Internal ‘chutes’ and legal ‘ladders’: negative behaviour anomalies in the NHS

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Abstract

Safeguarding workers from negative behaviours remains an ongoing concern for health sector organisations globally, and in the UK’s National Health Service (NHS). Although the term ‘negative behaviour’ includes acts ranging from bullying and physical violence to banter and rumours, only harassment has a legal definition in UK law. As a result, individual Trusts within the NHS have had to create their own internal policy frameworks in order to identify, address and redress a wide range of negative behaviours without legal definition. In our study of three NHS Trusts, we frame such NHS policy responses as ‘chutes’, or policies seeking to de-escalate the manifested negative behaviour, deal with conflict informally and restore business as usual. We contrast such ‘chutes’ with policy ‘ladders’, manifest in the instance of severe harassment cases (which we term ‘anomalies’), where legal obligations supersede organisational policy and escalate the matter in line with the appropriate legal provision. We find that organisational ladders are less effective than chutes across our sample with all three NHS Trusts recording lower incidence of anomalies than those reported by their employees.

Key words: Negative Acts; Bullying; Harassment, NHS; Anomalies

Introduction

In December 2022, members of the United Kingdom’s (UK) nursing union, the Royal College of Nursing (RCN), went on strike for the first time in the union’s 106 years of existence (Cooban, 2022). Nurses across England, Wales and Northern Ireland were joined by striking paramedics, causing ‘significant disruption’ across the UK, and necessitating over 600 members of Britain’s armed forces to step in and fill their ranks (Atkinson and Milligan, 2022). The two main causes for the strikes were levels of pay and challenging working conditions, which the general secretary and chief executive for the RCN described as: “a financial knife-edge at home and a raw deal at work” (Cooban, 2022).

While the working conditions of British healthcare workers are currently at the forefront of public attention, this does not mean that the matter is an issue isolated to the UK. Rather, one of the most exacerbating factors for workplace well-being – experiences of negative behaviours – is common and frequent in other nations as well (Fevre et al., 2010; Einarsen and Skogstad, 1996). Data from the latest European Working Conditions Telephone Survey (EWCTS), which ran between March and November 2021 suggests that approximately 35% of all workers across EU27 experienced some form of workplace discrimination or intimidation through verbal and physical abuse in the 12 months leading up to the survey (Eurofound, 2022:30). EWCTS (2022:30) also finds that healthcare workers experience the highest level of intimidation, which the World Health Organization (2022) suggests comes in the form of verbal abuse (58%); threats (33%) and sexual harassment (12%). Negative behaviours can result in workplace accidents, injuries, physical and psychological illnesses (Cioni and Savioli, 2016). Prolonged exposure to acts such as bullying can also lead to increased sickness absence (Skivens and Trystad, 2010), diminished commitment and early career exit (D'Cruz and Noronha, 2010; Kivimäki et al. 2000).

Kline and Lewis (2018) have conservatively concluded that the cost of bullying and harassment to the National Health Service (NHS) in England stands at £2.4 billion annually. Both fiscally and morally the working conditions within the NHS are deeply concerning, requiring a closer assessment of the prevalence of negative behaviours within trusts and how such instances are being resolved through legal mechanisms. This working paper reports the preliminary findings from ongoing research into the negative behaviours experienced by NHS staff in three UK Trusts – referred to as Alpha, Beta and Gamma NHS throughout the paper. The paper begins with a brief overview of the literature on negative behaviours, highlighting the prevalent tensions within the legal terminology used in the existing literature. It continues from this by outlining the attempt made by NHS policy to bridge the gap between the full range of negative behaviours which manifests in the workplace and the narrow legislative provisions which inform organisational responses to a specific type of negative behaviour – harassment. From this follows an evaluation of the NHS' ability to fulfil its legal obligations in the instance of extreme negative behaviours, such as cases of physical violence and those cases when this violence causes personal harm. This paper refers to instances of such extreme behaviours as 'anomalies' and establishes a framework for their analysis. Finally concluding that while the convoluted existing framework for dealing with negative behaviours does not disrupt the working of the specific NHS trusts, it leaves them poorly equipped to deal with anomalies in a legally responsible manner.

Literature Review: Establishing 'Negative Behaviours' and their Legal Framework

'Negative behaviours' is an umbrella-term used to describe any acts which are aggressive, unwanted, or humiliating for the target (Nielsen and Einarsen, 2012). The term includes overt behaviour, such as physical aggression and open conflict, as well as covert acts, such as rumour-spreading, jokes, and banter (Manolchev et al., 2022). They may also arise as a self-defence mechanism when circumstances of increased workload and job dissatisfaction cause workers to protect their current resources (Dlouhy and Casper, 2020) in working environments, where there are role conflicts, role ambiguity, work intensity, manager, and co-worker tensions (Salin, 2008; Ågotnes et al., 2018). Unlike incivility which may constitute milder or one-off misdemeanours (Hershcovis, 2011), negative behaviours tend to be defined as 'prolonged', 'frequent' or 'persistent' (Fevre, et al., 2010) acts, which can escalate (Ågotnes et al., 2018) or worsen over time (cf. Einarsen et al., 2011). To this effect, Fevre et al. (2010) and Woodrow and Guest (2014) propose that to be identified as such, negative behaviours need to be observed over a period of time, for instance, between six and twelve months, regardless of pattern, frequency and/or intensity of the experiences.

This brief overview highlights two areas of concern. *First*, the identification of negative behaviours through the tests highlighted by researchers and practitioners (see, for example, detailed guidance on bullying, harassment, and victimisation by ACAS, accessed 14/12/2022) does not immediately allow the target of such behaviours to access legal remedies. From the whole plethora of negative acts, only harassment is a legally defined term within the UK. Unfortunately, most of the existing literature exploring negative behaviours has failed to make this legal distinction and rather used 'bullying and harassment' as a term to describe a large variety of negative acts without consideration. Furthermore, the NHS' own policy (accessed 14/12/2022) does not distinguish between individual negative behaviours. Instead, it provides standardised guidance to its employees (and managers), which advocates for informal resolution and de-escalation, in a process with refer to as a 'chute', borrowing the term from the eponymous board game. Whenever the problem 'continues' even after recourse to the individual trust's grievance procedure and following a formal complaint, employees are advised to seek legal action but not without 'get[ting] professional advice before taking this step' (NHS Mental Health, accessed 14/12/2022). This presents a *second* area of concern. In some severe cases those chutes need to act as 'ladders', allowing extreme acts to be recognised as anomalies, requiring organisational policy to be superseded by the respective legal provision. It is imperative that employers provide their staff with such ladders, to meet their statutory duties to safeguard their employees from harm within the workplace.

This need for NHS policy to simultaneously provide chutes and ladders can be organisationally disruptive for individual Trusts such as the three studied in this paper. These trusts are formal organisations, which achieve internal order through the presence of five elements (Ahrne and Brunsson, 2019:7). As an example, (1) membership is open only to employees, there is (2) formal hierarchy, (3) rules as well as (4) sanctions, based on both national legislation and local NHS policies. Finally, staff performance is subject to (5) monitoring and surveillance, seeking to reduce waiting periods and streamline response times (NHS England, accessed 02/06/2022). This formal organisational order can give way to partial organisation in cases where one or several of the above components (or rules) are obscured, challenged or simple not followed (p. 18). In turn, this can lead to instances where a formal organisation (as a noun) may lack complete organisation (as a verb) (cf. Ahrne and Brunnson, 2011).

This paper argues that instances of such a complete lack of organisation may arise alongside certain anomalies, due to the NHS policy. The following methodology section offers more details on how these anomalies are defined, by providing an overview the project's questionnaire, and stages of the study.

Methodology

Research Strategy

A widely used approach to measuring negative behaviours in organisations is the revised Negative Acts Questionnaire (NAQ-R) (Einarsen et al., 2009). This instrument recognises different types of bullying behaviours, for instance, work-based bullying through unwarranted criticism of the target's work performance, personal bullying through rumours or other derogatory comments, and physical intimidation such as threats and violence (Einarsen et al., 2009).

However, one of the UK's first representative studies of bullying practices (the British Workplace Behaviour Survey – BWBS) moved away from formal 'bullying' questions (Fevre et al., 2010). In the cognitive-testing stage of the study, Fevre et al. (2010) found that respondents interpreted bullying in a variety of ways, causing response differences based on interpretations, rather than experiences. As a result, their adapted NAQ-R instrument includes 21 questions, clustered into the themes of 'unreasonable treatment', 'denigration and disrespect' and 'violence and injury', developed through factor analysis (Fevre et al., 2010:11).

This is the survey instrument used in our ongoing study, also. An overview of the response rate per Trust is provided in Table 1. Survey data for this study was collected from a sample of n=3,849 workers across three NHS trusts working in acute (Alpha NHS), paramedic/ambulance (Beta NHS) and community/acute contexts (Gamma NHS), using a

cross-sectional design (Lindell and Whitney, 2001) over the period of September 2017-September 2018. Questionnaires were distributed via the on-line Qualtrics ® platform with each individual organisational survey being open for approximately 6 weeks.

Participants were assured of their anonymity, the voluntary nature of participation, as well as their right to withdraw at any point. Each participant was automatically assigned a numerical ID when recorded into the database. The survey instrument is part of an on-going project and included a wider range of questions than those reported in this study. As a result, the response rate was calculated based on participants responding to all the questions linked to the hypotheses put forward above. A total of n=2514 complete questionnaires were analysed with a response rate of 65.32%.

Table 1: Response rates per Trust

	Alpha	**Beta**	**Gamma**	**All**
Sample	1201	1160	1488	3849
Observation	767	726	1021	2514
Response rate	63.86%	62.59%	68.62%	65.32%
Alpha= An NHS Acute Trust Beta = An Ambulance Service NHS Trust Gamma = An NHS Acute/Community Trust				

In this study, we also report the incidence of extreme cases of negative behaviour, or anomalies, obtained through Freedom of Information and compare them with employee reports of experiences of physical violence. In our survey, participants were asked over the past 12 months, whether they have (a) received actual physical violence at work, and (b) been injured in some way as a result of violence or aggression at work. After that, any employees who had experienced bullying were asked to identify what actions they had taken in response to the bullying or harassment they experienced. The options included speaking to individuals, i.e., colleague, line manager, and another manager, as well organizational representatives: i.e., HR, a Trade Union, Freedom to Speak Up Guardian, Trust's Counselling Services.

Participant Demographics

The mean age of all participants for this study was 44 years of age (SD = 11.25) with a gender split which included 852 males (33.89%) and 1,646 females (65.47%). 16 respondents chose the ‘prefer not to say’ option. The number of employees in management and line-management roles was 483 (19.21%), while there were 2,031 participants in non-management roles

(80.79%). The sample consisted mostly of long-serving workers with 1,526 people (60.50%) being in their current role for five years or more, 507 participants (20.17%) being employed between three to five years, 272 people (10.82%) and 48 people (8.51%) being in their current role for between one to two year and less than one year respectively. In line with existing literature, we also checked the impact of workers' gender (Evesson and Oxenbridge, 2015), management responsibility (Einarsen et al., 2011), and tenure/working years (Keuskamp, et al., 2012; Deery et al., 2011), sexual-identity (Gill & Scharff, 2013) and disability (Manolchev & Lewis, 2021) on bullying experiences. The number of employees whose self-identified are straight was 2249 (89.46%), while 126 participants were identified as LGBT (5.01%). The 139 respondents who chose the 'prefer not to say', 'unsure, and 'other' options were categorised into others (5.53%). Regarding 'disability' responses, 606 respondents (24.11%) had a long-standing health condition, while 1908 people (75.89%) did not indicate a disability.

Findings

We report initial results in Table 2, which provides a descriptive count of participants reporting experiences of negative acts.

Table 2: A count of negative act experiences per demographic characteristic and encounter type.

Negative Act Experiences Per:	**Alpha**	**Beta**	**Gamma**	**Details**
Gender	44 185	135 102 2	37 143 1	male female other
Encounter type	177 53	163 81	154 51	personal & witnessed others personal
Sexual-identity	201 1 3 10 0	201 4 7 4 0	154 7 3 2 0	hetero-sexual lesbian gay bisexual transgender

	14	23	15	prefer not to say
Disability	148 80	161 78	125 55	N Y
Management Position	56 172	NA	84 96	Y N
Working years/Tenure	8 17 51 42 25 86	7 14 58 43 42 75	13 31 37 38 23 39	less than 1y 1y - 2y 3y - 5y 6y - 10y 11y - 15y more than 15y

Internal Chutes

In line with official NHS policy on bullying and harassment at work, each of the Trusts' provisions offered a series of informal, de-escalation steps such as 'staying calm', talking to the bully explaining the effect of their behaviour, etc (NHS Mental Health, Advice for Life Situations and Events, accessed 15/12/2022). Employees in our sample adhered to this by speaking to the parties and engaging with the channels listed in Table 3. Due to the low number of responses from Beta NHS, Table 3 does not include employee data.

Table 3: Employee responses when encountering negative behaviour

	Response to negative behaviour	Total	Alpha NHS	Gamma NHS
1	Did nothing	128	71	57
2	Talk to the bully	89	48	41
3	Colleague	221	110	111
4	Line manager	192	92	100
5	Other manager	71	31	40

6	Trade Union	63	39	24
7	HR	36	22	14
8	Speak Up Guardian	14	0	14
9	Trust's Counselling Services	33	14	19
10	Others	81	41	40

The multiple available channels reflect the effort of each NHS Trust to diffuse conflict and seek informal resolution, yet there is an important consideration. Almost 50% of employees who encountered negative behaviours responded by using formal organisational channels, e.g. their line manager, another line manager, their Trade Union representative, Human Resources, the Speak Up Guardian, and the formal Counselling Service. However, as we show in the below section, the level of formal complaints is lower than experiences of physical violence and harm alone, behaviours which should be subject to legal escalation due to their severity.

Legal Ladders

We used responses to the violence items of the survey to evaluate employee experiences in Alpha, Beta and Gamma NHS (see Table 4). In Alpha NHS, 43 people of those who participated in the survey (6.33%) experienced physical violence at work and 37 (5.45%) were injured as a result of workplace aggression over the 2017-2018 period. In Beta NHS those numbers were, respectively, 70 (10.31%) and 57 (8.39%), while in Gamma NHS they were 25 (3.68%) and 20 (2.95%) for the same period.

This can be contrasted with the much lower number of formal complaints recorded by each of the Trusts, namely, 11 by Alpha NHS; 39 by Beta NHS and 15 by Gamma NHS for the 2017-2022 period.

Table 4: Anomaly reports by participants and officially recorded by each NHS Trust. The source of data is presented in square brackets.

Question	Alpha	Beta	Gamma	All
[SURVEY] Receiving actual physical violence at work	43 (6%)	70 (10%)	25 (4%)	252
[SURVEY] Being injured in some way as a result of violence or aggression at work	37 (5%)	57 (8%)	20 (3%)	

[Freedom of Information Request] Formal Complaints: 2017-2022 period	11	39	15	65

Conclusion and Next Steps

The brief overview of our study's initial findings suggests that internal NHS Trust policy is able to provide a better chute, than a ladder. The three NHS Trusts recorded a total of 65 formal complaints, yet employees within them reported 252 cases of violence and physical injury linked to violence.

This leads to the preliminary conclusion that NHS Trusts are not experiencing a disruption of organisation through competing internal rules and logics, since internal policies are effective as de-escalation devices but less so in instances where anomalies require legal process to be invoked. At the same time, it is possible to arrive at the opposite conclusion – competing predetermined rules obfuscate complete organisation and this is associated with ineffective policy devices. In any case, there is a striking difference in the numbers of self-reported instances of serious behaviour versus those which were escalated to the appropriate formal organs. This creates a need for further research on the way in which organisations – particularly individual NHS trusts – handle instances of severe negative behaviour, ensuring a better safeguarding of employees and smoother operations for the organisation.

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