**Workplace bullying in the NHS:**

**Prevalence, impact and barriers**

**to reporting**

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**Introduction**

**W**ORKPLACE BULLYING is a persistent problem in the NHS (Hoel & Cooper, 2000; NHS staff surveys; Quine, 1999), with significant negative implications for individuals, teams and organisations (Illing et al., 2013; Salin, 2009). Definitions vary, but Einarsen et al. (1994) define bullying as *‘a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty defending him or herself against these actions.’*

Bullying is regarded as *‘a significant source of social stress at work… and a more crippling and devastating problem for employees than all other work-related stress put together’* (Einarsen

& Mikkelsen, 2003, p.127). It has been associated with poorer psychological health and well-being, including social isolation and maladjustment, depression, helplessness, anxiety, and despair (Leymann, 1990). Bullying is linked to higher levels of both psychosomatic and musculo–skeletal complaints (Einarsen & Raknes, 1997), substance abuse (Traweger et al, 2006; van Heughten, 2010), sleep problems (Lallukka et al., 2011; Vartia, 2001), suicide ideation (Brousse, 2008), and risk of

cardiovascular disease (Kivimaki, 2003).

For organisations, the cost of bullying can be substantial (Rayner & McIvor, 2008): it has been estimated that the annual cost of workplace bullying in the UK is £13.75 billion, taking into account absenteeism, turnover and productivity (Giga et al., 2008). Detrimental effects extend to bystanders (Hoel & Cooper, 2000), and bullying has implications for patient safety (Paice & Smith, 2009) and quality of care (Woodrow & Guest, 2008). Furthermore, a bullying culture has been implicated in investigations into poor practice and patient care at NHS Lothian (Bowles, 2012) and Mid-Staffordshire NHS Foundation Trust (Francis, 2013).

This mixed-methods study aimed to examine the prevalence and impact of bullying behaviours between staff in the NHS and to explore the barriers to reporting bullying.

**Method**

***Participants***

Seven NHS organisations participated in the study, representing acute care, primary

care and mental health care provision. In large organisations (>3000 staff), a random sample of 850 staff was selected, whereas in smaller organisations (up to 600 staff), all staff were invited to participate. Paper and/or online questionnaires were distributed, according to the preference of the organisation. All staff in the questionnaire sample were also invited to participate in a telephone interview.

Questionnaires were returned by 2950 staff members with an estimated overall response rate of 46 per cent (this is likely to be an underestimate as some distribution relied on an email cascade system and distribution lists included some out-of-date email addresses). Most respondents were female (72.3 per cent, N=2133), and all age groups were represented. The majority of participants defined themselves as White British (81.7 per cent, N=2410), followed by Asian-Indian (5.3 per cent, N=157), although a number of ethnic groups were represented. Disability was reported by 2.7 per cent (N=81) and a further 5.1 per cent (N=149) did not disclose their disability status. A range of occupational groups were represented: the largest groups were the wider health care team (including admin, central/corporate services, maintenance and facilities), medical and dental staff and registered nurses. Telephone interviews were conducted with 43 participants.

Design

This mixed-methods study included an anonymous questionnaire and semi-structured telephone interviews. The questionnaire was developed to measure the prevalence and impact of bullying. It included the 22-item revised Negative Acts Questionnaire (NAQ-R; Einarsen et al., 1994), which measured the frequency of 22 negative behaviours on a five-point scale (never; now and then; monthly; weekly; daily). Overall bullying (according to a definition) was measured by a single-item with five response options: no; yes, but only rarely; yes, now and then; yes, several times a week; and yes, almost daily. To assess the impact of bullying on mental health, the 12-item General Health Questionnaire (GHQ-12; Goldberg, 1978) was included as an indicator of psychological distress. Further items were developed and piloted for this questionnaire, and included questions on the barriers to reporting bullying, sources of bullying, the frequency with which bullying between staff was witnessed, and whether any exposure to the 22 negative behaviours in NAQ-R had been reported to an authority figure. Participants were also asked about their job satisfaction, intentions to leave work, self-reported sickness absence, and demographic characteristics.

Semi-structured telephone interviews were conducted to investigate experiences of bullying in greater depth. With consent, the interviews were recorded and transcribed. The transcripts were analysed using inductive thematic analysis (Braun & Clark, 2006), and interview data were used to triangulate and elaborate on survey findings.

Results

Overall prevalence of bullying and witnessed bullying Overall, 19.9 per cent (N=575) of participating staff had been bullied to some degree (i.e., from rarely to daily) by other staff in the last six months, including 2.7 per cent (N=79) who had been bullied several times a week or almost daily. A large proportion of health care staff had witnessed colleagues being bullied at work: 43.4 per cent (N=1212) reported that they had witnessed bullying at least now and then in the last six months, and 5.3 per cent (N=148) had witnessed it daily or weekly.

*Prevalence of negative behaviours*

All of the 22 negative behaviours listed in the NAQ-R were reported by health care staff. The most prevalent behaviours included work–related behaviours (for example, unmanageable workload and someone withholding information that affects an individual’s performance), being humiliated over work, socially isolating behaviours (for example, being ignored) and being shouted at or being the target of anger.

*Sources of bullying*

Supervisors and managers were the most common source of bullying (51.1 per cent of those bullied, N=294), followed by peers (31.1 per cent of those bullied, N=179). Workplace culture was highlighted as a source of bullying by 18.3 per cent of bullied staff (N=105) and this theme was also evident in the interview data.

*‘Certain departments have an ethos of being rude, unpleasant and occasionally verbally*

*aggressive. When you have day to day contact with these people it can be exhausting and*

*severely undermines confidence in your abilities.’ (L204)*

*‘I think sometimes people can create a very negative culture where it’s not about a specific*

*incident of bullying,… you wouldn’t be able to put your finger on certain things but just that*

*there would be a culture that you worked under where you never felt comfortable… it’s just*

*how people are generally made to feel.’ (T120)*

Workload pressures, particularly among managers, were also regarded as partially to

blame for bullying behaviours.

*‘Quite often the people doing the bullying are actually stressed… if they are trying to get*

*something done, they’re stressed, the people in front of them aren’t performing or doing the*

*things they think they should be doing, then they sort of demonstrate that… with certain*

*bullying behaviours… which can verge on being abusive at times.’ (T65)*

*Reporting of bullying*

Bullying was under-reported. Of the staff who experienced bullying behaviours to some degree, between 2.7 per cent and 14.3 per cent reported it to someone in authority, depending on the behaviour.

There were numerous barriers to reporting bullying, particularly the belief that nothing would change, not wanting to be seen as a trouble–maker, the seniority of the bully, the belief that management would not take action and concerns that the situation might deteriorate further.

*Impact of bullying and negative behaviours*

Correlational analyses indicated that being directly exposed to higher levels of negative behaviours in the workplace, or witnessing bullying, was associated with higher levels of psychological distress, increased intentions to leave (i.e., thinking about quitting job, looking for another job and thinking about quitting due to bullying), higher rates of self–reported sickness absence and lower levels of job satisfaction.

Quantitative results were supported by interview data, which offered a richer insight into the impact of bullying on individuals.

*‘the stuff that happened to me was really quite trivial and petty but it’s like a drip drip drip*

*effect… it’s like a constant worry… you are living in fear all the time and it’s ridiculous for*

*something as trivial as that to make you feel so scared…’ (T22)*

*‘I couldn’t sleep…I burst into tears at work… I just couldn’t think straight’ (T18)*

Interviewed staff reported behavioural, emotional and physical effects on themselves as a result of bullying. Although the data presented here are cross-sectional and rely on participants’ perceptions, they suggest that bullying is perceived to have a causal role:

‘it affected me physically… symptoms which I realise now [were] psychosomatic because of the stress you were under and they’ve gone away since I came away from that’. (T143)

Bullying also had an effect on performance and communication within teams.

‘the other thing that it does is it stifles general discussion of support and help… you just basically get an environment where everyone sits quiet because they don’t want to ask a question because they think they are going to get attacked.’ (T13)

Conclusions

This mixed-methods study investigated the prevalence, sources and impact of bullying in the NHS and highlighted the most common negative behaviours experienced by staff. It extended previous research in health care by investigating the barriers to reporting bullying and explored these issues using qualitative interviews.

Despite increased awareness, the introduction of policies, and a greater range of training and organisational interventions, the problem of workplace bullying persists and there are considerable barriers preventing staff from reporting issues. Given current economic challenges in health care organisation and delivery, levels of bullying may be set to increase as research indicates that bullying rates are typically higher during times of organisational change, budget cuts and restructuring (Hoel & Cooper, 2000).

The study findings have implications for health care staff, managers and policymakers. Knowledge of the most prevalent behaviours should inform the development of interventions targeted at the most problematic negative behaviours. Questionnaire tools such as NAQ-R could be used to monitor the prevalence of negative behaviours as part of ongoing organisational development. A large number of staff witnessed the bullying of colleagues, and interventions could be designed to encourage bystanders to intervene and to provide the necessary skills to challenge negative behaviours.

There are few studies on the efficacy of workplace bullying interventions (Vartia & Leka, 2011), and there is a clear need for further research to identify evidence-based interventions (Illing et al., 2013).

This research highlighted the persistence of bullying and negative behaviours in health care; demonstrated a link between experiencing and witnessing negative behaviours and the health, well-being and organisational commitment of staff; and identified key barriers to reporting bullying. Removing these barriers and evaluating interventions to reduce negative behaviours in the workplace are important avenues for investment in the well-being of the health care workforce.

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