

Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS

J.C. Illing, M. Carter, N.J. Thompson, P.E.S. Crampton, G.M. Morrow, J.H. Howse, A. Cooke, and B.C. Burford

Durham University, School of Medicine, Pharmacy & Health



Published February 2013

This project is funded by the Service Delivery and Organisation Programme

Address for correspondence:

Professor J.C. Illing
Centre for Medical Education Research
Durham University
Burdon House
Leazes Road
Durham
DH1 1TA

© Queen's Printer and Controller of HMSO 2013. This work was produced by Illing *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Project 10/1012/01

Email: j.c.illing@durham.ac.uk

This report should be referenced as follows:

Illing JC, Carter M, Thompson NJ, Crompton PES, Morrow GM, Howse JH, *et al.* Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS. Final report. NIHR Service Delivery and Organisation programme; 2013.

Relationship statement:

This document is an output from a research project that was funded by the NIHR Service Delivery and Organisation (SDO) programme based at the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) at the University of Southampton. The management of the project and subsequent editorial review of the final report was undertaken by the NIHR Service Delivery and Organisation (SDO) programme. From January 2012, the NIHR SDO programme merged with the NIHR Health Services Research (NIHR HSR) programme to establish the new NIHR Health Services and Delivery Research (NIHR HS&DR) programme. Should you have any queries please contact sdoedit@southampton.ac.uk.

Copyright information:

This report may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to:

NETSCC, HS&DR.
National Institute for Health Research
Evaluation, Trials and Studies Coordinating Centre
University of Southampton
Alpha House, Enterprise Road
Southampton SO16 7NS

Disclaimer:

This report presents independent research funded by the National Institute for Health Research (NIHR). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and not necessarily those of the NHS, the NIHR or the Department of Health.

© Queen's Printer and Controller of HMSO 2013. This work was produced by Illing *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Project 10/1012/01

Criteria for inclusion

Reports are published if (1) they have resulted from work for the SDO programme including those submitted post the merge to the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors. The research in this report was commissioned by the SDO programme as project number 10/1012/01. The contractual start date was in June 2011. The final report began editorial review in April 2012 and was accepted for publication in December 2012. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The SDO editorial team have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report documentation. However, they do not accept liability for damages or losses arising from material published in this report.

Acknowledgements

The research team would like to thank the following workplace bullying experts, practitioners, methodology experts, and our Advisory Panel for their invaluable contributions to this project. We would also like to thank individuals who contributed in a confidential capacity.

Thorkatla Aðalsteinsdóttir, Life & Soul Psychology Consultancy
Pete Blakeman, Northern Deanery
Carol Borrill, Sheffield Health and Social Care NHS Foundation Trust
Ruth Briel, Tees Esk & Wear Valleys NHS Foundation Trust
Jenna Brown, North East Ambulance Service NHS Trust
Sue Covill, NHS Employers
Maxine Craig, South Tees Hospitals NHS Foundation Trust
Rainy Faisey, Consultant
Sabir Giga, University of Bradford
Kathryn Graham, CMP Resolution
Nic Hammarling, Pearn Kandola
Helge Hoel, University of Manchester
Keir Howe, GMB
Teresa Jennings, Northumbria Healthcare NHS Foundation Trust
Trevor Johnston, Unison
Michael Lassman, Equality Edge
Duncan Lewis, Plymouth University
Andreas Liefoghe, Birkbeck University of London
Kevin Meaney, New Tricks
Jane Miller, NHS Business Services Authority
Angela Paradise, South Essex Primary Care Trust
Wendy Pearson, North East Leadership Academy
Charlotte Rayner, University of Portsmouth
Heather Robb, Durham University
Tres Roche, Psych Solutions
Emma Rushmer, South Tees Hospitals NHS Foundation Trust
Stephanie Smith, City Hospitals Sunderland NHS Foundation Trust
Anne Stringer, Northumbria Healthcare NHS Foundation Trust
Paul Sukhu, North Middlesex University Hospital

© Queen's Printer and Controller of HMSO 2013. This work was produced by Illing *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Julian Topping, NHS Employers
Roy Westhead, County Durham & Darlington NHS Foundation Trust
Karen White, North East Ambulance Service NHS Trust
Jillian Wilkins, County Durham & Darlington NHS Foundation Trust
Geoff Wong, Queen Mary, University of London

Executive Summary

Background

Workplace bullying is a persistent problem in the NHS with negative implications for individuals, teams, and organisations. Bullying is a complex phenomenon and there is a lack of evidence on the best approaches to manage the problem.

Aims

Research questions

What is known about the occurrence, causes, consequences and management of bullying and inappropriate behaviour in the workplace?

Objectives

Summarise the reported prevalence of workplace bullying and inappropriate behaviour.

Summarise the empirical evidence on the causes and consequences of workplace bullying and inappropriate behaviour.

Describe any theoretical explanations of the causes and consequences of workplace bullying and inappropriate behaviour.

Synthesise evidence on the preventative and management interventions that address workplace bullying interventions and inappropriate behaviour.

Methods

To fulfil a realist synthesis approach the study was designed across four interrelated component parts:

Part 1: A narrative review of the prevalence, causes and consequences of workplace bullying

© Queen's Printer and Controller of HMSO 2013. This work was produced by Illing *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Part 2: A systematic literature search and realist review of workplace bullying interventions

Part 3: Consultation with international bullying experts and practitioners

Part 4: Identification of case studies and examples of good practice

Results

Narrative Review

Prevalence

Bullying prevalence rates vary depending on the measurement method used. Common methods include self-labelling as a target of bullying, with or without a definition of bullying, and rating the frequency of different negative behaviours. Recent meta-analytic data from 24 countries reported bullying prevalence rates from 11.3% to 18.1% depending on the measurement method. Around 15% of NHS staff report experiencing bullying from other staff members. The prevalence of bullying has been found to be higher among staff with disabilities.

Males have been found to engage in more workplace aggression than females. Particular leadership styles have been associated with bullying: autocratic, tyrannical and laissez-faire leadership (non-leadership).

Antecedents

Bullying is complex, with multiple causes at the individual, group, and organisational levels.

Individual antecedents characterise the target and perpetrator to understand how particular attributes may evoke bullying behaviours or the perception of bullying. Personality profiling of both groups is still exploratory and while there are trends towards certain personality traits, the evidence overall indicates that they are heterogeneous.

Social or group antecedents have focused on interactions within a group that can lead to bullying. These explanations are often theoretically based

© Queen's Printer and Controller of HMSO 2013. This work was produced by Illing *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

rather than empirical. Many of the explanations draw on social theories where observation, positive reinforcement, norms of behaviour acceptance, and lack of challenges to negative behaviour may perpetuate bullying.

Organisational antecedents often take a more holistic view of bullying, viewing the system at the root of the problem rather than an individual or group. Empirical evidence has found higher levels of bullying in times of organisational change, in hierarchal organisations, in the presence of destructive leadership styles, and where bullying goes unchecked through lack of disciplinary action.

Consequences

Empirical research has demonstrated that bullying has numerous negative implications for individuals, groups, and organisations. For an individual the consequences may include detriments to psychological and physical health and damaged home relationships. At the group level, witnesses of bullying have been found to have higher levels of psychological distress, higher rates of sickness, and lower organisational satisfaction. For organisations, consequences include lower job satisfaction, higher turnover, higher absenteeism, and a negative effect on patient care.

The economic implications of replacing staff and reduced productivity resulting from bullying can be significant: a recent review estimated that the annual cost of bullying to organisations in the UK is £13.75 billion, taking into account absenteeism, turnover and productivity.

Overview

Overarching theoretical models that attempt to explain bullying take a broad approach, incorporating individual, social and organisational antecedents and outcomes. These models often address the interplay between these different levels.

The literature suggests that the incidence, perception, and consequences of bullying depend on individual characteristics of both perpetrator and target, including personality variables. Social dynamics can exacerbate conflict if not managed. However, the interpersonal relationship also takes place in an organisational context in which factors such as leadership, organisational

change and work design can act to inhibit or precipitate conflict, which may be perceived as bullying by some individuals.

Realist Synthesis

The majority of papers identified were limited in their research design. However, rather than returning a report concluding 'more research is needed' we examined the details of interventions using a realistic synthesis approach. This enabled us to identify patterns by considering studies that, although deficient in terms of robust research findings, nonetheless offered insight into the important contextual factors and mechanisms that could explain why an intervention was likely to work or not.

We identified research that highlighted the link between the level of management support to employees and the level of psychological distress and workplace bullying. Supportive work environments protect individuals from some of the harmful effects of bullying.

Organisational climate was strongly influenced by the behaviours and values of managers and their commitment to supporting (or not) the wellbeing of staff. We identified that interventions were more likely to succeed if leadership commitment was present, and fail when it was absent.

Several studies identified that managers act as role models for employees, who then reflected their behaviours and values. Studies highlighted the need for managers to possess good interpersonal skills, to help identify and deal with incidents of bullying quickly.

Interventions were typically more successful when part of a strategic approach to tackling bullying at the organisational level, involving senior management support, structural support and resources, proactive and empowered staff, publicity, and readiness for change. The role of leaders and managers was crucial: to lend support and credibility to interventions, role model appropriate behaviours, drive and maintain change, and create a culture in which negative behaviours are challenged.

Training and team activities benefited from involving a critical mass of staff or being targeted at managers, and being delivered by skilled facilitators. Training content needed to be relevant and tailored to the local context.

Interventions should focus on key mechanisms for change: increasing insight into the perspective of others and differences in personal style, practicing conflict management and communication skills, instilling personal responsibility to challenge negative behaviours, generating solutions to local problems, empowering staff to implement change, and ensuring leaders are positive role models.

There was limited evidence on the effectiveness of therapeutic and supportive interventions directed at individuals, although some benefit was reported in case studies on coaching and mentoring.

Recommendations

- A culture should be established in which employees have a heightened awareness of workplace bullying, negative behaviours are challenged and positive behaviours endorsed.
- Focus preventative interventions firstly at the leaders and managers, who have the power to prevent and manage bullying and to change the culture.
- When an intervention is introduced, the support of leaders and managers is critical to intervention success.
- Formal policies and procedures should be promoted to outline the organisation's explicit commitment to tackling bullying.
- Proactive monitoring of organisational data should be considered to identify patterns and outliers to help target interventions.
- Use effective training to prevent and manage bullying. Focus on several key mechanisms: developing trainee insight into their own behaviour and its impact on others; creating a shared understanding of acceptable/unacceptable behaviours; developing interpersonal, communication and conflict management skills; and identifying local problems and causes of conflict and generating solutions.
- Training should be delivered to a critical mass of appropriate staff (particularly managers) or it risks being ineffectual.
- Consider mediation for informal resolution of conflict, but be aware of its limitations.

- Use counsellors who have knowledge of bullying and can draw upon a range of integrated therapeutic models.

Conclusions

This report has summarised evidence on the prevalence, causes, and consequences of workplace bullying and synthesised evidence on interventions focused on the prevention and management of bullying and harassment. It is clear from both reviews and expert insight that bullying is a complex problem that requires a broad-ranging, strategic approach that targets organisational, team-dyad and individual levels.

Tackling workplace bullying starts at the organisational level, with a focus on leadership and management. Organisations should establish cultures in which bullying and negative behaviours are challenged through implementing interventions that aim to prevent bullying before it occurs, manage bullying as it occurs, and offer support to help targets recover and bullies to change. An organisation with an anti-bullying ethos will be better equipped to anticipate and manage bullying proactively. The realist synthesis has strengthened recommendations by highlighting that interventions are more likely to be successful if leaders are supportive and committed to change.

Interventions designed to increase insight into the perspectives of others, develop conflict management and communication skills, and instil personal responsibility to challenge negative behaviours (e.g. through training) are also likely to contribute to an anti-bullying culture and develop skills that enable managers and employees to avoid conflict escalation.