Workplace bullying: measurements and metrics to use in the NHS

Final Report for NHS Employers

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Foreword

The aim of this report is to identify how workplace bullying can be tracked over time, to indicate what measures and metrics can be used to identify change, and to provide comparators for other sectors in the UK and internationally.

Bullying can encompass a range of different behaviours. Deciding on a definition of workplace bullying can clarify what is regarded as bullying, but it may also narrow the focus and exclude relevant issues of concern. For example, bullying definitions typically state that negative behaviours should be experienced persistently over a period of time. The threshold for behaviours to be defined as 'bullying' could be set to include one or two negative acts per month over the previous six months; or more stringently to include only behaviours that occur at least weekly over the previous twelve months. Choosing an appropriate threshold for frequency and duration of behaviours raises several questions: should occasional negative behaviours be regarded as bullying? Would one or two serious episodes of negative behaviour be regarded as bullying? Some researchers use the criteria of weekly negative behaviours over six months to identify bullying, but others argue that occasional exposure to negative acts can act as a significant stressor at work (Zapf et al., 2011).

We have identified a range of tools and metrics that can be used to track change over time. However, there are a number of important issues to consider when measuring bullying which may affect the interpretation of the results. In particular, bullying prevalence rates vary considerably depending on the type of metric and definition of bullying used. For example, one international review found prevalence rates ranging from less than 1% for weekly bullying in the last six months up to 87% for occasional bullying over a whole career (Zapf et al., 2011).

There are three main types of direct measures of bullying: self-labelling without a definition, self-labelling with a definition, and the behavioural experience method. Self-labelling metrics typically ask a respondent to identify themselves as a target of bullying (e.g., "Have you been bullied at work?" with a yes/no response, or "How often have you been bullied at work?" with a frequency scale such as never/occasionally/monthly/weekly/daily). This approach is quick and easy to administer, but is more subjective as responses will be based on the respondent's interpretation of bullying. This approach can be improved with the provision of a definition of bullying, and a request to use the definition when responding. However, following pilot work, Fevre et al. (2011) argued that respondents tended not to read and digest bullying definitions as they had already decided what bullying meant to them.

The behavioural experience method offers a more objective approach, but is typically longer and more time consuming. This method involves respondents rating the frequency with which they have experienced different negative behaviours (e.g., "How often has someone humiliated or belittled you in front of others?" with a frequency scale such as never/now and then/monthly/weekly/daily). These behavioural inventories may not mention bullying, but capture the prevalence of

specific negative acts, and a total score may be calculated. The threshold for the frequency and number of negative acts, or a total score, required for an experience to be regarded as bullying can be chosen by the researcher. Although this enhances the objectivity of the measure, it may be that the respondent themselves may not regard their experience as bullying.

In a meta-analysis of bullying studies conducted across 24 countries, Nielsen et al. (2010) found an overall prevalence rate of 18.1% for self-labelling with no definition, 11.3% for self-labelling with a definition, and 14.8% using a behavioural experience checklist. For best practice, it is recommended that both the self-labelling with a definition and the behavioural experience method are used in bullying research (Zapf et al., 2011).

It is also important to be specific about the type of bullying being measured. In particular, if the measure is designed to capture bullying at work between co-workers this should be explicitly stated, so that bullying from patients and their relatives is excluded.

Interpretation of the results may also be somewhat complex. Although increases in bullying prevalence should undoubtedly be addressed, we need to be mindful that an increase in reported bullying may reflect a change in culture: changing expectations of the behaviour of colleagues and managers, or a move towards greater openness and willingness to address concerns that were previously ignored or condoned. A measure of employees' trust in the organisation to respond appropriately to such allegations may act as a positive indicator.

The perceived and actual anonymity of responses is a critical factor. Employees are understandably wary about providing sensitive information on bullying and have voiced concerns regarding being identified and the potential repercussions of reporting bullying (Carter et al., 2013). There is a considerable discrepancy between the prevalence of bullying as captured in anonymous questionnaires and direct reports of bullying made to the organisation (e.g., to managers or HR; Scott, Blanshard & Child, 2008). Protecting the anonymity of respondents, and ensuring that individuals cannot be identified, will be important factors in the administration of a bullying measure.

Some metrics are already routinely collected by the NHS, and if examined closely could provide useful indicators of change. Direct indicators include complaints about bullying and responses to ongoing NHS staff surveys. Indirect metrics can be used to capture factors that are associated with bullying, such as psychological wellbeing (including stress, anxiety and depression), sickness rates, job satisfaction and organisational commitment. However, factors other than bullying will affect these measures. The prevalence of witnessed bullying could also be considered as an important metric. A large proportion of NHS staff report that they have witnessed bullying between staff, and this is associated with negative outcomes for individuals and teams (Carter et al., 2013).

Comparing the NHS prevalence rates with other sectors in the UK and internationally is complex. Ideally comparators would have used the same definition, measurement

method and reporting period, but the definitions and metrics often differ. Total populations are the ideal, but are rarely provided. Single site studies are less generalisable than multi-site studies, and total samples are preferred over open invitations to unknown populations which may be more likely to attract responses from those who have experienced bullying.

This report begins with several definitions of bullying, describes direct and indirect measures of bullying, and compares the prevalence of bullying in the NHS to other sectors in the UK, and to the healthcare sector internationally.

Contents

1. Definitions of workplace bullying

There are many definitions of bullying and a lack of consensus regarding what is, and what is not, bullying. The issue is further confounded by the subjectivity of the target's perception.

One definition that is widely used by organisations in the UK is the definition adopted by the Advisory, Conciliation and Arbitration Service (ACAS). ACAS defines workplace bullying as: "Offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient" (ACAS, 2014).

Similarly, UNISON defines bullying as: "persistent offensive, intimidating, humiliating behaviour, which attempts to undermine an individual or group of employees."

A more detailed definition, incorporating the notions of persistence, duration and an imbalance of power is offered by Einarsen, Hoel, Zapf & Cooper (2011, p.22): "Bullying at work means harassing, offending, or socially excluding someone or negatively affecting their work. In order for the label *bullying* (or *mobbing*) to be applied to a particular activity, interaction, or process, the bullying behaviour has to occur repeatedly and regularly (e.g., weekly) and over a period of time (e.g., about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying if the incident is an isolated event or if two parties of approximately equal strength are in conflict."

A related definition of victimisation from bullying that has been adopted in recent research (e.g. Glambek et al, 2015; Nielsen et al, 2010; 2011), based on Einarsen, Raknes & Matthiesen (1994), stated that: "Bullying (for example harassment, torment, freeze-out or hurtful teasing) is a problem in some workplaces and for some employees. To be able to call something bullying, it has to occur repeatedly over a certain period of time, and the bullied person has difficulty in defending him- or herself. It is not bullying when two persons of approximately equal "strength" are in conflict, or if it is a single situation".

2. Direct Measures

Direct measures of bullying ask respondents explicitly about their exposure to bullying and negative behaviours. As described in the Foreword, there are three main types of direct measures of bullying: self-labelling without a definition, self-labelling with a definition, and the behavioural experience method.

Each measure has strengths and weaknesses, particularly relating to relative subjectivity and ease and speed of administration. However, it is important to note

that bullying rates are likely to vary depending on the method selected and the perceived and actual anonymity of the responses. This section describes several tools designed to measure bullying directly, including examples of all three approaches.

We have focused on tools most suited to measuring bullying in the NHS, but it is important to note that the examples provided here do not represent an exhaustive list - other metrics and inventories are available. For example, the 60-item Workplace Aggression Research Questionnaire (WAR-Q; Neuman & Keashly, 2004) has been used as a bullying inventory. It asks respondents to report how frequently they have experienced aggressive behaviours and the source of the behaviour (sample items: glared at in a hostile manner; excluded from work-related social gatherings), but it was regarded as too long for current purposes. The Leymann Inventory of Psychological Terrorization (LIPT; Leymann, 1990, 1996) has also been used in bullying research. Respondents rate how often they have been subjected to bullying behaviours (sample items: you are silenced; others ridicule you), but similarly, with 45-items it is time consuming to complete, particularly when shorter inventories are available.

2.1 Formal complaints about bullying

Formal reporting to organisations is typically much lower than prevalence rates from anonymous questionnaires. Scott, Blanshard and Child (2008) reported that only 18% of their New Zealand sample had made formal complaints despite 50% reporting some exposure to bullying. Cultural constraints are also likely to exist, for example, Bairy et al. (2007) found 90% of bullying incidents were left unreported in an Indian hospital setting.

Research has highlighted numerous barriers to reporting bullying, including the belief that nothing will change or that the situation would deteriorate, not wanting to be seen as a trouble-maker, the seniority of the bully, and concerns regarding career repercussions (Carter et al., 2013). Although it is important to track formal bullying complaints alongside other metrics, these complaints are unlikely to provide an accurate representation of the scale of the bullying problem in an organisation.

2.2 The Negative Acts Questionnaire-Revised (NAQ-R) and Short Negative Acts Questionnaire (S-NAQ)

Description

The Negative Acts Questionnaire - Revised (NAQ-R; Einarsen et al., 2009) measures the prevalence of 22 potentially bullying behaviours that can occur in the workplace. Example items include: being ignored or excluded, persistent criticism of your work and effort, and being shouted at or being the target of spontaneous anger. The scale includes three main factors: personal bullying, work-related bullying and physically intimidating bullying. Respondents rate the frequency that they have experienced each of the negative acts in the last six months using a 5-point scale (never, now and then, monthly, weekly, daily).

NAQ-R provides prevalence data for each of the 22 negative behaviours as well as an overall score. The overall NAQ-R score can range from 22 (meaning that the respondent 'never' experienced any of the 22 negative behaviours) to a maximum of 110 (meaning that the respondent experienced all of the 22 negative behaviours on a daily basis). The tool uses behavioural language and avoids use the terms 'bullying' and 'harassment' in order to provide a more objective measurement. Furthermore, the data may be used in multiple ways: 1) researchers can select a cut-off criterion for bullying (e.g. at least two negative acts on a weekly basis over six months, Mikkelsen & Einarsen, 2001) or derive a cut-off score using statistical procedures, 2) use the total score for analysis (e.g. correlation, regression), and 3) differentiate between respondents with different levels of exposure to bullying using Latent Class Cluster analysis (LCC).

The NAQ-R was empirically developed and validated and has been widely used in many countries (e.g. Hogh et al, 2012; Jiminez et al., 2007; Salin, 2001). It has well-established validity and reliability and, unlike some other behavioural inventories which may have been used in a small number of studies, the NAQ-R is the most commonly used behavioural scale in the field of bullying research. However, with 22 items, the scale is somewhat time-consuming to complete.

A shorter, 9-item version has been developed (Short Negative Acts Questionnaire, S-NAQ; Notelaers & Einarsen, 2008) and has been used to measure bullying in numerous studies in several countries, including Belgium, Italy, Spain, Norway and Jordan (e.g. Balducci et al., 2012; Hauge, Skogstad & Einarsen, 2010; Rodriguez-Munoz et al., 2009). The authors of the Short Negative Acts Questionnaire (S-NAQ) are currently working on a paper describing evidence of validity, but this has not yet been published (Notelaers, 2016, personal communication; see appendix for items). International studies have provided evidence of the validity and reliability of this reduced scale in languages other than English, although the items have been translated into English for publication purposes (see appendix for items). Interestingly, the S-NAQ has also been adapted to measure perpetrator behaviour, with respondents rating how often they have engaged in negative acts (e.g. How often have you spread gossip or rumours about a colleague?) as well as rating how often they have been the target of such behaviours (e.g., Baillien et al., 2015).

The NAQ-R and S-NAQ are often used alongside a self-labelling bullying question ("How often have you been bullied at work in the past six months") with the following definition: "We 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 in defending him or herself against these actions. We will not refer to a one-off incident as bullying." Responses are made using a frequency scale (no; yes, but only rarely; yes, now and then; yes, several times per week; and yes, almost daily) although some researchers have employed the response options from the NAQ-R itself (never, now and then, monthly, weekly, daily). This provides an overall measurement of subjectively perceived bullying.

Validation

In a study by Einarsen et al. (2009), the authors analysed NAQ-R data from a UK sample of 5288 respondents, and concluded that the tool was a valid and reliable measure of exposure to workplace bullying. The 22 items grouped into three factors: work-related bullying, person-related bullying, and physically intimidating bullying; but may also be used as a single-factor scale. The NAQ-R correlated with self-labelled bullying and measures of mental health and psychosocial work environment, demonstrating good construct validity. The test publishers report that the NAQ-R reliability is typically between 0.87 and 0.93 (Bergen Bullying Research Group, 2010), and a study with a large NHS sample reported a Cronbach's alpha of 0.93 (Carter et al., 2013), indicating good internal consistency reliability.

One of the strengths of using this instrument for measuring bullying in the workplace is that it can be used to distinguish between different groups and to assess the severity and frequency of bullying; for example, from infrequent incivility to more severe bullying. In addition, it measures the prevalence of bullying without respondents labelling themselves as targets, although it is often used in conjunction with a self-labelling question (Einarsen et al., 2009).

Examples of studies that used the NAQ-R

The NAQ-R has been used in numerous studies across different countries and occupational settings. The Bergen Bullying Group has gathered data from over 40,000 respondents in 40 countries in a database and hopes to develop norm data and conduct cross-cultural comparisons.

In the UK, Carter et al. (2013) used the NAQ-R to investigate the prevalence of negative behaviours and workplace bullying in the NHS with a sample of 2950 NHS staff across seven organisations. The study found that: 20% of staff self-identified as a target of bullying; 43% reported that they had witnessed bullying, 18% had experienced at least one negative behaviour on a daily or weekly basis, and 34% had experienced five or more negative behaviours to some degree over the last 6 months. Directly experienced and witnessed bullying were associated with poorer psychological wellbeing, lower job satisfaction, increased intentions to leave work, and higher levels of self-reported sickness absence.

The NAQ-R was also used by O'Driscoll et al. (2011) in a survey of over 1700 employees across 36 organisations in New Zealand. They found that 18% of respondents had been bullied, using the criterion of experiencing at least two negative acts weekly or more often over the past six months. Exposure to bullying was associated with higher levels of strain, reduced well-being, lower organisational commitment, and lower self-rated performance.

Fevre, Lewis, Robinson and Jones (2011) adapted the NAQ-R in a large scale UK study on ill-treatment at work (see appendix for items). Following extensive pilot work and cognitive testing, they asked participants about their experience of 21 negative behaviours in face to face interviews (n=3979). The negative behaviours grouped into three factors: unreasonable treatment (e.g., someone continually checking up on you or your work when it is not necessary), denigration and disrespect (e.g., teasing, mocking sarcasm or jokes which go too far), and violence (e.g., actual violence at work). The most commonly experienced behaviours were being given an unmanageable workload or impossible deadlines (29.1%), having your opinions and views ignored (27%), and being shouted at or someone losing their temper with you (23.6%).

The short version (S-NAQ) has been used in a number of studies. For example, in Belgium, De Cuyper, Baillien & De Witte (2009) used the S-NAQ to investigate the relationships between bullying, job insecurity and perceived employability in a sample of workers in the textile and financial services industries; and Stouten et al. (2010) found that ethical leadership was associated with lower levels of bullying, using a sample of electronics factory workers. An Italian version of the S-NAQ was validated with public sector employees (Balducci et al., 2010) and has been used in a study examining bullying and role stressors in the work environment with a sample of healthcare workers (Balducci et al., 2012). In Norway, the S-NAQ has been used to test the relative impact of bullying as a workplace stressor in a large representative sample of the Norwegian workforce (Hauge, Skogstad & Einarsen, 2010).

Using the NAQ-R

The NAQ-R was developed by the Bergen Bullying Group (http://www.uib.no/en/rg/bbrg). The website provides guidelines for free use of the tool for non-profit research purposes. One condition of use is that anonymised data are shared with the Bergen Bullying Group for the purposes of norm development. However, the authors could be contacted to discuss use of the NAQ-R, or the short NAQ, as a measure of bullying in the NHS.

2.3 Bullying Risk Assessment Tool (BRAT; Hoel and Giga, 2006)

Description

The Bullying Risk Assessment Tool (BRAT) was developed to assess the risk of negative behaviour and bullying at the individual and group level. The BRAT is a 29-item scale which measures experiences in the organisation over the previous six months using a six point Likert scale (Strongly agree, Agree, Slightly agree, Slightly disagree, Disagree, Strongly disagree). It consists of five factors: organisational fairness, team conflict, role conflict, workload, and leadership. Example items include: “New staff are made to feel welcome when starting employment in the organisation” and “Conflict in my work unit is common,” see appendix for full scale).

The primary aim of the BRAT is as a risk assessment tool for identifying risk of bullying at a group level, therefore informing decision -making and the prioritisation of areas for management action.

Validation

Hoel and Giga (2006) developed the BRAT and concluded that it was a valid and reliable measure of the risk of bullying. Each of the five factors independently predicted negative behaviour (measured in comparison to the NAQ-R; Einarsen & Hoel, 2001), whilst all factors with the exception of ‘workload’ predicted self-labelled bullying measured with a global definition of bullying. The measure also predicted negative impact on wellbeing (as measured by the GHQ-12; Goldberg, 1978).

The BRAT has not been widely adopted in the workplace bullying literature; to date no research applications have been published, to our knowledge. The extensive usage of the NAQ-R as a tool that can offer global and occupational comparisons may be one reason for this lack of widespread usage, as well as the existence of other generic measures of the work climate and environment. However, the BRAT’s psychometric properties are of a similar standard to existing tools. The advantage the BRAT could offer to organisations is that its purpose is to identify risk within the organisation whereas the NAQ-R is largely a research tool designed to measure the prevalence of bullying.

2.4 Quine workplace bullying questionnaire

Description

The scale includes 20 bullying behaviours taken from the literature and grouped into five categories: threat to professional status (example item: persistent attempts to belittle and undermine your work); threat to personal standing (example item: undermining your personal integrity); isolation (example item: freezing out, ignoring, or excluding); overwork (example item: undue pressure to produce work); and destabilisation (example item: shifting of goal posts without telling you). An additional item was included in Quine (2002) to measure racial or gender discrimination.

Respondents were asked whether they had been persistently subjected to any of these behaviours in the past 12 months using a binary yes/no response.

This tool has satisfactory reliability (Cronbach's alpha = 0.81; Quine, 2001) and enables the measurement of a wide range of bullying behaviours. The original tool has not been as widely used in published research as the NAQ-R, but it has been used as the basis of local surveys with trainee doctors (e.g. Obstetrics & Gynaecology bullying questionnaire, see below).

Examples of studies that used the Quine workplace bullying questionnaire

This bullying scale has been used in three published studies by Quine with NHS samples (Quine 1999, 2001, 2002).

Quine (1999) conducted a questionnaire study in an NHS community trust (n=1100, 70% response rate) to determine the prevalence of workplace bullying, examine the association between bullying and occupational health outcomes, and test the protective role of support at work. Results showed that 38% of employees reported experiencing one or more types of bullying and 42% had witnessed the bullying of others in the past twelve months. Those staff that had been bullied reported lower levels of job satisfaction, and higher levels of job induced stress, depression and anxiety along with a higher intention to leave their job. Support offered at work was seen to help with some of the effects of bullying. Results of the study suggest that the provision of a supportive positive work environment may help to protect people's health and wellbeing.

Quine (2001) investigated bullying prevalence, relationships between bullying and health outcomes, and the moderating role of support at work in a sample of community nurses in an NHS trust. Quine compared the experience of nurses (n=396; subset of a sample of n=1100 across the trust) to other staff. The study found that, within the 12 month reporting period, 44% of nurses had experienced one or more types of bullying compared with 35% other staff. Fifty percent of nurses had witnessed the bullying of others, compared to 36% of other staff. Nurses who had experienced bullying reported lower job satisfaction and higher levels of anxiety and depression with a greater inclination to leave their job. Nurses were somewhat protected, up to a point, from the effects of bullying by support in place at work.

A third study by Quine (2002) surveyed junior doctors (house officers to senior registrars, n=594, 62% response rate) who had been randomly selected from British Medical Association (BMA) membership lists. The 21-item version of the Quine scale (with the addition of an item on racial and gender discrimination) was used to investigate the prevalence of bullying, alongside a self-labelling question with a definition. Overall, 37% of respondents identified themselves as a target of bullying on the self-labelling item, and 84% had experienced one or more of the bullying behaviours from the Quine scale in the previous 12 months.

The study also identified that black and Asian doctors were more likely to experience bullying than white doctors (45% compared to 39%), and that women were more likely to experience bullying than men (43% compared to 32%).

2.5 Obstetrics and Gynaecology questionnaire (Adapted from Quine)

Doctors working in obstetrics and gynaecology (O&G) have often raised concerns about bullying and other undermining behaviour (Rimmer, 2014). The Royal College of Obstetricians and Gynaecologists (RCOG) suggested that organisations should consider proactive monitoring of data to identify patterns and outliers to help target interventions, including the use of regional training committee surveys.

Description

In response to the national General Medical Council's National Training Survey results highlighting bullying as an issue in the specialty, the Northern Deanery's School of O&G initiated an annual trainee survey of inappropriate workplace behaviour (Northern Deanery, 2012; Illing et al., 2013). Overall bullying rates failed to indicate what behaviours were most problematic or reveal which units were experiencing difficulties (Illing et al., 2013), therefore the O&G school adapted Quine's bullying questionnaire to measure specific bullying behaviours. Trainees were asked to rate the frequency with which they had experienced each of 21 negative behaviours on a frequency scale (no, rarely, a few times, frequently). The tool includes all items from Quine (2002; see appendix), with the addition of "unwelcome sexual advances."

The questionnaire also asks about the source of the bullying, whether trainees have witnessed bullying, and where the bullying occurred. It includes free-text boxes for additional feedback.

Application

The questionnaire was distributed to all O&G trainees in the Deanery and responses were collated and anonymised by the school. The results for each unit were colour-coded using a traffic-light system. Amber was coded to the unit if 1 or 2 trainees

reported issues (<15% of trainees in the unit), and red was coded if 3 or more trainees reported issues. Units were then compared and particular issues were identified in certain units. The results were triangulated with the GMC trainee survey, the national specialty survey, and other local research. The results were then fed back to each NHS Trust, before being made freely available to all of the participating units. The school worked with each trust to address any issues. In the first year, the response rate was approximately 50%, which has since grown to over 95%. The data show trends indicating that units initially flagged as red have reduced bullying behaviours over time, and are now flagged as amber or green.

The longitudinal nature of the data can enable schools to identify causes of problems, not just identify that bullying is occurring. For example, negative behaviours increased in one unit following a difficult period of short-staffing, highlighting that pressure was being placed on trainees to cover additional shifts (Illing et al., 2013). The cycle of monitoring and feedback has also raised the profile of bullying issues and increased awareness of specific problematic behaviours in particular units. This enables interventions to be targeted where they are most needed.

Other specialty schools in the Deanery have adopted the survey and several have reworked the behavioural items into a school charter (Illing et al., 2013).

2.6 NHS Staff Survey

Description

The NHS staff survey explores the experiences of healthcare staff in the UK. The NHS staff survey is the largest survey of staff opinion in the UK. It is conducted every year with a random sample of staff. The survey findings provide a valuable resource for policy makers, managers, and researchers that can be used to gain insight into the working conditions of NHS employees. The 2015 NHS staff survey involved 297 NHS organisations in England with responses from 299,000 NHS staff (41% response rate). The contractors support NHS organisations in distributing and gathering responses from staff which can be conducted online and/or on paper.

The survey results can be analysed and compared in many different ways; for example by trust, region, demographic group and profession. Benchmarking groups for the 2015 staff survey include: acute trusts, combined acute and community trusts (new in 2015), acute specialist trusts, mental health / learning disability trusts, combined mental health / learning disability and community trusts (new), community trusts, ambulance trusts, clinical commissioning groups, commissioning support units, social enterprises, and scientific and technical organisations (new).

The major strengths of the NHS Staff survey include the large sample size and its availability as an existing tool that is publically accessible. However, it does not target all NHS staff, as this would have huge cost implications. To address issues

related to differences in the profile of respondents, weighted data is available. This helps to ensure that no organisation appears better or worse than others because of occupational group differences or trust size. For example, staff in a certain category level (e.g. band, profession) may respond more positively or negatively than other groups to specific questions. However, when comparing results over time, it is recommended that unweighted data are used, as the calculations for weighted data vary year to year. All data reported in this section are unweighted.

The survey findings are broken down into 32 key areas, which include questions about experiences of bullying, harassment or abuse from patients and from staff. Questions related to bullying use a self-labelling format and no definition is provided.

The bullying questions have changed three times since 2009. In 2009, respondents were asked two questions: “In the last 12 months have you personally experienced harassment, bullying or abuse at work from…manager/team leader” and “In the last 12 months have you personally experienced harassment, bullying or abuse at work from…other colleagues,” both with a yes/no response option. Bullying from manager/team leaders was reported in the survey by 8% of staff, and bullying from other colleagues was reported by 12% of staff. In 2010 and 2011, a single question combining staff groups was presented: “In the last 12 months have you personally experienced harassment, bullying or abuse at work from…manager/team leader or other colleagues” and 14% of staff reported that they had experienced bullying (results were the same for 2010 and 2011). In 2012, respondents were asked: “In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...managers/team leader or other colleagues” and the response options changed from yes/no to a frequency scale (never / 1-2 / 3-5 / 6-10 / more than 10). This format was retained for three years, and results indicated that 22% of staff had been bullied one or more times in 2012, 22% in 2013 and 21% in 2014. In 2015, the question was separated again and the survey found that 13% of staff had been bullied by managers in the last 12 months, and 16% had been bullied by other colleagues (item wording shown in the example below).

The NHS staff survey also asks about reporting of bullying, harassment or abuse, but this includes bullying from patients and relatives as well as managers and colleagues. Results have indicated that between one third and one half of the workforce have reported bullying themselves (46% in 2009, 47% in 2010, 46% in 2011, 37% in 2012, 37% in 2013, 37% in 2014, 34% in 2015). Colleagues have reported bullying, harassment or abuse for 7-8% of staff (7% in 2009, 8% in 2010, 7% in 2011, 7% in 2012, 7% in 2013, 8% in 2014, 7% in 2015).

Examples of workplace bullying questions from 2015 NHS Staff Survey:

In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...managers?

Response options: Never | 1 – 2 | 3 – 5 | 6 – 10 | More than10

In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...other colleagues?

Response options: Never | 1 – 2 | 3 – 5 | 6 – 10 | More than10

The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

Response options: Yes, I reported it | Yes, a colleague reported it | No | Don't know | Not applicable

2.7 General Medical Council (GMC) National Training Survey (NTS)

Description

The National Training Survey (NTS) is run annually by the GMC and explores the experiences of trainee doctors working in healthcare. The results are used to monitor the quality of medical education and training in the UK. All doctors in training are asked for their views about their training (over 53,000). In 2016, the GMC plan to roll out a new national survey of trainers alongside the existing doctors in training survey.

The NTS findings can be broken down into: post specialty by trust/board, programme group by trust/board, programme type by Local Education Training Board (LETB)/deanery, GP scheme by GP group, foundation school by foundation scheme, programme specialty by programme level, training group by country, country, LETB/deanery, trust/board, site, and place of qualification. Benchmark groups may include post specialty groups, programme groups, programme types, GP group, all foundation trainees, all F1 trainees, all F2 trainees, and all UK trainees.

The GMC has recently changed how it approaches reports of bullying in the NTS. In 2015, medical trainees were asked three questions on bullying: two questions on their exposure to bullying and harassment as a victim and a witness, and one question on exposure to undermining behaviour from a senior doctor (see below for item wording). The bullying questions did not specify that the source of bullying should be another staff member, therefore they could also capture bullying by patients and relatives. The undermining question did specify that the source should be a consultant or GP. Due to issues with the interpretation of the results, the GMC do not publish a breakdown of the bullying data in their online reporting tool. The most recent published data (from 2014) indicated that 8.0% of trainees had been bullied and 13.6% had witnessed bullying. Respondents were also invited to raise a concern about bullying in a free text box which would be investigated by the GMC and Deanery/LETB. In these cases, anonymity was not protected and the GMC advised it could share information with other organisations (e.g. Royal Colleges), particularly if there were concerns regarding patient safety.

In the 2016 NTS (currently open for data collection), the three questions on exposure to bullying and undermining have been removed, although the option to raise a bullying concern and initiate an investigation remains. A single question asks whether the trainee has been a victim of, or witness to, bullying, and response options include: Yes, and I wish to report it here / Yes, but I don't want to report it here / No. If trainees state that they do not wish to report bullying, they are invited to provide a reason. The survey documentation explains the process for trainees who wish to provide specific details of bullying experiences, and advises them that anonymity is not protected. The new question format enables trainees to state that they have been exposed to bullying without launching an investigation and compromising anonymity. However, the single item conflates directly experienced and witnessed bullying.

Following investigations into bullying and undermining, local organisations may seek to implement interventions such as a workplace behaviour champion initiative or a review of their policies. The GMC tracks deanery and LETB responses and their progress in resolving issues. These mechanisms for escalation and ongoing monitoring may lead to effective change in the working environment for trainee doctor, although only 1% of respondents raise a concern in this way. An example of how an organisation may use data from the GMC survey is provided by the School of Paediatrics at the Northern Deanery (Northern Deanery, 2012). The GMC survey indicated that trainees were sometimes experiencing behaviour from colleagues that could be undermining, harassing or in some situations bullying in nature. This has since been monitored by the School using a rolling feedback questionnaire linked with Annual Review of Competence Progression (ARCP) / Record of In-Training Assessment.

In addition to the direct questions on bullying, the GMC has recently added questions under the category of 'supportive environment'. These items aim to capture positive aspects of the working environment, as well as causes for concern (e.g., whether staff are treated fairly and show each other respect; see below for item wording). It is likely that these questions would act as an indirect measure of negative behaviours, with low scores indicating a risk of bullying environments.

Examples of bullying related questions from the 2015 GMC NTS:

How often, if at all, have you been the victim of bullying and harassment in this post?

Response options: Every day | At least once per week | At least once per fortnight | At least once per month | Less often than once per month | Never | Prefer not to answer

How often, if at all, have you witnessed someone else being the victim of bullying and harassment in this post?

Response options: Every day | At least once per week | At least once per fortnight | At least once per month | Less often than once per month | Never | Prefer not to answer

In this post, how often if at all, have you experienced behaviour from a consultant/GP that undermined your professional confidence and/or self-esteem?

Reponses options: Every day | At least once per week | At least once per fortnight | At least once per month | Less often than once per month | Never | Prefer not to answer

Do you wish to raise a bullying or undermining concern here?

Response options: Yes | No

Your bullying or undermining concern:
Please use the text box below. Your comment will be taken seriously and investigated. This means that it is your responsibility to:

- write factually and accurately about your own experience, not hearsay
- describe specific incidents
- describe specific behaviours

Once finished, please use the categorisation questions below.

Please specify who has been doing the undermining/bullying described in your concern (please select all that apply)

Reponses options: Consultant/GP (within my post) | Consultant/GP (outside my post) | Nurse/midwife | Other doctor | Other trainee | Management | Patient/relative | Other (please specify)

Which behaviour types describe your concern?

Response options: (Please select all that apply) Belittling or humiliation | Threatening or insulting behaviour | Deliberately preventing access to training | Bullying relating to a protected characteristic | Other (please specify)

Examples of bullying related questions from the 2016 GMC NTS:

Have you been the victim of, or witnessed, any bullying or harassment in this post?

Response options: Yes, and I wish to report it here | Yes, but I don't want to report it here | No

Which of the following describes why you don't want to report this? (Please select all that apply)

Response options: The issue has already been resolved locally | I have raised it, or intend to raise the issue locally instead | I don't think the issue is serious enough to report | I don't think reporting will make a difference | Fear of adverse consequence | Other

Supportive environment questions from the 2016 GMC NTS:

Please state whether you agree or disagree with the following statement about your post:

In general, the working environment is a supportive one.

Staff, including doctors in training, are treated fairly.

Staff, including doctors in training, treat each other with respect.

The working environment is one which helps build the confidence of doctors in training.

If I were to disagree with senior colleagues, they would be open to my opinion.

Response options: Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree

2.8 Trade Unions, Professional Bodies and Charitable Organisations

There are many trade unions, professional bodies and charitable organisations which carry out work to identify and measure levels of workplace bullying. For example: the British Medical Association (BMA); the Advisory, Conciliation and Arbitration Service (ACAS); UNISON; the Royal College of Nursing (RCN); Trades Union Congress (TUC); and the Chartered Institute of Personnel and Development (CIPD). This work is sometimes conducted by the organisation themselves or may be externally commissioned. The surveys tend to be anonymous and allow organisations to gather insights into the work environment. The investigations often involve surveys, interviews and a range of different question formats.

Although these types of initiatives are very important in gauging the prevalence of workplace bullying, the size of the samples are often much lower than the NHS staff survey. Also the purpose of the survey may be influenced by the current political climate or organisational driver, and the sample may be limited to those who are members of the organisation (e.g. UNISON) rather than a more representative sample.

UNISON Members Survey

Description: UNISON, one of the largest public sector trade unions serving more than 1.3 million members, has conducted or commissioned several staff/member surveys to explore conditions at work. One survey has been repeated for the past three years to explore experiences of nurses and midwives in the NHS. The survey spot tests a typical 24 hour day among nurses and midwives (3,000 responses). UNISON also states that local branches may conduct their own survey to gather evidence on the scale and extent of bullying in the workplace and provides example questions (see appendix).

Examples of bullying questions from the UNISON trade union survey:

Is bullying at work: (Tick relevant box)

A very serious problem? Yes / No

A serious problem? Yes / No

A minor problem? Yes / No

A non-existent problem? Yes / No

Have you ever been bullied at this place of work? Yes / No

What form does the bullying take? (tick relevant box)

Shouting / Threats / Abuse / Intimidation / Humiliation / Excessive criticism / Setting unrealistic targets or deadlines / Altering targets, deadlines and so on / Excessive work monitoring / Keeping you out of things / Victimising you / Malicious lies or rumours / Refusing reasonable requests such as for leave / Other (please state)

Royal College of Nursing (RCN) Employment Survey

Description: The RCN employment survey has been conducted since the 1980s; the 2015 version was the 25th in the series. The online survey was sent out to a stratified random sample of the RCN membership and asked questions on a range of work-related issues including pay, pensions, workload and staffing, training, and views on nursing as a career, as well as questions on bullying and harassment.

The 2015 survey achieved a total of 4,137 usable responses, representing a response rate of 6%. The 2015 survey report indicated that there is a significant problem of bullying and harassment as 34% of respondents identified this as a problem in their workplace.

Examples of bullying related questions from the RCN Employment Survey:

Agreement with the following statements:

Bullying and harassment are not a problem where I work:

I am confident I would be treated fairly if I reported harassment by a colleague*

I am confident my colleagues would be treated fairly if they reported harassment by a member of staff*

Response options: strongly agree| agree| neither agree nor disagree| disagree | strongly disagree

*Although these items refer to harassment, they could be adapted for bullying specifically

2.9 Witnessing bullying

Measures of witnessed bullying may be useful indicators of the general prevalence of bullying and the quality of the work environment. Exposure to bullying as a witness is associated with poorer psychological wellbeing, lower job satisfaction and increased intentions to leave, and research indicates that a large proportion of the NHS workforce have witnessed bullying (e.g., 43% of NHS staff; Carter et al., 2013).

Many of the metrics available to measure bullying have been, or can be, adapted to measure witnessed bullying. Several examples are provided below.

Examples of items measuring witnessed bullying

Single-item self-labelling metrics (Carter et al., 2013; Quine, 1999):

In the past six months, how often have you witnessed another staff member being bullied by other staff at work?

Response options: Never | Now and then | Monthly | Weekly | Daily

Have you witnessed work colleagues being subjected to workplace bullying from peers, senior staff, or managers during the last twelve months?

Response options: No | Rarely | A few times | Frequently

Example items from adapted NAQ-R:

In the past six months, how often have you witnessed other staff experience the following negative acts from other staff at work?

Someone withholding information which affects their performance

Being humiliated or ridiculed in connection with their work

Being ordered to do work below their level of competence

Response options: Never | Now and then | Monthly | Weekly | Daily

Example item from the 2015 GMC NTS:

How often, if at all, have you witnessed someone else being the victim of bullying and harassment in this post?

Response options: Every day | At least once per week | At least once per fortnight | At least once per month | Less often than once per month | Never | Prefer not to answer

3. Indirect Measures

Bullying is associated with a range of other variables, some of which may act as indicators of workplace issues. Examples include: poorer physical and mental health such as anxiety, depression and helplessness (Leymann et al., 1990), suicide ideation (Brousse et al., 2008), psychosomatic problems and musculo-skeletal complaints (Einarsen et al., 1996), increased risk of cardiovascular disease (Kivimaki et al., 2003), lower job satisfaction (Carter et al., 2013), and higher levels of substance abuse (Traweger et al., 2004), sickness absence (Kivimaki et al., 2000), medical errors (Paice & Smith, 2009), and intention to leave the job (Carter et al., 2003).

These indirect metrics do not measure bullying specifically and scores may be influenced by a number of factors not related to bullying. However, they may help to identify problematic units and offer a broader insight into the risk factors for bullying and impact of negative behaviour.

3.1 General Health Questionnaire (GHQ)

Description

The General Health Questionnaire (GHQ; Goldberg, 1978) is one of the most widely used measures of general mental health and well-being. The GHQ is a self-administered screening questionnaire that assesses many of the health problems linked to bullying, including depression, anxiety, social dysfunction and somatic symptoms. The questionnaire focuses on breakdowns of normal function, rather than assessing lifelong traits. It is therefore a suitable measure to use when exploring the effects and occurrence of bullying. The GHQ is available in several versions (60, 30, 28 or 12-items) but the 12-item (GHQ-12) is the most extensively used version (Lopez & Dresch, 2008). The GHQ-12 is very quick to administer (it takes around two minutes to complete) and score, making it more suitable for research purposes where time is limited, and it has comparable psychometric properties to the longer versions. The GHQ-12 has been translated into many languages and extensively validated in general and clinical populations across the world (e.g., Hardy et al., 1999; Quek et al., 2011; Sterling, 2011; Werneke et al., 2000).

However, the GHQ-12 is not freely available and must be purchased from the publisher. It is a proprietary scale and there are regulations related to publishing the items.

The GHQ-12 focuses on the psychological components of ill health and refers to recent mental states, rather than chronic illness. As discussed above, GHQ-12 scores may be the product of a number of different factors or other life events and will not necessarily identify bullying or provide causal evidence that bullying has a negative impact on staff. For example, Einarsen et al. (1996) showed that self-esteem and social anxiety moderated the relationships between bullying and self-report measures of psychological, psychosomatic and musculoskeletal health complaints. Targets of bullying with high social anxiety reported more psychosomatic

symptoms than did targets with low social anxiety. Mikkelsen (2001) further proposed that individual variables such as perceived locus of control, attributional style and coping strategies are likely to influence the extent to which targets of bullying develop severe health problems.

Finally, respondents need to be willing to disclose their experiences and mental state in a survey (Hoel and Cooper, 2000).

Examples of use of the GHQ-12 in bullying studies

Hoel and Cooper (2000) conducted the first nation-wide survey of workplace bullying across a number of occupations and industrial sectors in Britain (sample size: 5288), including the NHS. They measured both physical and mental health, the latter being measured by using the GHQ-12. They found significant relationships between measures of bullying and health, including among those who were previously bullied, with correlations between total score on the revised Negative Acts Questionnaire (NAQ-R), self-labelled bullying, total GHQ score and intention to quit.

Carter et al. (2013) investigated the prevalence and impact of bullying in a sample of 2950 NHS staff across trusts and occupational groups. Bullying was measured with the NAQ-R and a self-labelling item (with a definition of bullying), and psychological wellbeing was measured using the GHQ-12. Carter et al. (2013) found that individuals who were exposed to negative behaviours in the workplace (NAQ-R total score) had higher levels of psychological distress. This included those who were targets of bullying and those who had witnessed the bullying of colleagues.

3.2 Sickness and absence levels

Occupational health is becoming increasingly recognised in many NHS trusts, with stress indicators such as sick leave being used to monitor the health of employees and identify those who might benefit from appropriate interventions (Ritchie et al, 1999). The immediate financial consequences, relating to the costs that result from an increase in absenteeism, are also recognised (Kivimaki, 2000). In terms of indirectly measuring outcomes of bullying or bullying interventions, there is value in routine monitoring of sickness absence data. Rayner and McIvor (2008) analysed organisations that had high and very low levels of bullying. When addressing bullying issues, they suggested that organisations should measure key factors in the initial ‘preparing the ground’ stage, including bullying, sickness, early leavers, formal complaints, and staff attitude surveys. Illing et al. (2013) further highlighted the need for proactive monitoring of organisational data, such as sickness, which can identify patterns and outliers to help target interventions where they are needed. Kivimaki et al. (2000; 2003) and Voss et al. (2001) also reported that workplace bullying was related to a 25% to 90% increase in the risk of recorded sickness absence, and around 2% of all absences within one hospital setting were due to bullying (Kimivaki

et al., 2000). Another study has reported that the risk of long-term sickness absence (six weeks or more) was double for frequently bullied care workers, compared to non-bullied staff (Ortega et al, 2011).

Sickness absence records are collected routinely by the personnel departments in many workplaces, therefore the data should be readily available. Using this objective data will minimise potential recall and response set biases that are associated with self-reported indicators of health. Bullying has been found to be associated more strongly with medically certified sickness absence (more than three days absence) than with self-certified sickness absence (Farquharson, 2012) and self-reported absenteeism (Kivimaki, 2000). Sickness absences can accurately reflect the health of working populations, at least in terms of physical and social functioning.

However, there are a number of limitations to the use of sickness absence data. Controversy exists about the status of sickness absence as a global measure of health. Rates of bullying are not always directly measured alongside sickness rates (Illing et al, 2013). Even when bullying rates are measured, causal relationships cannot be assumed (Carter et al, 2013). It is possible that those with higher sickness absence are more likely to be bullied or that they are more likely to perceive behaviour to be bullying. Understanding whether bullying will lead to ill health and sickness absence can only be addressed by longitudinal studies that are able to investigate the causal relations between work factors and health outcomes and by randomised controlled trials of interventions (Michie, 2003). Even when explored, respondents may be reluctant to discuss causes of absence (Ritchie et al, 1999).

Although bullying is frequently associated with sickness absence (Ortega et al, 2011; Voss et al, 2001), presenteeism (attending work when sick) may also occur in targets of bullying. They may attend work to avoid being labelled as a malingerer, even when it may be beneficial to be absent from work (Hoel & Einarsen, 2011). Socioeconomic status can also impact on this (Ritchie et al, 1999). Underreporting of absence among the medical profession is also reported (Ritchie, 1999). Sickness rates may be due to other reasons, for example a physical illness, whilst certified absences may also be a byproduct of the medical care process (Kivimaki, 2003). Employees may also take sick leave without actual illness.

Examples of use of sickness absence rates in bullying studies

Sickness rates may be one of the more obtainable forms of ‘objective’ data. Hoel and Giga (2006) sought to measure the potential efficacy of bullying interventions, and asked organisations to provide some ‘objective’ pre/post intervention data. Of the five participating organisations, complete data was available from four organisations for sickness absenteeism, whilst turnover rates were more difficult to obtain, with only two organisations providing complete records at both points of measurement.

Carter et al. (2011) also used sickness rates in their study to measure the impact of bullying, however these were self-reported. The majority of respondents said none of their sick leave was due to work-related stress or bullying, but 11% felt that at least some sick leave was due to stress, and 5% felt that at least some sick leave was due

to bullying. Self-reported measures of sickness rates may be less reliable than medically certified absence. However, exposure to bullying and negative behaviours was associated with higher sickness absence, along with other factors (Carter et al, 2013).

3.3 HSE Management Standards Indicator Tool

In tackling the risk of workplace stress, the Health and Safety Executive (HSE) developed a Management Standards approach (Mackey et al, 2004) based on a taxonomy of six stressors – demands, control, support, relationships, role and change. The Management Standards risk assessment process involves a two pass process: firstly, broad areas of potential concern are identified, then specific issues explored with a view to providing targeted and effective interventions. To undertake this, an indicator tool was developed.

The indicator tool comprises 35 items and 7 subscales. Each subscale represents one of the demands, with the exception of social support which is divided into managerial support and peer support. Within the 'Relationships' subscale a number of items relate to bullying, including: "I am subject to bullying at work," "There is friction or anger between colleagues," and "I am subject to personal harassment in the form of unkind words or behaviour."

Across the UK, the HSE Management Standards Indicator Tool is widely used and constitutes an accessible resource for proactively tackling stress. The limited focus on 2-3 questions specific to bullying might diminish the scope it offers in providing detailed insight into bullying. Therefore it may be more appropriate as a first pass tool alongside use of a more robust, bullying-specific measure as a follow up in order to understand workplace problems in more depth.

Validation

Edwards et al. (2008) conduced a large scale analysis of the Indicator Tool by collecting data from 39 different organisations (n=26,382). A confirmatory factor analysis found a fit between the data and the tool. Toderi et al. (2013) recently found further supporting evidence in both UK and Italian versions of the tool that the data fits into the proposed seven factor model. In contrast, Glozier and Wright (2005) questioned some of the tool's properties. In a moderate sample of employees (n=235) it was concluded there was a lack of sensitivity in identifying stress risk, therefore heightening the possibility of an underestimation of stress. Brookes et al.'s (2013) recent systematic review of the utilisation of the HSE indicator concluded that it is a psychometrically sound measure.

Examples of use of the HSE tool

Bevan, Houdmont, and Menear (2010) examined the utility of the tool in prison workers (n=1038). The tool was employed as a means to identify areas requiring improvement and to prioritise areas for action. Kerr, McHugh, and McCory (2009) used the HSE Management Standards within a community-based Health and Social Services Trust (n=707) alongside measures of key outcomes such as near misses and errors, which demonstrated utility in a healthcare setting.

Houdmont, Kerr and Randall (2012) implemented the HSE Management Standards in the UK police (n=1729) and developed reference values that could be used for benchmarking and intervention-targeting purposes, and against which progress in reducing exposure could be assessed.

3.4 Exit interviews

A number of studies have recognised the relationship between exposure to bullying and intention to leave the organisation (e.g. Hogh et al., 2011). Simon (2008) found that bullying was a significant determinant of intention to leave in newly qualified nurses in the US, and Hogh et al (2011) found a similar relationship in a Danish study. These findings indicate that targets of bullying may seek to leave the organisation, and capturing the role of bullying as a reason for departure may have some potential.

Exit interviews are discussions between a departing employee and employer, designed to obtain information about their employment experience and motivations for leaving (Evans, 2006). Such interviews may provide information to help organisations reduce the cost of future turnover.

However, the evidence base for the efficacy of exit interviews is limited, particularly for bullying issues. Knouse et al. (1996) found that attitudes towards supervisors influenced employee willingness to discuss general issues during exit interviews. Feinberg and Jeppeson (2000) found differences when they compared reasons for leaving provided in an exit interview with a follow up survey and concluded that the information given in exit interviews was not valid. The effectiveness is further impaired as frequently organisations fail to use exit interview information for any real purpose (Johns and Johnson, 2005). To date, research on exit interviews has not investigated their use as a bullying metric.

3.5 Other measures

There are many measures which may be associated with workplace bullying and could highlight areas of concern. Detailed discussion is beyond the scope of the current report, but measures of the work environment, culture and climate may identify problematic units and are likely to be negatively associated with bullying. For example, Hall, Dollard & Coward (2010) developed a 12-item measure of psychosocial safety climate (PSC-12) which measures domains such as management commitment, management priority, organisational communication, and organisational participation that are relevant to employee psychological safety and health, and might act as a proxy indicator of the risk of bullying. PSC-12 was found to be negatively related to bullying (Law et al., 2011).

At a team level, the Aston Team Performance Indicator (ATPI; West, Markiewicz and Dawson, 2006) measures elements of team work such as team tasks, processes, effectiveness, member satisfaction, and attachments. For example, conflict and member participation are measured as facets of team processes. High conflict and low participation of members could also be indicators of the presence of workplace bullying. These areas have not received extensive empirical research, therefore the utility for use in the NHS would be difficult to judge without further studies

As described in section 2.7, the GMC has recently added several items measuring ‘supportive environment’ to their annual trainee survey, which could act as useful indirect bullying metrics. These items give trainees the opportunity to rate aspects of the working environment, including whether staff are treated fairly and show each other respect.

The NHS staff survey also captures additional relevant data, such as manager behaviour (support, valuing work, feedback, etc) and whether staff have felt unwell due to work-related stress.

3. Workplace bullying in the UK: Comparison of Public, Private and Voluntary Sectors

This section focuses on levels of workplace bullying outside of the NHS, using examples from other sectors in the UK. Workplace bullying prevalence in the NHS is compared to public, private and voluntary sectors, to enable NHS system and local organisations to benchmark themselves.

The prevalence of workplace bullying in the NHS

Workplace bullying is a significant problem in the NHS, evidenced from a range of sources: the NHS staff survey (2015) found that 13% of staff had been bullied by managers and 16% had been bullied by other colleagues in the last 12 months (sample size: 299,000). In a study of seven NHS Trusts, Carter et al. (2013) reported that 20% of NHS staff had been bullied to some degree (from rarely to daily) by other staff, and 43% had witnessed bullying, in the last 6 months (sample size: 2950). Lastly, in a recent survey of medical trainees the General Medical Council (2014) found that 8% of trainees had been bullied (sample size: 49,994) and 14% had witnessed bullying.

General Population

A large scale study on the experience of ill-treatment at work was conducted by Fevre et al. (2011). The authors collected data from 4000 members of the public in face-to-face interviews in their own homes. The respondents were asked about exposure to ill-treatment at work using a modified form of the Negative Acts Questionnaire (NAQ), but they were not directly asked if they had been bullied (see appendix for items). Fevre et al. found that 40% of respondents reported experiencing incivility at work within the last two years. However, 22.3% reported being treated in a disrespectful or rude way, 29.1% had been given an unmanageable work load, 14.7% had been insulted or had offensive remarks made about them, and 4.9% had experienced physical violence at work.

Experiencing both unreasonable treatment and incivility and disrespect was found to be more common in the public sector. Hotspots of risk were identified in public administration and defence, and health and social work.

Perpetrators of unreasonable treatment and incivility were more likely to have managerial duties, be full-timers, work in associate professional and technical jobs, have very intense work, experience organisational change or not think their organisation cared for individuals or their principles. Self-identified perpetrators of incivility and disrespect were characterised as having managerial duties, permanent jobs, at least 3-4 years tenure and be high earners.

An online survey of over 2000 workers commissioned by employment law specialists Slater and Gordon (2015) found that 37% of employees reported they had been bullied and a further 21% had witnessed bullying. The issues identified in the report were tight deadlines, personality clashes and office politics. Ten percent of respondents reported they had heard racist insults and approximately 17%

witnessed a co-worker being subjected to inappropriate sexual remarks. Childish pranks were seen by 24% of those surveyed while one in 15 saw their colleague's work being sabotaged, and 5% percent had witnessed physical violence between workmates.

Bullying was mainly disguised as 'workplace banter' in 56% of cases and 68% said the behaviour was 'subtle' e.g. not inviting colleagues to join work drinks lunches and meetings.

Public sector

Research commissioned by UNISON (2011) highlighted that 35% of staff employed in the public sector reported bullying. The percentage reported varied slightly within the sector. The main perpetrator was someone working at a more senior level (74%). The common behaviours reported were: rude and disrespectful behaviour, setting unrealistic targets, isolation/exclusion, excessive work monitoring and criticism, withholding information and intimidation. Similar rates of 31-36% were reported across a range of workplaces.

In 2015, UNISON conducted an online survey of the police. The survey was completed by 1,015 police officers across England (84%), Scotland (10%) and Wales (6%). The majority who completed the survey were female (60%). When asked if they were currently being bullied, 16% said yes; and 59% had witnessed colleagues being bullied. The main types of behaviour reported were humiliation (63%), excessive criticism (56%), victimisation (42%), exclusion (41%), excessive monitoring (40%), setting unrealistic targets (37%), and intimidation (37%). The main causes identified were poor management (73%), workplace culture (47%), staff cuts (36%), inadequate managerial training (36%) and stressed managers (30%). When asked if they had ever been bullied in their current workplace, 53% said yes, an increase since 2002 (28%). In the Hoel and Cooper (2000) study (discussed below) the percentage who reported being a victim of bullying was lower. It is possible that the variation in prevalence may reflect the rank of the police officer, which was not reported by Hoel and Cooper.

Further education and higher educational institutions in Wales

Lewis (1999) reported on workplace bullying in further education and higher educational institutions in Wales. The survey targeted members of the College and University lecturers' trade union NATFHE in Wales. Members were sampled from both further and higher education covering 32 different institutions. A list of 3,612 members were targeted and a 50% response rate was achieved. Eighteen percent of respondents reported they had directly experienced bullying.

Table 1: A summary of studies conducted in the UK (prevalence, sector, type of study and authors)

Sector	Prevalence of bullying in previous 6 months or more	Type of study and numbers	Authors
General population **Union members**	18% in last 6 months 37% ever bullied	Respondents were asked to tick their workplace experience of bullying based on whether they had suffered from an event	Lewis (1999)
British citizens	37% ever bullied	Online survey 2000 British workers Response to online survey on bullying no definition and no measurement tool	Slater and Gordon (2015)
Sectors Combined British workplace behavior survey 65% (2587) private sector; 33% (1298) public sector; 2.4% (94) third sector	33% in last 24 months	3979 face to face interviews at home. Used Negative Acts Questionnaire	Fevre et al. (2011)
Public Sector Local government Higher education Further education Police School	35% 36% 32% 33% 31% 35%	Online survey by UNISON Response to online survey, no definition, no measurement tool	The Centre for Organisation Research and Development (CORD) at Portsmouth Business School during May 2011.

Sector	Prevalence of bullying in previous 6 months or more	Type of study and numbers	Authors
Police	71% (in last month or more)	Online survey 1,015 83% non-managerial Response to online survey, no definition, no measurement tool	Unison (2015)
Voluntary sector 29 voluntary organisations in Leicester	15% in previous year	71% response rate (n= 178) Questionnaire not identified (assume researchers devised it)	Dawood, Shariffah, Rahah Sheik (2013)
Private Sector Large international company	15%	Questionnaire 386/total not provided Workplace Relationships Questionnaire (WRQ) a 54-item self-completion questionnaire to measure bullying.	Cowie et al (2000)

Voluntary sector

A study of 29 voluntary organisations was conducted by Dawood et al. (2013). They explored the nature and prevalence of workplace bullying in the voluntary sector. The study was conducted across 29 voluntary organisations in one city, Leicester. The findings were based on 178 questionnaires (response rate = 71%). Fifteen per cent of the respondents reported being bullied over the previous year and 28% in the previous five years.

Mixed sector survey

It is quite challenging to interpret different prevalence rates across sectors when they have used different reporting periods and different measurements and methods. However, a study by Hoel and Cooper (2000) investigated bullying across all sectors. The large survey included 12,350 employees across Great Britain but excluding Northern Ireland and received 5,300 returned surveys providing a usable response rate of 43 per cent. The survey involved employees across the private, public and voluntary sectors. They identified a broad sample of 200 organisations, 70 agreed to take part in the survey. Taken together these organisations employed just under one million employees.

The study adopted a definition used by Einarsen and Skogstad (1996). "*We 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 in defending him or herself against these actions. We will not refer to a one-off incident as bullying*."

The age range of the sample followed a normal distribution with a mean age of 43. There was also an even gender split (52% men and 48% women). The respondents posted their questionnaire directly back to the researchers.

The sample included populations from across the public, private and voluntary sectors. In this survey the NHS trust staff were in the middle of the table for workplace bullying at 11%. Some of the lowest reported prevalence was in the private sector, with the public sector reporting some of the highest rates.

Table 2: Hoel and Cooper survey sample

Area of work	Total sample	Returned quests.	Response rate %
NHS Trusts	1,069	535	50.5
Post/Telecom.	1,000	273	27.3
Civil Service	250	141	56.4
Higher Educ.	1,072	487	45.4
Teaching	1,000	426	42.6
Local Authority	924	388	42.0
Manufact./Eng.	177	82	46.3
Manufact. IT	475	189	39.8
Brewing	160	68	42.5
Pharmaceutic	350	197	56,3
(Total manufct.)	(1,162)	(536)	(46.1)
Hotels	493	163	32.7
Retailing	855	354	41.4
Banking	820	262	32.0
Voluntary Org.	317	123	38.8
Dance	196	85	43.4
Police Service	10000	483	48.3
Fire Service	1,167	520	44,6
Prison	1,000	471	47,1
Total sample	12,350	5,288	42.8%

(Permission gained to reproduce this table)

Table 3: Hoel and Cooper study, Prevalence of bullying - per sector

Sector	Not bullied	Occasionally Bullied		Regularly bullied		Total bullied	Sector
	n	%n	%	n	%	%	n
Post/Telecom.	222	83.8 30	11.3	13	4.9	16.2	265
Prison	389	83.8 68	14.7	7	1.5	16.2	464
Teaching	356	84.4 63	14.9	3	0.7	15.6	422
Other	12	85.7 1	7.1	1	7.1	14.3	14
Dance	73	85.9 12	14.1	0	0.0	14.1	85
Police Service	423	87.9 47	9.8	11	2.3	12.1	481
Voluntary Org.	108	89.3 12	9.9	1	0.8	10.7	121
Banking	228	88.4 27	10.5	3	1.2	11.6	258
NHS Trusts	474	89.4 44	8.3	12	2.3	10.6	530
Local Authority	342	89.5 39	10.2	1	0.3	10.5	382
Civil Service	127	90.1 12	8.5	2	1.4	9.9	141
Fire Service	469	91.1 40	7.8	6	1.2	8.9	515
Hotel industry	149	92.5 11	6.8	1	0.6	7.5	161
Higher Educ.	448	92.8 29	6.0	6	1.2	7.2	483
Retailing	327	93.2 20	5.7	4	1.1	6.8	351
Manufacturing	513	95.9 21	3.9	1	0.2	4.1	535

(Permission gained to reproduce this table)

Table 4: Prevalence of bullying and witnessed bullying

Sector	**Bullied last 6 months (%)**	**Bullied last 5 years (%)**	**Witnessed bullying last 5 years (%)**
Post/Telecom.	16.2	27.9	50.4
Prison	16.2	32.1	64.0
Teaching	15.6	35.9	57.7
Other	14.3	20.0	40.0
Dance	14.1	29.6	50.0
Police Service	12.1	29.2	46.4
Banking	11.6	24.6	39.6
Voluntary Org.	10.7	26.7	55.6
NHS Trusts Local Authority	10.6 10.5	25.2 21.4	47.2 42.7
Civil Service	**9.9**	**25.7**	**47.1**
Fire Service	8.9	20.0	43.2
Hotel industry	7.5	16.8	46.3
High. Educ.	7.2	21.3	42.8
Retailing	6.8	17.6	33.7
Manufacturing	4.1	19.2	39.0
Totals	10.6	24.7	46.5

Private: large international company

The Cowie et al. (2000) study used the Workplace Relationships Questionnaire (WRQ), a 54-item self-completion questionnaire, to measure bullying. The questionnaire was distributed amongst employees of large international organisations in both the UK and in Portugal. However, only the UK data are reported here. Questionnaires were collected from 386 participants in the UK. The sample was made up of 52% male respondents, and 48% female. The age range was 21 to over 50 years and 53% were aged between 30 and 50 years of age. Over a quarter of employees were in their current job for less than one year (26.6%), for one to two years 9.7%, for two to five years 27.4%, for five to ten years 8.2%, and for ten years plus 28.2%. The majority were white (94.2 percent) and the remaining 5.8% were from ethnic minority groups (Black or Asian).

Participants were introduced to the following definition of bullying before answering questions on the experience and perception of bullying in the workplace: “Bullying is negative behaviour that occurs repeatedly over time and causes distress. It includes: threat to professional status, threat to personal standing, isolation, unrealistic workload, destabilization unwanted physical contact.”

Three measures of bullying were used: six items focused on whether the participant had been subjected to the bullying behaviour outlined in the definition in the last six months; the status of the perpetrator (e.g. manager or colleague); and thirdly, the five item Bergen Bullying Index, measuring the degree to which bullying is perceived to be a problem.

The results for the UK sample identified 15% reported being victims of bullying. Of the remainder non-bullied sample, 47% reported some experience of bullying behaviours in the workplace.

Discussion

There are relatively few UK studies measuring the prevalence of bullying compared to the number of international studies. Studies have used different reporting periods; making comparison more difficult (UNISON, 2015) and some online surveys have invited respondents to complete a survey (UNISON, 2011; Slater and Gordon, 2015) without knowing the population they were drawing from. It is possible that respondents who are already concerned with workplace bullying completed the survey, resulting in over inflation of the percent of the sample reporting that they had experienced bullying.

Some surveys used single locations (Dawood et al., 2013) that may not generalize to the rest of the country or to other organisations. However, some surveys did include total populations (GMC, 2014) and others very large populations (NHS staff survey, 2015). However, both of these use subjective items to measure bullying without first offering a definition of bullying.

Other studies (Hoel and Cooper, 2000; Carter et al., 2013) have targeted large samples, but not total populations. In addition, they have offered a definition of workplace bullying and used a tool (Negative Acts Questionnaire) that measured behaviours more objectively. Using the same research method and measurement enables more robust comparisons to be made between sectors.

Focusing on the study by Hoel and Cooper (2000), we can see that 10.6% of workers in the health sector reported workplace bullying. This is lower than the rates reported in the NHS staff survey and in a sample of NHS staff (Carter et al. 2013). The healthcare respondents formed the largest sample (n=1069) in the Hoel and Cooper study, but this group was significantly smaller than the Carter et al. study (n=2950) which used the same scale, and the data were collected more recently. Generally, the healthcare sample reported a higher prevalence rate than workers in the private sector (hotel industry, retailing and manufacturing) but the same rate as banking. The voluntary sector was similar at 10.7%. However, when the sample was subdivided into sectors, the sample sizes become very small (e.g. dance n=85, voluntary organisations n= 121).

4. Workplace bullying internationally: comparators with UK health service

Workplace bullying has been studied internationally across a number of different countries. A meta-analysis by Nielsen et al. (2010) included seventeen studies from Scandinavian countries (i.e. Denmark, Norway, Sweden), 23 studies had other European origins (e.g. Croatia, Finland, Italy, Spain, the UK). Eight (15%) studies originated in North America (USA and Canada), and other studies from Australia, Japan, and China. Outside the scope of the meta-analysis, other studies have been conducted in India (D'Cruz, 2014), Greece (Galanaki and Papalexandris, 2013), Turkey (Yildrim and Yildrim, 2007) and beyond.

Nielsen et al. (2010) concluded that the estimated global prevalence rate for workplace bullying ranged from 11% to 18% depending on the measurement method used. Global variations have been recognised by Power et al. (2013), particularly cultural differences in acceptability. For example, high performance orientated countries were often also more tolerant of bullying in contrast to high human orientated countries where bullying is less accepted.

Globally healthcare settings and professionals have frequently been examined as to the prevalence and impact of bullying through large scale national studies of multi-sector prevalence (e.g. Driscoll et al., 2011) or taking a specific health-sector/ organisation focus (e.g. Cooper-Thomas et al, 2013). A review of seventeen studies by Johnson (2009) described the implications for healthcare with respect to impact on decreased productivity, increased sickness absence, employee attrition and at the individual level, the damaging effect to physical and psychological health. Trepanier et al. (2015) provided robust evidence of the longer term impact of bullying, finding that in a group of Canadian nurses (n=699), those who had experienced bullying had impaired satisfaction and increased burnout 12 months later.

Within the nursing profession a large scale review of 136 studies by Spector, Zhou, and Che (2014), which included data from 151,347 nurses, found that 39.7% had experienced bullying. Individually both qualified nurses and those in training have been studied (See table 5). The prevalence reported in these studies ranges from 9.2%-85%, such a difference might be explained by cultural context and the level of experience by the nurse. In comparison, Carter et al. (2013) found 20% of registered nurses in the UK responded that they had experienced bullying.

Table 5: A summary of international studies of bullying experienced by nurses. Showing the country, prevalence, participant group, key measures and authors

Country	Prevalence	Sample	Design	Study
United States	31%	Newly licensed registered nurses (n=511)	NAQ-R	Simon et al. (2008)
Denmark	9.2%	2154 Nurses one year after graduation	Single item, social support and health	Hogh, Hoel and Carneiro (2011)
Turkey	86%	505 nurses - 325 (64%) public sector; 180 (36%) private sector	Bespoke survey	Yildrim and Yildrim (2007)
United States	21.3%	Newly qualified nurses (n=194)	NAQ, Healthcare Productivity measure	Berry et al. (2012)
Korea	17.2%	Intensive Care Unit Nurses (n=134)	NAQ-R Nursing Work Environment Scale	Yun, Kang, Lee and Yi (2014)
Canada	33%	415 newly graduated nurses (<3 years of experience)	Conditions of Work Effectiveness Questionnaire, NAQ-R, Maslach Burnout Inventory	Laschinger, Grau, Finegan, Wilk (2010)
Canada	88.72%	Undergraduate Nursing Students (n=674)	Survey developed by Stevenson et al (2006)	Clarke, Kane, Rajacich, Lafreniere (2012)

The prevalence of bullying during training is evident in related professions. McCormack, Djurkovic and Casimir (2014) reported that healthcare trainees were subjected to a range of work-related and person-related forms of bullying behaviours. Stubbs and Soundy (2013) found 25% of physiotherapy trainees in their sample (n=52) experienced bullying. Furthermore, Whiteside, Stubbs and Soundy (2014) described difficulties for physiotherapy trainees in dealing with the situations and a range of factors that influenced the acuity of the experience.

Doctors

Within the medical profession, the experiences of junior doctors and seniors have been examined (See table 6). The prevalence reported in these studies ranges from 18%-50%. In the UK, Carter et al. (2013) found 23% of doctors said that they had experienced bullying, in comparison to 37% reported by Quine (2002), and 18% by

Paice et al. (2014). The differences reported might be explained by cultural context (such as those reported by Power, 2013). Specialty variations may also be a consideration – for example, Musselman et al. (2013) described how bullying might be legitimised and rationalised by trainees during the specific cultural context of surgical training. The level of experience of the doctor may also be an important variable; a systematic review by Fnais et al. (2015) demonstrated a high prevalence of bullying of doctors during medical training.

Table 6: A summary of international studies of bullying experienced by doctors. Showing the country, prevalence, participant group, key measures and authors

Country	Prevalence	Sample	Design	Study
New-Zealand	18%	Nine healthcare organisations (n=727)	NAQ-R	Cooper-Thomas et al (2013)
New-Zealand	50%	Junior doctors: 141 house officers and 232 registrars	Anonymous Cross-sectional questionnaire	Scott, Blanshard and Child (2008)
Australia	25%	1666 individuals – 866 medical students, 800 registered doctors.	Electronic cross-sectional analysis of data collected through the DeC study.	Askew, Schluter, Dick, Rego, Turner and Wilkinson (2012)
Germany	Workplace bullying associated with increased depressive symptoms after one year and three years.	621 Junior hospital physicians	Depressive symptoms measured by the state scale of the German Spielberger's State-Trait Depression Scales. Exposure to bullying – one question.	Loerbroks, Wegl, Li, Glaser, Degen, Angerer (2015)
India	53% of men and 35% of women were subjected to bullying. 90% of bullying incidents went unreported.	174 doctors (115 PGs and 59 Junior doctors)	Cross sectional. Anonymous questionnaire	Bairy, Thirumalaikolundusubramanian, Sivagnanam, Saraswathi, Sachidanand, and Shalini (2007)

Discussion

These studies measured the prevalence of bullying in countries across the world. The studies share similar limitations to those in the UK with respect to differing measurements and reporting periods, making comparisons difficult. Nielsen et al. (2010) provides a comparison across multiple countries, although acknowledging variations in measurement, showing a range in prevalence between 11% and 18%.

Within the healthcare setting, similar study findings have been found internationally as those in the UK (e.g. Carter et al., 2013; Hoel and Cooper, 2001) confirming that bullying is a phenomenon experienced by healthcare professionals globally. Study participants include doctors, nurses, physiotherapists and healthcare trainees suggesting that not one particular group is at risk. Trainees in any of the professions do have a heightened risk of bullying (Berry et al., 2012; Stubbs and Soundy, 2013; Askew et al., 2012) suggesting this is an area where focused monitoring is required. The consequences of these experiences of bullying are also established; the negative implications of bullying for healthcare culminating in reduced organisational performance and detrimental effects on individual staff wellbeing (Johnson, 2009; Loerbroks et al, 2015).

5. Summary and Discussion

This report aimed to identify potential measures of workplace bullying which may be used to track change over time, and to compare prevalence rates in the NHS to other sectors in the UK and the healthcare sector internationally.

The measurement of bullying is a complex issue, compounded by the lack of definitional consensus, differences in opinion regarding the threshold for classifying behaviour as bullying, and the inherent subjectivity of the perceptions of targets, perpetrators and witnesses. The prevalence of bullying will vary depending on the type of measurement and criteria used. Meta-analytic findings suggest that lower prevalence levels will typically be found using self-labelling with a definition, and higher levels will be found for self-labelling without a definition (Nielsen et al., 2010). Bullying prevalence using the behavioural experience approach varies considerably depending on the criteria for bullying (e.g., including occasional exposure to negative acts, or requiring at least two negative acts on a weekly basis for six months) and the reference period (e.g., previous six months, twelve months or whole career).

This report has reviewed several potential measures of workplace bullying, including direct and indirect metrics. Direct measures included formal complaints, several versions of the widely used revised Negative Acts Questionnaire (NAQ-R), the Bullying Risk Assessment Tool (BRAT), Quine's workplace bullying inventory and adaptations (e.g. in Obstetrics & Gynaecology), and examples from UNISON and the Royal College of Nursing (RCN), as well as metrics from existing annual questionnaires administered by the Picker Institute (NHS staff survey) and the General Medical Council (National Training Survey, GMC NTS).

Different measurement approaches have different strengths and limitations which are important to consider, including relative subjectivity versus objectivity, number of items and related completion time. Key strengths and weaknesses of direct measures are summarised in table 7. Some measures (e.g. NHS staff survey, GMC NTS) involve one or two items asking respondents to self-identify as a target of bullying and these have the advantage of being quick to complete and score. Lengthier behavioural inventories (e.g. NAQ-R, Quine questionnaire) are more time-consuming but provide more detailed information and offer greater objectivity. The perceived and actual anonymity of responses is also likely to affect prevalence levels and response rates.

Use of routinely administered questionnaires with existing arrangements for annual data collection, analysis and reporting, such as the NHS staff survey and GMC NTS, has obvious cost benefits. However, the NHS staff survey targets a sample of the NHS workforce rather than all staff, and it does not provide a definition of bullying, nor does it ask about witnessed bullying. The GMC NTS invites all trainee doctors to take part, but it is focused solely on the medical workforce, and recent changes to items mean that the prevalence of directly experienced bullying and witnessed bullying are now combined.

Table 7: Key strengths and weaknesses of direct measures of bullying

Direct Measure	Strengths	Weaknesses
Formal complaints	Routinely collected	Under-estimate of bullying prevalence due to underreporting Not anonymous
NAQ-R	Empirically developed Good evidence of validity and reliability More objective Provides detail on prevalence of specific negative behaviours Widely used internationally across occupational groups Can be anonymous Test administrator can select threshold for bullying	Longer, more time consuming (although shorter S-NAQ version available)
BRAT	Evidence of validity and reliability	Identified risk of bullying, not actual prevalence Longer, more time consuming No published applications
Quine / O&G questionnaire	More objective Provides detail on prevalence of specific negative behaviours Used with samples of UK NHS workforce Can be anonymous Test administrator can select threshold for bullying	Longer, more time consuming
GMC NTS	Whole population of trainee doctors invited to participate Existing tool, administered annually Existing arrangements for data collection, analysis and reporting Can explore relationships with other variables in the survey (e.g. supportive environment, handover, feedback)	Limited to medical workforce (trainees; but a survey for trainers has recently been introduced) Not anonymous More subjective, no definition Conflates directly experienced and witnessed bullying
NHS staff survey	Large NHS sample across occupational groups Existing tool, administered annually Existing arrangements for data collection, analysis and reporting Can explore relationships with other variables in the survey (e.g. health and wellbeing, manager behaviours)	Not total population More subjective, no definition No question on witnessed bullying Question format has been changed several times
Trade Union tools	Can be anonymous Unions may be more trusted with sensitive information RCN tool includes questions on confidence in the organisation's response to bullying	Sample may be limited to union members Typically lower response rates More subjective

It is regarded as best practice to include both a self-labelling item (with a definition) and a behavioural experience checklist (Zapf et al., 2011). One measurement option would be to adopt a two-stage approach, with a single-item self-labelling measure as a primary metric, with a more detailed behavioural experience approach for areas of concern. Measuring witnessed bullying and using indirect metrics could also be helpful in the identification of potentially problematic areas.

The indirect measures reviewed in this report may also provide useful information, particularly when measuring the risk or impact of bullying in the workplace. Triangulating multiple sources of information such as national and local surveys, organisational data, local intelligence and qualitative feedback will offer a more detailed assessment of any bullying issues, and enable interventions to be targeted where there is greatest need. Proactive monitoring of such data is recommended as part of a broad approach to preventing and managing bullying (Illing et al., 2013).

The report also compared prevalence rates in the NHS with other sectors in the UK and in the healthcare sector internationally. However, such comparisons are complex due to differences in bullying definitions, measurement methods and reporting periods. The review of international studies indicated that bullying is a significant problem in the healthcare sector in other countries, and that trainees may be particularly at risk.

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7. Appendices

Negative Acts Questionnaire – Revised (NAQ-R)

The following behaviours are often seen as examples of negative behaviour in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work?

Please circle the number that best corresponds with your experience over the last six months:

1	*2*	*3*	*4*	*5*
Never	*Now and then*	*Monthly*	*Weekly*	*Daily*

1)	Someone withholding information which affects your performance	1	2	3	4	5
2)	Being humiliated or ridiculed in connection with your work	1	2	3	4	5
3)	Being ordered to do work below your level of competence	1	2	3	4	5
4)	Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	1	2	3	4	5
5)	Spreading of gossip and rumours about you	1	2	3	4	5
6)	Being ignored, excluded or being 'sent to Coventry'	1	2	3	4	5
7)	Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life	1	2	3	4	5
8)	Being shouted at or being the target of spontaneous anger (or rage)	1	2	3	4	5
9)	Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	1	2	3	4	5
10)	Hints or signals from others that you should quit your job	1	2	3	4	5
11)	Repeated reminders of your errors or mistakes	1	2	3	4	5
12)	Being ignored or facing a hostile reaction when you approach	1	2	3	4	5
13)	Persistent criticism of your work and effort	1	2	3	4	5
14)	Having your opinions and views ignored	1	2	3	4	5
15)	Practical jokes carried out by people you don't get on with	1	2	3	4	5

16)	Being given tasks with unreasonable or impossible targets or deadlines	1	2	3	4	5
17)	Having allegations made against you	1	2	3	4	5
18)	Excessive monitoring of your work	1	2	3	4	5
19)	Pressure not to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses)	1	2	3	4	5
20)	Being the subject of excessive teasing and sarcasm	1	2	3	4	5
21)	Being exposed to an unmanageable workload	1	2	3	4	5
22)	Threats of violence or physical abuse or actual abuse	1	2	3	4	5

23. Have you been bullied at work? We 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 in defending him or herself against these actions. We will <u>not</u> refer to a one-off incident as bullying.

Using the above definition, please state whether you have been bullied at work over the last six months?

- No ☐
- Yes, but only rarely ☐
- Yes, now and then ☐
- Yes several times per week ☐
- Yes, almost daily ☐

Short NAQ (S-NAQ, 9-items; variations shown in brackets)

1. Someone withholding information which affects your performance
2. Spreading of gossip and rumours about you
3. Being ignored by people at work [Being ignored, excluded, or being ‘sent to Coventry’]
4. Having insulting or offensive remarks made about you (i.e. habits, background, attitude or private life)
5. Being shouted at [Being shouted at or being the target of spontaneous anger (or rage)]
6. Repeated reminders of your errors or mistakes
7. Facing a hostile reaction when you approach others [Being ignored or facing a hostile reaction when you approach]
8. Persistent criticism of your work and performance [Persistent criticism of your work and effort]
9. Being the subject of unwanted practical jokes [Practical jokes carried out by people you don’t get on with]

Adapted NAQ (Fevre et al., 2011)

Unreasonable Treatment
Being treated unfairly compared to others in your workplace
Your employer not following proper procedure
Being given unmanageable workload or impossible deadlines
Pressure from someone else not to claim something which by right you are entitled to
Someone continually checking up on you or your work when it is not necessary
Having your opinions and views ignored
Pressure from someone else to do work below your level of competence
Someone withholding information which affects your performance

Denigration and Disrespect
Feeling threatened in any way while at work
Intimidating behaviour from people at work
Being shouted at or someone losing their temper with you
Teasing, mocking sarcasm or jokes which go too far
Persistent criticism of your work or performance which is unfair
Hints or signal from others that you should quit your job
People excluding you from their group
Being treated in a disrespectful or rude way
Being insulted or having offensive remarks made about you
Gossip & rumours being spread about you or having allegations made against you
Being humiliated or ridiculed in connection to your work

Violence
Injury in some way as a result of violence or aggression at work
Actual violence at work

The Bullying Risk Assessment Tool (BRAT)

The following items relate to your experience within your organisation. Please rate each item by circling the number that best corresponds to your experiences / thoughts over the last 6 months.

1 Strongly agree	**2** Agree	**3** Slightly agree	**4** Slightly disagree	**5** Disagree	**6** Strongly disagree

1. New staff are made to feel welcome when starting employment in the organisation	1 2 3 4 5 6
2. Conflict in my work unit is common	1 2 3 4 5 6
3. I am clear about what is expected from me	1 2 3 4 5 6
4. This organisation does not value equal opportunity for everyone	1 2 3 4 5 6
5. I have confidence in my line managers abilities	1 2 3 4 5 6
6. Staff shortages are common in my unit	1 2 3 4 5 6
7. I enjoy working in the teams that I am involved with	1 2 3 4 5 6
8. I am not clear about how to carry out my job	1 2 3 4 5 6
9. Vacant positions are filled without delay within my unit	1 2 3 4 5 6
10. My line manager tries to control every single aspect of what is going on at work	1 2 3 4 5 6
11. The grading / rank structure in this organisation is transparent	1 2 3 4 5 6
12. I don't get on with some of my colleagues	1 2 3 4 5 6
13. I have received sufficient training to carry out my job	1 2 3 4 5 6
14. My unit often makes use of temporary staff	1 2 3 4 5 6
15. My line manager values constructive criticism	1 2 3 4 5 6
16. People in this organisation are not rewarded properly	1 2 3 4 5 6
17. I find my colleagues to be co-operative	1 2 3 4 5 6
18. I face conflicting demands in my job	1 2 3 4 5 6

19. Cover for absent staff is provided immediately within my unit	1 2 3 4 5 6
20. My line manager exploits his / her position of power	1 2 3 4 5 6
21. I feel my contribution to the organisation is recognised	1 2 3 4 5 6
22. Different professional groups don't work well together within my unit	1 2 3 4 5 6
23. My job description is clearly defined	1 2 3 4 5 6
24. I feel that there isn't enough time in the day to complete my work	1 2 3 4 5 6
25. My line manager consults me before decisions affecting me are made	1 2 3 4 5 6
26. The organisation's resources are not distributed fairly	1 2 3 4 5 6
27. My line manager is sensitive to how I feel	1 2 3 4 5 6
28. Existing work pressures make it difficult to take time off work	1 2 3 4 5 6
29. Work is shared equally among the people I work with	1 2 3 4 5 6

Quine bullying questionnaire (1999, 2001, 2002)

Have you been persistently subjected to any of these behaviours in the past twelve months? (yes/no; Quine, 1999, 2001):

In the last 12 months have you experienced from peers, senior staff or general managers any of the following in the workplace (no, rarely, a few times, frequently; Quine 2002):

Threat to professional status
Persistent attempts to belittle and undermine your work
Persistent and unjustified criticism and monitoring of your work
Persistent attempts to humiliate you in front of colleagues
Intimidatory use of discipline or competence procedures

Threat to personal standing
Undermining your personal integrity
Destructive innuendo and sarcasm
Verbal and non-verbal threats
Making inappropriate jokes about you
Persistent teasing
Physical violence
Violence to property

Isolation
Witholding necessary information from you
Freezing out, ignoring, or excluding
Unreasonable refusal of applications for leave, training, or promotion

Overwork
Undue pressure to produce work
Setting of impossible deadlines

Destabilisation
Shifting of goal posts without telling you
Constant undervaluing of your efforts
Persistent attempts to demoralise you
Removal of areas of responsibility without consultation

Additional item added in Quine (2002):
Discrimination on grounds of race or gender

Additional item added in Obstetrics & Gynaecology tool:
Unwelcome sexual advances

UNISON draft bullying survey

Source:UNISON (2013). Tackling bullying at work. A UNISON guide for safety reps.

Branches can use the following survey to gather evidence on the scale and extent of bullying in the workplace.

Bullying at work is persistent offensive, intimidating, humiliating behaviour, which attempts to undermine an individual or group of employees. It can take many forms, including shouting at or humiliating an individual, especially in front of colleagues; picking on an individual; undermining someone's ability to do their job; abusive or threatening behaviour which creates a stressful or intimidating atmosphere. Such bullying behaviour is an abuse of power and a denial of our right to be treated with dignity and respect. Bullying causes stress. It damages the health and safety of staff and adversely affects the quality of service provided.

UNISON is concerned about the amount of bullying that goes on at work. In order to convince management that bullying of staff is a serious problem and that changes are needed to eliminate bullying, your UNISON branch is conducting this survey. We need your views and experiences on any bullying you face at work. Please help us to help you by answering the following questions. Your replies will be treated as confidential (you will notice that you have not been asked to provide your name).

Where do you work?

What is your job?

(Give a description if your job title would identify you)

Are you: Male / Female

Is bullying at work: (Tick relevant box)

A very serious problem? Yes / No

A serious problem? Yes / No

A minor problem? Yes / No

A non-existent problem? Yes / No

Have you ever been bullied at this place of work? Yes / No

Are you currently being bullied? Yes / No

If yes, when did the bullying start?

What are the main sources of bullying?

From your line managers

From senior managers

From colleagues

From the public (clients, patients, customers and so on)

From visitors

From contractors' staff

Other (please state)

What form does the bullying take? (tick relevant box)

Shouting / Threats / Abuse / Intimidation / Humiliation / Excessive criticism / Setting unrealistic targets or deadlines / Altering targets, deadlines and so on / Excessive work monitoring / Keeping you out of things / Victimising you / Malicious lies or rumours / Refusing reasonable requests such as for leave / Other (please state)

How often does the bullying happen? (tick relevant box)

Daily / Weekly / Monthly / Less than monthly

Have you or other staff in your area ever had time off work because of bullying?

Yes / No

Have any staff left their job because of bullying at work in your area? Yes / No

If yes, how many?

What do you think causes bullying? (tick relevant box)

Stressed managers / Stressed colleagues / Excessive workloads / Pressure to meet deadlines / Pressure to meet work targets / Staff shortages / Pressure not to take

sick leave / Inadequate training for managers / Inadequate training for staff / Poor management / Performance approach / Other reasons (please state what they are)

What measures would you like to see to reduce bullying?

Do you have access to a counselling service? Yes / No

If yes, how effective is it? (tick relevant box)

Very effective / Sometimes effective / Useless

Any other comments?

Thank you for completing this questionnaire. Please return it to the person who gave you this survey.