from the Trust values, professional codes of conduct and bullying and harassment negative behaviours.

13. The content, use and training of PDRs is reviewed to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus and a positive emphasis on individual development needs.

14. An appropriate KPI regime is introduced which recognises the key indices upon which to measure B&H performance and hold managers to account at a Trust, Divisional and Team level.

Training and Education

Findings

Bullying and Harassment Training

"I am not aware of what is available. It has not been rolled out as a programme, if it was we would not be here now.."

Whilst this view opined by a long serving member of the Trust may be very singular, during my investigation, and reflected throughout this report, there has been a consistent theme relating to the availability of appropriate bullying and harassment training. Contributors reflected many different experiences of receiving training, its content and value. Whatever the sentiments expressed, what cannot be disputed is that the mandatory training figures show a clear focus on Equality, Diversity and Inclusion over B&H both in relation to those expected to undertake it, all staff for EDI as opposed to just managers for B&H. And the completion rates, which reflect 81% and 71% accordingly. This situation seemed to be reproduced in the quality and impact of the relevant training and education.

Many contributors observed that training such as Conflict Resolution and Unconscious Bias were well received, with appropriate content and delivered in a facilitative style. But it was observed that such training did not seem to have the feel of a 'suite' of core skills training that supported managers. Conflict resolution was aimed at dealing with issues arising with patients, carers and families as opposed to other staff.

"The Trust's position is made quite clear, whether all of the staff understand it is the challenge.."

"Staff are being bullied but they see it as the norm or do not understand that what is happening is bullying."

"In terms of bullying and harassment training, I think that needs to be revamped and not sugar coated"

These are but some of the views of interview and workshop contributors who were almost unanimous in their view that the existing training does not deliver in two keys areas; Firstly, by raising the awareness of all staff as to what behaviour constitutes bullying and what does not; Secondly, that managers need more than an understanding of policy and procedure, but an experiential or situational understanding of how to deal with these issues.

The issue of educating all staff as to what constitutes bullying and harassment, or in due course, the behavioural standards is considered a foundation to improving behaviour within

the Trust. it is key for staff to understand the boundaries of their own behaviour and the importance of speaking out when they encounter such experiences, either as recipients or as witnesses. Those contributing at workshop also felt it important that all staff should understand how to give and receive feedback if speaking out or challenging was not to be perceived as a personal attack.

I have used the term 'education' as it was clear that this is what is required as opposed to training. More specifically I am firmly of the view that such education should be delivered in a way that is easily digested and contains clear examples of unacceptable behaviour. It should highlight the right of managers to challenge poor behaviour and performance in an appropriate way, but also a clear message that it is right to challenge such poor behaviour and resolve any issues with adult to adult discussion. Education should provide confirmation on seeking advice, support and how to formally report it if necessary.

A range of tools for promoting this understanding were considered at workshops and it was felt that the intranet, posters and short animated videos, were considered ideal mediums. This issue was considered to be a priority.

The need to bring situational or experiential training into managers training was considered fundamental to providing confidence to manage these situations, as it allowed the grey areas of the negative behaviours to be discussed and exampled. Accordingly, it will heighten awareness of negative behaviours and poor leadership/management behaviours that lead to perceptions of B&H and enable leaders/managers to challenge their own and each other's behaviours, as well as of those they manage. This will require a culture of openness and sharing, and a willingness to speak out without fear of retribution and reprisal.

There was also a view from contributors that this training could readily be linked to or be part of training around managing difficult conversation. Any B&H or Behavioural Standards training for managers should be mandatory for all staff with a people management or leadership role. I emphasise leadership here as I consider medical staff to fall into this category, albeit some may not have direct people management responsibilities. As mentioned earlier in the report medical staff, particularly consultants, wield significant power and influence and with that comes leadership responsibilities the setting of proper example.

Managing Difficult Conversations

"…. The problem is too many of our bands six and 7's really don't know how to have difficult conversations, to 'nip things in the bud' or tackle poor performance, and so things carry on unchallenged."

In common with many other similar inquiries and reports into B&H, there was overwhelming evidence provided that many managers, particularly those new to people management role, lack the skills and confidence to tackle a range of difficult conversations, people or situations.

Many contributors, including senior managers, identified that they had never had any such training and that most of their junior managers would benefit from this training. Many identified the lack of this skill being a reason for a seemingly *laissez- faire* approach to dealing with low level issues or why some attempts to do so escalated into conflict and grievance.

I consider this a fundamental and core management skill, vital at foundation management level or when stepping into such a role for the first time. This is not just an issue of managing B&H behaviours, but is an essential skill for dealing with poor performance / capability, poor behaviour, and sick absence. It is not just about addressing such instances but managing difficult people or situations. Even the proper completion of the PDR process can be uncomfortable process for managers and a point of conflict.

Training on managing difficult conversations should be a mandatory part of manager training for new to role or new to Trust managers. Ideally it should be mandated for all managers, but I recognise the costs and logistic involved. It is strongly felt that a programme to cover all foundation and 2nd tier managers should commence as soon as possible, and consideration should be given to making the training available to those staff who genuinely aspire to leadership and are close to taking that step.

Investigator Training

The need for investigator training has been articulated earlier in this report, however there is a need for clear understanding of what I have found to exist and what is needed. The view occasionally expressed that "investigation is simply gathering the facts and presenting them" is misplaced and fails to recognise the skills required, principles that govern good investigations and the consequences of getting it wrong.

Basic investigation and case handling skills form part of the core skills of every manager and as such this training should be an intrinsic part of foundation management training for managing ER issues. This view was strongly expressed by workshop contributors.

Of greater importance is the enhanced training that should be given to those staff who, as part of their role as a manager or as a 'cadre of selected volunteers', will be expected to conduct investigations on a regular basis. Whilst the training currently delivered takes attendees through the workplace investigative process and does deal with some problematic challenges they may face, it places greater emphasis on the process that the investigative skills or techniques required or principles which guide the process.

"I have been trained but it was some time ago. Whilst I went through the process I not sure I was taught too much about how to really investigate.."

Discussions with contributors revealed a lack of skill and understanding of such things as; the setting of terms of reference, investigation planning, documenting the inquiry, understanding proportionality, planning and conducting proper interviews and the delivery of a report able to withstand scrutiny and challenge. This is consistent with what I have found in other trusts and organisations who operate similar case management models. Enhanced or revised training will do much to improve the skills and confidence of investigators to conduct thorough, quality investigations in a timely fashion. In my view, this training is vital to improving case handling of all ER cases and its delivery can be done completed within a day.

In cases where the role of the investigator is more permanent or frequent, such as within the ER team, I take the view that this training should be more in-depth and expanded to provide and embed a greater understanding and skills set.

I earlier mentioned a 'cadre of selected volunteers'. This concept arose from a workshop where a view emerged that not all investigators need be managers especially if availability was an issue. Whilst historically managers have been selected, this has mainly been on the assumption that as part of their role they will be dealing with ER issues of their own staff or those within the division. However, there is no reason, in principle, why non-managerial staff could not be trained if they showed the aptitude and competence for the role. The main difficulty here, I suspect, would be extraction from core duties to facilitate an investigation, but the proposition may be worth considering as the message it would send would be quite powerful.

Conclusions

Given the identified levels of B&H in the Trust, the apparent lack of understanding amongst staff and managers as to what does and does not constitute unacceptable behaviour, and the displays of poor behaviour identified at all levels, I am driven to the conclusion that current B&H training is not meeting staff needs both at a managerial and non-managerial level.

All staff, but particularly managers and consultants, need a heightened awareness of negative behaviours and poor leadership/management behaviours that lead to perceptions of B&H or are not in keeping with Trust values. This requires specific education to accustom themselves as to what bullying and ill-treatment is (and is not), what behaviours the Trust values and those it does not, and which foster a culture in which individuals can speak out without fear of retribution and reprisal.

B&H training for managers must include interactive sessions where they explore B&H behaviours, understand their role in them and the processes required to tackle them in early intervention.

There is substantial evidence that many managers, particularly those new to people management role, lack the skills and confidence to tackle a range of difficult conversations, people or situations which militates against early intervention in many ER issues particularly B&H.

Investigator training does not contain the emphasis on investigation skills and techniques needed to ensure that those charged with conducting inquiries have the tools and confidence to deliver timely, effective and quality investigations which will stand scrutiny.

All staff particularly managers should understand the value of undertaking such training and the strategic importance attached to it by the Trust. Given the pressures on staff time the Trust may wish to review what training in the 'mandatory' portfolio is truly mandatory and ensure that steps are taken to ensure completion, and where it is not, hold staff to account. This may best be achieved during the PDR process.

Recommendations

15. An education programme should be put in place for all staff to heighten awareness of B&H negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how staff should respond when they are recipients of such behaviour.

16. Mandatory B&H training for managers should be reviewed and must include interactive sessions where they explore B&H behaviours, understand their role in them and the processes required to tackle them in early intervention.

17. All managers, particularly those in foundation management role or new to post should receive appropriate training for managers to provide the skills and confidence to challenge poor behaviour by managing difficult conversions or difficult people.

18. Training for investigators should be reviewed to ensure appropriate weight is being given to investigation skills and principles as well as process.

Final Observations and Acknowledgements

Throughout this inquiry I have been struck by the professionalism, care and consideration of those who contributed and all of the staff I have met. It is evident that the Trust has committed, talented and caring people focussed on delivering the highest levels of patient care in quite challenging circumstances. Those present or former members of staff who came forward care very deeply that the Trust should be a well-regarded, happy, and compassionate workplace where its staff can give of their best to the communities it serves.

For many their sense of loyalty and commitment has been tested to breaking point by a culture, cascading from the top down, of performance driven patient care at the expense of the people delivering that care, in which bullying and harassment have been able to thrive and long been tolerated.

This is not to demonise the entire Trust, but to acknowledge evidences of unacceptable behaviour by some, whether non-managerial, managerial or medical staff, inflicts damage on everyone and potentially undermines the ability of the Trust to deliver the very best patient care.

Whilst much of this report, by its very nature, paints a dim picture and only uses a measured proportion of the volume of information and personal accounts provided, I do not believe that the problems are insurmountable. It is recognised that the inquiry looks back over the last few years during which time people and circumstance may have changed, however, there remain urgent problems that the Trust now needs to tackle.

Underpinning all the recommendations in this report is the need for broad cultural change and the need to restore the trust and confidence of the staff in the leadership, processes and systems through which poor behaviour is managed. Delivering such change will require a genuine and demonstrable commitment on the part of the Board and senior management teams across the Trust, including recognition that it will be difficult to build confidence that there will be fundamental change, particularly if some of those expected to be the levers of change are regarded as part of the change that is needed.

I would like to express my gratitude to everyone who has contributed to this inquiry. The overwhelming view was one of positivity and optimism, which was frequently linked to the recent arrival of some key executives. I was taken aback by the level of anticipation as to the conduct and findings of this inquiry and the expectations of action that may follow it. I hope they feel that this report does justice to their contributions, but I emphasise that this has been an inquiry into the nature and extent of the problems, not an investigation into any individual.

There is now a responsibility to act and I am confident that the new CEO will ensure a swift and appropriate response to this inquiry. The findings in this report and the recommendations made will, I hope, be of real assistance in that task. I recognise that some recommendations, and the actions required to make them effective, may challenge thinking around workforce policies and practices that have been shaped by years of NHS HR tradition or culture. Such is the scale of the bullying and harassment problem, both within the Trust and wider NHS, I believe the current situation presents an opportunity for the Trust to take a more enterprising, if not radical, approach to effect sustainable and long-term change.

Andrew MJ Gent
Director
Ashfold Consulting Limited

20th December 2018

Summary of Recommendations

I recommend that:

Levels

1. The mechanisms for reporting wrong doing are reviewed to produce clear and accessible reporting channels including:
    a. Clarification of the roles of the EDI network and Freedom to Speak Up Guardians;
    b. The introduction of an independent confidential reporting line; and
    c. An overhaul of the Whistleblowing Policy

2. The Trust considers the introduction of a network of Resolution Advisors.

3. The exit interview process is urgently reviewed, revised and re energised.

4. An Information Management Strategy is devised with a view to the collation, analysis and publication of key data sets to provide for a greater understanding of the issues and target interventions.

Handling

5. The Trust builds upon the recent changes to the ER Team to enhance its recording, case management, investigative and the decision-making capacity including:
    a. Mandating the timing and format of the reporting and recording of all ER issues;
    b. Augment of the ER Manager role in relation to decisions to investigate and decisions to enter formal proceedings;
    c. Providing suitable level of investigative capability and capacity; and
    d. Develop relevant case management KPIs to inform the Trust and TPI's to inform the team

6. All or a significant sample of key cases from the last three years is reviewed to ensure that, given the nature of the allegation, the handling, investigation and outcomes are appropriate.

7. The Trust reviews the structure, training and use of workplace investigators to establish the Trusts' preferred model for managing workplace investigations.

8. Relevant policies are reviewed and revised to ensure they are fit for the effective management of behavioural issues of all members of staff including:
    a. Introducing a structured management action/advice file note process;
    b. Introduce appropriate links to engage the MHPS procedures; and
    c. Publish all formal disciplinary hearing outcomes

Culture

9. The past failures of the senior team are publicly acknowledged, and the CEO builds a senior team that gives confidence to the workforce that positive change will occur and that the team understand the expectations of the staff in this regard.

10. A strategy is devised to identify and appropriately tackle those staff subject of or making repeated complaints and this is acted upon as a matter of priority.

11. A strategy is devised to identify those teams where behaviour or performance presents as problematic with a view to making appropriate interventions to address the issues.

Accountability and Governance

12. That a Behavioural Standards Policy or Framework is created which clarifies the expected standards of behaviour and is drawn from the Trust values, professional codes of conduct and bullying and harassment negative behaviours.

13. The content, use and training of PDRs is reviewed to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus and a positive emphasis on individual development needs.

14. An appropriate KPI regime is introduced which recognises the key indices upon which to measure B&H performance and hold managers to account at a Trust, Divisional and Team level.

Training and Education

15. An education programme should be put in place for all staff to heightened awareness of B&H negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how they should respond when they are recipients of such behaviour.

16. Mandatory B&H training for managers should be reviewed and must include interactive sessions where they explore B&H behaviours, understand their role in them and the processes required to tackle them in early intervention.

17. All managers, particularly those in foundation management role or new to post should receive appropriate training for managers to provide the skills and confidence to challenge poor behaviour by managing difficult conversions or difficult people.

18. Training for investigators should be reviewed to ensure appropriate weight is being given to investigation skills and principles as well as process.

Bibliography and References

Documents and Data

Data

- Staff Survey 2017;
- Sickness Absence;
- Vacancy Rates;
- Temporary and Agency Staffing Levels;
- Exit Interviews Summaries;
- Complaints and PALs data;
- ER Case Data;
- BH and ED compliance Sept18;
- Workforce Indicators October 2018; and
- Student Dashboards QEH & UHL Q1

Policies

- Attendance;
- Grievance;
- Disciplinary;
- Capability;
- Dignity at Work -Bullying and Harassment;
- Sickness absence;
- Speak Up – Whistleblowing;
- Maintaining High Professional Standards; and
- Lewisham and Greenwich MES Report August 2017

Other documents

- Exit Interview Reports and Summaries;
- PDR content and the Online Appraisal manual;
- 2017 CQC Report;
- Visions and Values Refresh Report;
- Workforce Strategy (V2) November 2018;
- UHMB Behavioural Standards Framework;
- Code of conduct for NHS managers 2002;
- Various emails and documented submissions;
- Education and Development Brochure 2018-19---Version-3;
- Conduct in Meetings Poster; and
- Leadership capacity review report Part one – findings.

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Appendix A – Interview Guide

1. Explain my background, Neutral evaluation task and confidentiality
2. Name & Role?
3. Time in LGT?
4. Time in Role?
5. Previous experience?
6. B&H Training – what is available?
7. What has been trained?
8. B&H awareness by staff and managers?
9. Dealt with any B&H incidents?
10. Suffered B&H incidents?
11. Witnessed B&H incidents?
12. What are the main issues of B&H arising?
13. How do you think they are dealt with?
14. What B&H performance data do you receive.?
15. Areas of good practice?
16. Areas of poor practice?
17. PDRs how, quality, effect on Values/ Behaviour?
18. What is the Trusts message and how is it perceived?
19. What the does Trust do well?
20. What could be improved?
21. Overall view of how B&H is addressed in LGT
22. Anything else you wish to add or that my enquiry my find information or valuable?
23. Is there anybody you think I should interview inside or outside of the organisation?

Appendix B – Workshop Recommendations

ACCOUNTABILITY AND GOVERNANCE

Ensure policies promote clear behavioural expectations and link B&H behaviour to Values and Codes of Conduct – Behavioural Standards Framework?

Review the content, use and training of PDRs to ensure they are a meaningful method of reflecting overall performance, including a behaviours and values focus, and staff development needs.

Devise and introduce an appropriate KPI regime which recognises the key indices upon which to measure performance and hold managers to account at a Trust, Divisional and unit level

LEVELS

To review reporting mechanisms to produce clear and accessible reporting channels in which the staff have confidence including:

- Revised or expanded questions in the staff survey (or Friends and Family) to include B&H negative behaviours
- Clarifying roles of EDI Network and Freedom to Speak Up Guardians
- An appropriate confidential reporting line (independent if necessary) including anonymous reporting
- Consider the introduction of Resolution Advisors (internal)

That an information management strategy is created to collate , analyse and publish key data sets to understand the issues and target interventions

- Data sets – WRES, Staff Survey, Exit interviews, ER Case Management, PALS, SI, Datix, Sickness etc (> 12)
- Analysis and publication Trust wide performance, 'Hots spots' identification and root cause analysis

HANDLING

Build upon the recent changes to the ER Team :

- Improve reporting and recording of all ER issues
- Enhance ER Manager role in relation to decisions to investigate or enter formal proceedings
- Provide (short term) investigative capacity to ER Team
- Introduce reviewing process to ensure standards are met and ID learning

Review the structure, use and training of workplace investigators.

- 20-30 trained investigators (band-8)
- Create Investigation Continuum

Review and revise relevant policies to ensure they provide for the effective management of behavioural issues of all members of staff including:

- B & H is part of Trust Values which are embedded in a "Behavioural Standards" Policy or Framework
- Introduction of management action file notes
- Appropriate link with MHPS
- Publication of disciplinary hearing outcomes

Training and Education

Review, revise and mandate training and education to:

- Raise the awareness of all staff as to what is unacceptable behaviour, how it should be challenged and managed

- Training for managers should focus on situational learning more than policy

Introduce or revise foundation or induction training for managers to provide the skills and confidence to have difficult conversations and challenge poor behaviour/ performance at an early stage

Appendix C – BWBS 21 B&H Behaviours

Question	Never	Rarely	Sometimes	Monthly	Daily
Someone continually checking up on you or your work when it is NOT necessary?					
Having your views and opinions ignored?					
Someone withholding information which affects your performance?					
Pressure from someone else to do work below your level of competence?					
Being given an unmanageable workload or impossible deadlines?					
Your employer not following proper procedures?					
Being treated unfairly compared to others in your workplace?					
Being humiliated or ridiculed in connection with your work?					
Gossip and rumours being spread about you or having allegations made against you?					
Being treated in a disrespectful or rude way?					
People excluding you from their group?					
Being shouted at or someone losing their temper with you?					
Intimidating behaviour from people at work?					
Feeling threatened in any way while at work?					
Pressure from someone else NOT to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses)					
Being insulted or having offensive remarks made about you					
Teasing, mocking, sarcasm or jokes which go too far					
Receiving actual physical violence at work					
Injury in some way as a result of violence or aggression at work					
Hints or signals from others that you should quit your job					
Persistent criticism of your work or performance which is unfair					

As identified by Fevre, R., Lewis, D., Robinson, A. and Jones, T. (2011). *Insight into ill-treatment in the Workplace: patterns, causes and solutions*. Cardiff University

GLOSSARY

B&H	Bullying and Harassment
BME	Black and Minority Ethnic
BWBS	British Workplace Behaviour Survey
CEO	Chief Executive Officer
CQC	Care Quality Commission
EDI	Equality and Diversity Inclusion
ER	Employee Relations
ET	Employment Tribunal
HR	Human Resources
KPI	Key performance Indicator
MES	Medical Engagement Scale
MHPS	Maintaining Higher Professional Standards
PDR	Performance and Development Review
TME	Trust Management Executive
TPI	Team Performance Indicator
WED	Workforce and Education Department