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

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1. Aims/Objectives:

Research question

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

Objectives

- Summarise the evidence on workplace bullying and inappropriate behaviour (Part 1)
- Summarise the empirical evidence on the causes and consequences of workplace bullying and inappropriate behaviour (Part 1)
- Describe any theoretical explanations of the causes and consequence of workplace bullying and inappropriate behaviour (Part 1)
- Synthesise evidence on the preventative and management interventions that address workplace bullying interventions and inappropriate behaviour (Part 2,3,4)

2. Background:

Bullying Behaviours and Prevalence

Workplace bullying and harassment is a significant problem in the NHS. The most recent national NHS staff survey indicated that 17% of staff had experienced bullying, harassment or abuse from other staff in the last year (NHS Staff Survey 2009), and this figure has remained relatively constant over the past few years. The prevalence of bullying in the NHS has been corroborated by other studies (Quine, 1999; Kivamaki, Elavainio and Vahtera, 2000; Paice and Smith, 2009).

Workplace bullying has been defined as
"…harassing, offending, socially excluding someone or negatively affecting someone's work tasks…it has to occur repeatedly and regularly…and over a period of time. 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." (Einarsen, Hoel, Zapf & Cooper, 2003, p15).

This definition demonstrates the breadth of behaviours that can be classified as bullying, and overall prevalence rates are not sufficiently informative for NHS managers to develop targeted strategies or commission appropriate interventions.

In a recent large scale survey of NHS staff in North East England (n=2950), our research has found comparable overall prevalence rates as the NHS staff survey, but extended our current understanding of inappropriate behaviours by adopting a behavioural level analysis of workplace bullying (Carter et al., 2010). Our study identified the most prevalent negative acts experienced by different occupational groups in the NHS, using an inventory of 22 bullying behaviours (the revised Negative Acts Questionnaire, NAQ-R; Einarsen, Raknes, Matthiesen & Hellesøy, 1994; Hoel, 1999), which has been used widely in bullying-related research (e.g. Einarsen, Hoel, & Notelaers, 2009). These behaviours range from social isolation and exclusion to being given tasks with impossible deadlines, and being humiliated over work to physical abuse. It is likely that different prevention and intervention strategies will be required to tackle different inappropriate behaviours. Understanding the most prevalent and problematic behaviours is currently enabling NHS Trusts participating in our study to devise interventions targeted at these behaviours.

The real impact of bullying in the NHS may be even more widespread than these surveys suggest, as our research found that 43% of NHS staff had witnessed workplace bullying in the last six months. Evidence indicates that witnessing bullying, even if individuals are not themselves directly targeted, is also associated with negative outcomes including higher levels of psychological distress, increased intentions to quit, and lower job satisfaction (Carter et al., 2010).

It is also important to consider the prevalence rates of inappropriate behaviours among specific demographic groups. For example, our research found that staff with disabilities experienced considerably higher levels of bullying behaviours, compared to staff without disabilities (Carter et al., 2010), as have other studies (e.g., Fevre et al., 2008). This may inform specific NHS strategies and policies relating to equal opportunities.

Causes/antecedents

The antecedents of bullying can be attributed to individual, organisational and social factors.
At an individual level personality factors of both perpetrator and victim can affect the onset, escalation and consequences of the bullying process (Einarsen, 2000; Hoel et al, 1999). At a social level behaviour such as anger, blaming and retaliation can generate feelings of social injustice and cause bullying (Ferguson, 1984; Homans, 1974). Negative organisational environments are associated with bullying (Zapf, 1999). A hostile work environment can elicit interpersonal conflict and peer bullying (Einarsen et al, 1994) while poorly organised work environments, where role and reporting structure are unclear, have also been related to bullying (Leymann,1996). The risk of bullying may increase during periods of change and increased pressure. Change implemented through an autocratic style can cause bullying (Sheenan, 1999) while changes of supervisor and job role are also possible antecedents to bullying (Hoel and Cooper, 2000).

The impact of bullying on health at work

Bullying is regarded as “a significant source of social stress at work…and a more crippling and devastating problem for employees than all other work-related stress put together” (Einarsen & Mikkelsen, 2003). For individuals, being exposed to bullying can have serious

implications not only for organisational commitment and job satisfaction, but also for mental and physical health (Einarsen & Mikkelsen, 2003). It has been associated with poorer psychological health and well-being, including social isolation and maladjustment, depression, helplessness, anxiety, and despair (Leymann, 1990). Bullying is also linked to higher levels of both psychosomatic and musculo-skeletal complaints (Einarsen & Raknes, 1997), physical strain (e.g. chronic fatigue, sleep difficulties and stomach problems) and sickness absence (Beswick, Gore, & Palferman, 2006).

Our own research findings, based on a large scale questionnaire study across all NHS occupational groups, indicated that being exposed to more negative behaviours in the workplace is associated with higher levels of psychological distress, increased intentions to quit, and lower job satisfaction (Carter et al., 2010). Although our analyses are based on cross-sectional data, other longitudinal research suggests that bullying is a cause, rather than a consequence, of lower job satisfaction and work engagement (Rodriguez-Munoz et al., 2009). Furthermore, the detrimental effects of bullying extend beyond those directly targeted: witnessing bullying is also associated with higher levels of psychological distress, increased intentions to quit, and lower job satisfaction (Carter et al., 2010).

At an organisational level, the cost of bullying can be substantial: taking into account absenteeism, turnover and productivity, a recent review estimated that the annual cost of bullying to organisations in the UK is £13.75 billion (Giga, Hoel & Lewis, 2008). Organisations that fail to manage bullying cases have received substantial financial penalties as well as negative publicity (e.g. Green vs Deutsche Bank, 2006). Of greater concern for the health and social care sector are studies that have demonstrated a link between increased stress and poorer job performance (lower levels of consideration, tolerance, concentration, and perseverance), which can have a detrimental effect on patient care (e.g. Mojoyinola, 2008; Motowidlo, Packard & Manning, 1986; Randle, 2003). Furthermore, the recent Boorman Review (2009) reported that 80% of staff believe the state of their health affects patient care. These risks, coupled with the higher prevalence of workplace bullying in the health and social care sector (Zapf, Einarsen, Hoel & Vartia, 2001), make tackling bullying a key priority for NHS organisations.

Interventions

“Interventions are efforts of agents acting independently of the disputants (bully and target) who influence the development of the interaction” (Saam, 2009). They are commonly classified according to focus (as prevention, protection and treatment; Chappell & Di Martino, 2000) and by level (i.e., individual, work group and organisation). Heames and Harvey (2006) proposed a multilevel model of bullying interventions, and defined the *dyadic- level* of bully and victim, the *meso-level* of bully and the group, and *macro level* of bully and organisation. Rather than considering these levels as an escalation or mutually exclusive, they reflect the organisational perspective towards the bullying problem. Some organisations view bullying as a personality issue, to be solved between the conflicting dyad, others instead consider it a much wider problem that requires addressing through coaching for the bully, counselling, performance management and representative training.

An initial review of potential interventions highlighted several approaches which may be organised within this framework (see Table 1): mediation, assertiveness training, stress

management training, help-lines, bullying policies, counselling, internal communication/awareness-raising programmes, coaching, risk assessment, team-building exercises, conflict management training, mentor or buddy schemes, behavioural 'Compacts', induction programmes, use of personality inventories and multisource feedback to raise awareness of differences in work and communication styles, behaviour-change training, leadership and management development programmes, sign-posting/listening services, and formal grievance procedures. If successful, the review would seek to synthesise evidence on these and other interventions. Several approaches are discussed further below.

		Level of intervention *(Heames and Harvey, 2006)*		
		Dyadic level Individual /Dyad	*Meso Level* Team	*Macro Level* Organisation
Intervention focus (Chappell and Di Martino, 2000)	Prevention	Coaching Training (e.g. assertiveness, stress management, conflict management) Mentor/buddy scheme	Risk Assessment Awareness Training Team building Behavioural Compact	Risk Assessment Communications Behavioural Compact Organisational Development Bullying policy Internal communications Induction
	Protection	Coaching Training (e.g. coping skills) Mentor/buddy scheme	Training (e.g. behavioural change)	Organisational Development Bullying policy
	Treatment	Counselling Coaching Mediation Help-lines Training (e.g. assertiveness, stress management, conflict management) Signposting/ Listening services Formal grievance	Mediation Team building	Bullying policy

Table 1: Potential workplace bullying interventions to consider

The main interventions used by Trusts to address workplace bullying have been identified as counselling, internal communication/awareness-raising programmes and help-lines (NHS Employers). These interventions are typically employed alongside formal investigations and hearings. The approach taken by Trusts follows a systemic approach based on Hubert's (2003) five-stage model (prevention, uncovering, support, intervention, and after-care) to prevent and overcome undesirable interaction at the workplace. The focus of Hubert's model is on establishing relevant policies and strategies while assigning specific responsibilities to the various professional disciplines involved. Within this model, the dominant interventions are counselling and formal investigations and hearings, although the utility of these approaches is hampered by widespread under reporting of

bullying and harassment.

Mediation has increased in prominence in recent years as an intervention tool for conflict resolution and cases of workplace bullying. However, concerns over the sensitivity of any existing power imbalance between individuals and lack of support during the mediation process question the appropriateness of its application as a bullying intervention (Hubert, 2003; Ferris, 2004). Mediation emphasises restorative approaches but this may be detrimental in bullying cases as the mediation process may not fully acknowledge the harm caused to the victim. The emphasis on reaching an agreement over future behaviour, without fully addressing previous bad behaviour, may also limit its efficacy in ameliorating the impact of bullying (Aquino, 2000).

Hoel and Giga (2006) employed a behaviourally based bullying intervention with the rationale that by raising awareness of negative behaviour and bullying in a group context, and providing participants with appropriate tools to deal with difficult situations, bullying would be reduced. The study demonstrated a positive effect in some of the participating groups, however generalisability evidence was limited by its small sample size.

Coaching is an emerging intervention at both the group and individual level. By raising awareness of an individual's own behaviours and practicing appropriate skills (e.g. interpreting the behaviours of others, assertiveness), coaching can act to rebalance power relations between a bully and target or enable a bystander to reduce the negative impact of bullying on others. Coaching of senior management, trade union members, co-workers and management on types of bullying behaviours has been applied in some organisations (Kilburg, 1996). More recently, coaching has been directed at abrasive executives who may be perceived as bullies (Crawshaw, 2006).

Use of a behavioural 'Compact' has been adopted by some organisations to define acceptable standards and promote positive behaviour. A Compact is a practical agreement on what behaviours staff can expect of each other, which sets the ground rules for relationships. The development of a Compact explicitly commits individuals to maintain a standard of behaviours within the work setting. The development of a compact within a training intervention, which is then adopted after the session, may also improve the transfer of that training to the work context, and it acts as a measure of acceptable behaviour.

Other emerging interventions include organisational development and teambuilding (Saam, 2009). Spurgeon (2003) has suggested that interventions targeted on stress are likely to also impact bullying. However, the efficacy of these interventions, particularly in addressing the damaging effect of bullying on health, remains under-researched and there is a need for further investigation (Kompier et al., 1998; Cox et al., 2000; Murphy & Sauter, 2003).

In addition, workplace bullying interventions are subject to a number of general limitations. Typically they are not targeted towards specific problematic behaviours. Often the focus of the design is too generic with little regard for occupational groups or organisational contexts. Frequently, bullying interventions are incorporated into a broader programme of activity such as management training or stress and wellbeing initiatives, which may be appropriate to address certain issues related to bullying, but do not necessarily offer a

comprehensive and targeted approach.

A failure attributed to some training programmes has been the lack of interactivity and engagement by delegates, with employers using information-giving sessions when deeper educative approaches were more appropriate. Training which involved actors who presented real or invented scenarios to serve as discussion points, while expensive, has been reported as offering a useful alternative which is rich in interactivity (Raynor and McIvor, 2008).

Although generic training designs may be applied to a range of work contexts, they offer limited specificity for the organisation. This approach also fails to focus on the most prevalent bullying behaviours in a particular team or organisation. The term bullying encompasses a range of different behaviours; for example the Revised Negative Acts Questionnaire (NAQ-R) recognised 22 different behaviours that could be perceived as bullying. When developing a bullying intervention, it is important to understand the potential variation in negative behaviours across groups and organisations, and to design interventions targeted at the most problematic behaviours. For example, an intervention designed to tackle socially excluding behaviours might be very different to one designed to tackle physically intimidating behaviours. Intervention literature recommends a context specific approach which is responsive to local needs (Kompier, et al 1998; Giga et al, 2003).

In addition, organisations often use multiple approaches concurrently or may apply different interventions to different occupational groups. As a result, it can be difficult to isolate the effects of one specific intervention.

There is a clear need to conduct an evidence synthesis on bullying and harassment interventions. Practitioners, including NHS managers, require an evidence-based evaluation in order to commission services that will deliver reductions in inappropriate behaviours and minimise the negative consequence of bullying and harassment for individuals and for organisations.

How can we add to existing knowledge?

Currently, there is a lack of peer-reviewed publications on bullying and harassment interventions, particularly studies that evaluate interventions using an experimental, controlled design. However, the grey literature may be a valuable resource to explore potential interventions. In addition, the evaluation of interventions targeted at, for example, stress or conflict management may offer insights into approaches which may reduce the incidence of inappropriate behaviours or may provide individuals with transferable skills to handle inappropriate behaviours. Commissioners of interventions (e.g., HR Directors) and practitioners who deliver bullying and harassment training and interventions are also likely to have valuable insights into the efficacy and acceptability of various bullying interventions. In addition, we plan to describe examples of good practice, which may offer practical suggestions and share lessons learned.

3. Need:

The health need

Workplace bullying has serious implications for mental and physical health, and staff wellbeing and health are important contributory factors in the provision of good patient care. The Boorman Review (2009) reported that 80% of staff believe the state of their health affects patient care, and patients themselves are sensitive to psychological disturbances in staff, which in turn has implications for their care (MacPherson, Eastley, Richards, & Mian, 1994). Furthermore, studies have demonstrated a link between increased stress and poorer job performance, which can have a detrimental effect on patient care (e.g. Mojoyinola, 2008; Motowidlo, Packard & Manning, 1986; Randle, 2003).

The Boorman Review (2009) recommended 'that Trusts should put into place arrangements to identify mental health issues affecting staff and ensure they are tackled at an early stage before they become debilitating,' and highlighted the bullying and harassment of staff as a contributory factor to stress and mental health problems (Boorman Review, 2009). Despite the persistence of workplace bullying in the NHS (e.g. NHS Staff Survey 2009, 2008), there is very little research on bullying interventions. There is an urgent need to develop and evaluate bullying interventions that have a long-term efficacy in the workplace. A primary stage in achieving this goal is to understand and evaluate current evidence.

Developing effective interventions that reduce workplace bullying and build a culture of respect are likely to increase staff health and wellbeing, improve job performance, and reduce sickness absence; all of which may result in improved patient care.

The expressed need

This bid is in response to a call from NIHR / SDO which highlights the need for a summary of the prevalence, causes and impact of workplace bullying and an evidence synthesis on interventions. This review will enable better understanding of how workplace bullying can affect the health and wellbeing of NHS employees and what interventions and strategies can be employed to prevent and manage inappropriate behaviours.

The sustained interest and intent

Workplace bullying remains of international and national interest and will remain highly relevant to the NHS workplace. Workplace bullying is frequently examined in the media and reported through organisational metrics. The ongoing need to improve performance as well as staff wellbeing inevitably places the reduction of workplace bullying as an organisational priority that will remain of interest. An evidence synthesis of interventions will generate further interest by identifying knowledge gaps and possible future research directions for development.

The capacity to generate new knowledge

The proposed evidence synthesis will identify existing workplace bullying interventions currently being practiced. It is likely that some of these interventions will not have been examined fully with an NHS context. These knowledge gaps and uncertainty will not be addressed within the current study and will therefore require new research. In addition, the review may highlight avenues for future research to develop and evaluate new interventions.

An organisational focus consistent with SDO mission

The focus of the study will consider the NHS context. Bullying has a debilitating effect on the health of teams and individuals, and improvements in the performance of teams and individuals as a result of a reduction in bullying will enhance the management of care in the NHS. The evidence synthesis will also examine non health sector industries and other countries. Our focus will be to consider context and our review will discuss what the findings mean in a healthcare context.

Generalisable findings and prospects for change

The project will produce findings that will be of value to the NHS management community. Findings will be of benefit to a range of stakeholders; for example, NHS Trusts presently in the process of commissioning interventions, HR teams who might be struggling with high levels of workplace bullying and those involved in the development of interventions. The findings will offer a resource to support decision making around employing effective interventions and strategies for the purpose of change and improvement.

As a means to influence change this will be communicated through academia and where possible media engagement. Our existing networks and those developed during the project, will enable an incremental and considered dissemination strategy.

Building on existing work

This project will be the first SDO commissioned study to specifically examine workplace bullying however we will build on other related projects. We will attempt to frame findings in relation to the SDO knowledge bank. For example, McKee (2010) investigated the relationship between cultural dimensions and staff perceptions of wellbeing and patient safety concluding that there is a requirement for integrated thinking around strategies, which this evidence synthesis will offer.

The study will use realist synthesis and narrative review approaches. Employing these approaches will further expand our general understanding of the application of alternative evidence synthesis approaches. It will therefore add to the existing SDO commissioned evidence synthesis projects.

4. Methods:

Method

An evidence synthesis will be conducted using multiple methods, including a narrative review and a realist synthesis approach (Pawson 2005; Pawson & Bellamy 2006). The narrative review methodology was selected for the review of existing evidence on the prevalence, causes and consequences of inappropriate behaviours because the aim of this component is to describe and summarise findings, rather than evaluate interventions. Furthermore, much of the empirical data uses a similar methodology (questionnaires) and a limited array of tools, which reduces the need for a complex review strategy. The primary knowledge gap in research on workplace bullying relates to the efficacy of interventions, therefore the main focus of the synthesis will investigate interventions.

The realist synthesis was selected to guide the evaluation of strategies and interventions designed to prevent and manage workplace bullying. Taking the realist synthesis perspective allows data collection to focus on bullying interventions as different programmes of intervention. The evidence synthesis can prioritise reviewing what is it about a specific programme that works, within a given population and context. In a realist synthesis, the researcher seeks to identify: 1) the underlying mechanism that explains how the resources (material, social, cognitive, or emotional) provided by an intervention influence an individual's actions; 2) the contextual and individual characteristics that determine whether a mechanism is triggered; and 3) the range of impacts that result from different combinations of contextual features and mechanisms (known as the 'outcome pattern', Pawson & Bellamy, 2006).

The strength of using this approach is that it adopts the perspective of considering 'families of mechanisms' i.e. groups of different types of interventions (such as counselling, behavioural training, etc) rather than 'families of programmes'. This is important for synthesising bullying interventions which will likely be drawn from a range of contexts such as management, education, stress management and psychology. Specifying the unit of analysis at a mechanism level will allow like for like interventions, possibly borne from different contexts, to be reviewed.

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

1. A narrative review on the prevalence, causes and consequences of workplace bullying
2. A systematic review of the evidence of the effectiveness of prevention and management strategies
3. Consultation with international experts and practitioners on the range of prevention and management strategies, evidence of impact and assessment of feasibility.
4. Identification and examination of a number of case studies that exemplify good practice interventions

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

A narrative literature review will summarise evidence on the prevalence, causes and consequences of workplace bullying and harassment. The review will involve a database search using Medline, Embase, Psychinfo, Web of Knowledge and ERIC to identify suitable papers. Search terms may include: *workplace bullying, mobbing, inappropriate behaviour, isolation, intimidation, victimisation, conflict, harassment, negative behaviours, toxic workplace, counterproductive workplace behaviours, prevalence, occurrence, causes, antecedents, outcomes, and consequences.* All NHS occupational groups will be considered within the search. These will include nurses, midwives, healthcare assistants, medical/dental, allied health professionals, healthcare scientists/ technicians, wider health care team (.e.g. admin, corporate services, facilities) and general management. Sectors outside of the NHS, such as manufacturing, professional services, leisure industry and third sector etc. will also be reviewed.

Abstracts will be reviewed and appropriate articles will be selected for detailed review. Where articles offer empirical evidence into the prevalence, causes and consequences of

workplace bullying and harassment, they will be included in the literature review

Part 2: Systematic literature search and review of strategies and interventions designed to prevent and manage workplace bullying and harassment

The review will involve three main stages: database search, filtering by abstract, and detailed review.

- A comprehensive literature search will be conducted across the most relevant databases (Medline, Embase, Psychinfo, Web of Knowledge and ERIC) in accordance with the guidance developed for the Best Evidence Medical Education systematic reviews. The process will be repeated to examine grey literature. The search strategies created will be designed for maximum sensitivity (recall) to ensure that all efforts are taken not to overlook any papers of significance. The searches will cover the period Jan 1991 to Jan 2011 and will not be limited by geography or study methodology.

  The developing search strategies for each of the five databases will be drawn up using specific controlled vocabularies. Key papers of core relevance to the topic will be identified and the strategies will be refined using combinations of controlled vocabularies, free text and search syntax. Strategies will be finalised when they retrieve all the key papers known to be in each database. Initial full abstract lists will then be visually scanned and clear false hits will be eliminated. Members of the advisory board will be engaged in the process to ensure an appropriate search strategy is conducted. An indicative list of search terms may include: *workplace bullying, mobbing, inappropriate behaviour, isolation, intimidation, victimisation, counselling, coaching, stress, interventions, conflict, harassment, negative behaviours, toxic workplace,* and *counterproductive workplace behaviours.*

  All NHS occupational groups will be considered within the search. These will include nurses, midwives, healthcare assistants, medical/dental, allied health professionals, healthcare scientists/ technicians, wider health care team (.e.g. admin, corporate services, facilities) and general management. Sectors outside of the NHS, such as manufacturing, professional services, leisure industry and third sector etc, will also be reviewed.

- Filtering by abstract. Abstracts for all papers (where the abstract was included in the database results) will be read by a member of the research team, and considered against the inclusion criteria:

  - Workplace bullying/inappropriate behaviour
  - English language
  - Peer reviewed article

- If a paper is felt to satisfy the criteria, or in cases where an abstract is not available but the title suggested it might be appropriate, the full paper will be obtained from

electronic journals, library hard copies, or inter-library loan. This will reduce the total number of papers. Papers which do not meet all the criteria, but are nonetheless of interest – for example review articles, or articles from non-clinical domains – will also be obtained.

- Detailed review. Each of the obtained papers will be read by two member of the research team, and content recorded on a pro-forma summarising the key points: aim, participants, design, results, conclusion, potential mechanisms, contextual characteristics and programme patterns of outcome. Possible good practice case studies will also be identified during review.

- If a paper is not felt to be relevant following this review, a note will also be made to this effect. Review papers, comments and editorials will be reviewed to identify any salient points.

Inclusion and exclusion criteria

The inclusion and exclusion criteria will be drawn up in line with our research questions to ensure that the papers selected will be relevant. The likely criteria are listed below, however these may be modified as necessary as the study progresses.

We will not restrict our search to NHS-based papers and sources, but will also include papers and resources from business and industry. Non NHS sectors such as manufacturing, professional services, banking, leisure, third sector, uniformed services etc., will be included.

INCLUSION CRITERIA FOR PAPERS

1. Is it about workplace bullying, harassment or inappropriate behaviour? AND
2. Is it within an workplace setting AND
3. English language AND
4. Is the study about either:

   i) coaching / mentor/buddy scheme OR

   ii) counselling OR

   iii) behavioural level training OR

   iv) mediation OR

   v) organisational development OR

   iv) support service OR

   v) team building OR

   vi) help-lines OR

   vii) signposting/listening services OR

viii) risk assessment OR

ix) behavioural compact OR

x) bullying policy OR

xi) intervention OR

xii) formal grievance OR

xiii) internal communications OR

xiv) reviews related bullying interventions, stress management interventions, educational programmes focusing on inappropriate behaviour change.

Note: Papers that are opinion based rather than evidence based might be included in the absence of a weight of evidence and/or to capture practitioner perspectives

EXCLUSION CRITERIA FOR PAPERS

1. Papers that are not about workplace bullying, harassment or inappropriate behaviour
2. Papers that do not use an adult sample e.g. child bullying
3. Papers that do not use a workplace setting e.g. prison population
4. Papers published in a language other than English

In-depth review of evidence
Papers will be assessed against research quality and patterns of outcome.

Research quality
The research quality of papers will be assessed using the BEME guide to assessing papers (See Tables 2 and 3). In applying the BEME framework we are able to report on the overall quality of bullying intervention research however it is possible that in limiting the review to Grades 3-5 the evidence synthesised would be too narrow. This part of the review will allow a critical appraisal of methodology used across the studies in the synthesis.

Table 2. Gradings of Strength of Findings of the Paper	
Grade 1	No clear conclusions can be drawn. Not significant
Grade 2	Results ambiguous, but there appears to be a trend.
Grade 3	Conclusions can probably be based on the results.
Grade 4	Results are clear and very likely to be true.
Grade 5	Results are unequivocal.

Table 2. Gradings of Overall Importance of the Paper	
Grade 1	Papers with numerous deficiencies in the rigour or appropriateness of the methodology or the statistical analysis
Grade 2	Papers with some deficiencies in the rigour or appropriateness of the methodology or the statistical analysis
Grade 3	Papers with doubts about the rigour or appropriateness of the methodology or the statistical analysis
Grade 4	Papers with rigorous methodology and appropriate statistical analysis, but doubts about adequate sample size
Grade 5	Papers with generalisable findings, rigorous methodology, adequate and appropriate sample size.

Combined use of both the BEME systematic review methodology and the realist synthesis approach will strengthen the quality and the utility of the review. The BEME approach ensures that papers are evaluated using standardised criteria and that both the strength of findings and overall importance of the paper are considered in the review. The realist synthesis will use quality papers identified in the BEME review as a sound analytical foundation from which to investigate key mechanisms, contextual characteristics and outcome patterns (described below) associated with bullying interventions.

Programme efficacy: mechanisms, context and outcome patterns

The evaluation of the efficacy of various interventions will be organised where possible according to the principles of realist synthesis. That is, the underlying mechanisms, important contextual characteristics, and the outcome patterns will be identified and discussed. Mechanisms refer to theoretical explanations of the causal power of the intervention. Contextual characteristics may refer to the uptake of a service, the opinions and reactions from users, cost, feasibility, time requirements, framing of the intervention, and marketing strategies. Outcome patterns may refer to, for example, a reduction in bullying/inappropriate behaviours, a change in health and well-being outcomes, or some negative (or unanticipated) outcomes.

1.1.1 Part 3: Consultation with subject matter experts

To ensure that the synthesis remains grounded at an applied level, consultation with NHS practitioners and bullying research experts will be a foundation of the design. This will be achieved through the establishing of a project advisory panel and ongoing consultation with organisational practitioners. The panel will be recruited through existing networks we have established in related projects. A recent conference which we hosted to disseminate our own work was attended by around 80 NHS staff interested in bullying. Following that event we have had interest from a number of delegates to be involved in future work.

An advisory board will be established which will be consulted (e.g. via telephone conference and email) at key stages during the project. Our experience during our current research project on workplace bullying has been that although there are clear benefits in face to face meetings it is often difficult to get the full range of advisors available at the same time/place. Advisory panel engagement will predominantly be through

video/telephone conferencing and email contributions which will reduce the related cost and time commitment of those involved.

Anticipated membership may include practitioners and policy makers. Particular attention will be paid to ensuring that we have a broad representation from occupational groups in the NHS. Their involvement will take place at key stages of the project:

- During development of the search strategy, vocabulary etc.
- Following the abstract filter where the collection of papers will be discussed holistically
- During the review where programme patterns are being discussed.
- Opportunity to comment on report drafts.
- Collaboration in Part 4: examples of good practice

We will engage with subject matter experts throughout the project. This will achieve further insight into interventions and offer opportunities to identify gaps, for example interventions used by practitioners may have only limited coverage in literature.

Subject matter experts will be identified from existing links that have been established through previous conference attendance and professional membership of relevant bodies (e.g. BPS DOP, IAWBH, CIPD).

A range of data collection methods will be adopted including telephone interviews/ conferences, face to face meetings and on-line engagement. We have recently demonstrated our approach to engagement through hosting a knowledge sharing event with around 80 NHS staff in the Northeast of England. As part of the conference the team, along with other researchers and local practitioners, presented information on workplace bullying research and interventions. Time was also taken for delegates to share their own experience of managing bullying. The delegates represented a range of occupational groups, NHS management levels and organisations. We have approached some of the delegates to be part of our advisory board to ensure a breadth of representation from practitioners.

1.1.2 Part 4: Examples of good practice

Examples of organisational good practice will be identified throughout parts 1-3 of the study. Examples will be used to illustrate interventions in context, and will describe the organisational context, efficacy, uptake, and lessons learned, where possible. The examples described will offer a rich insight into a few of the interventions being examined within the in-depth review of evidence and consultation. We have used this approach in a previous study (Jelley et al, 2010) and found it to be an effective method of illustrating interventions in organisational context.

5. Proposed plan of Investigation:

Activity	A	M	J	J	A	S	O	N	D
Refine search terms	x								
Literature search and sourcing articles for narrative (Part 1) and systematic review (Part 2)	x	x	x	x					
Reading and coding articles		x	x	x	x	x			
Writing of summary report				x	x				
Liaison with advisory board (Part 3)	x			x			x		
Consultation with experts (Part 3)	x			x	x			x	
Producing examples of good practice (Part 4)					x	x	x	x	
Writing of full report to include methodology, key findings and conclusions							x	x	x

The main deliverables at the end of the project include a full report and a summary of the key findings of the review and synthesis. This report will 1) identify evidence on the range of effective prevention and management strategies for inappropriate behaviours involving bullying and harassment; 2) summarise the occurrence, causes and consequences of inappropriate behaviour, bullying and harassment; 3) outline the latest thinking in the area from experts, and 4) identify and describe examples of best practice on bullying interventions. Upon completion, a presentation will also be designed for the SDO to facilitate discussion of the findings. A short interim report halfway through the project timeline will also be produced to describe progress. Other potential outcomes include presentations at relevant conferences and NHS organisations as well as publications in peer reviewed journals. This will ensure that a wider audience, including NHS managers, will be aware of key findings from the study.

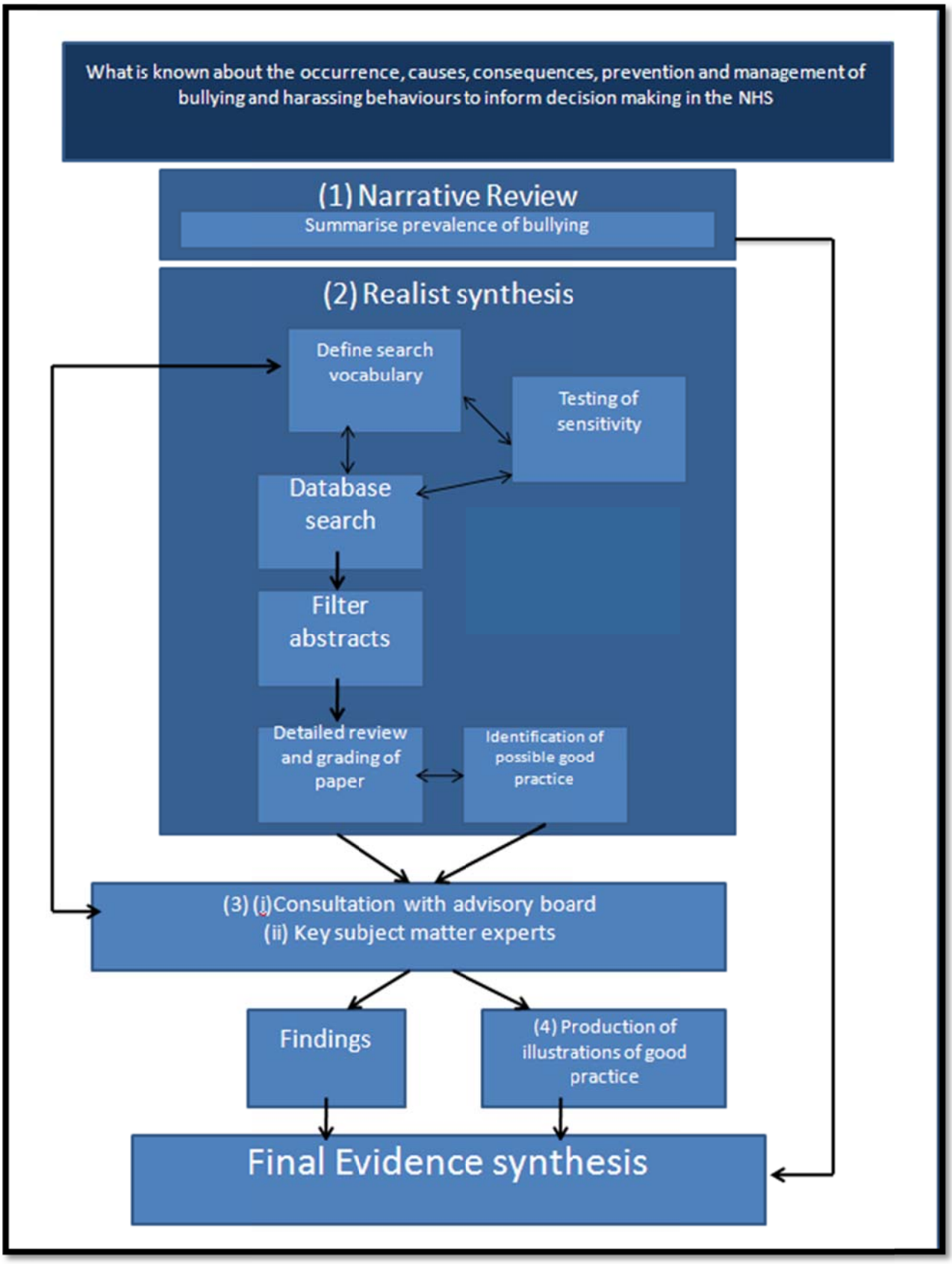

Figure 1. Research flow diagram

6. Project Management:

The project team will include: Jan Illing (JI), Madeline Carter (MC), Neill Thompson (NT), Paul Crampton (PC), Bryan Burford (BB), and Gill Morrow (GM). Collectively the team brings expertise in evidence synthesis methodologies, knowledge of workplace bullying research and a track record of conducting research that has informed policy and practice. Although we have a track record of working within the field of Medical Education our recent projects have focused on the wider healthcare team. Our workplace bullying research concentrated on all NHS occupational groups, other studies have focused on podiatrists, paramedics, dentists, nurses and occupational therapists.

7. Service users/public involvement:

Key service users include NHS organisations, particularly functions related to human resources. We have existing relationships with NHS HR professionals in several Trusts, and we are linked in with NHS Employers and the local HR Directors network. These contacts will ensure active involvement of service users in identifying search terms and examples of best practice in bullying interventions. At the recent sharing event we hosted we established contacts with representatives from other occupational groups, staff side representatives and other interested individuals. We aim to engage with these groups to benefit from their involvement and insight. Service user involvement will be a key aspect of the project which will be ensured through the role of the Advisory Panel. We will also engage service users to provide feedback on findings.

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