The NHS: A health service or a “good news factory”?

A thesis submitted to The University of Manchester for the degree of PhD Business and Management in the Faculty of Humanities

2015

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Abstract

The University of Manchester

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PhD Business and Management

The NHS: A health service or a “good news factory”?

Evidence exists that the NHS has had, over many years, persistent problems of negative and intimidating behaviour towards staff from other employees in the NHS. The evidence also suggests the responses to this behaviour can be inadequate. Pope and Burnes (2013) model of organisational dysfunction is used to investigate and explain these findings.

A qualitative approach was taken to research the organisational responses to negative behaviour, and the reasons and motivations for those responses. Forty three interviews and six focus groups were conducted. The Framework Method of thematic analysis was chosen for the main analysis and fourteen Framework Themes were identified. ‘3 word summaries’ of the culture were analysed. Further analysis was undertaken of words relating to fear, rationalisations/justifications, what people don’t want to do, the culture, and assumptions/beliefs. The model of organisational dysfunction has been extended.

The findings show that participants consider the NHS to be a politically driven, “top down”, “command and control”, hierarchical organisation; a vast, enclosed, bureaucratic machine/system under great pressure. They believe there is a culture of elitism, fear, blame, bullying and a lack of accountability; a culture where power, self-interest and status matters. There is constant change. Saving money and achieving targets are seen to be the priority. A lack of care and humanity is described and negative behaviour seems to have become tolerated and normalised. Bullying is mentioned many times, and viewed as “rife” and “endemic”. Good practice/behaviour can be punished, and bad rewarded, as can failure. Corrupt and unethical behaviour is identified as are totalitarian and Kafkaesque characteristics. Participants describe resistance to voicing concerns and any information which puts individuals or organisations into a ‘negative light’. Employees who raise concerns can be victimised. The “top-down bullying culture…suppresses constructive dissent”. There can be rhetoric, “empty words” and “spin”, rather than reality. A desire for “good news” and the rejection and hiding of “bad news” is described.

There seem to be “islands” and “pockets” with a positive culture, however, the generalised evidence suggests the NHS is systemically and institutionally deaf, bullying, defensive and dishonest, exhibiting a resistance to ‘knowing’, denial and “wilful blindness”; a dysfunctional, perverse and troubled organisation. The NHS could also be described as a coercive bureaucracy and under certain definitions, a corrupt entity. The NHS appears to be an organisation with a heart of darkness; a “self perpetuating dysfunctional system”. There may be widespread “learned helplessness”. Overall, the needs of the NHS and the protection of image appear more important than the welfare of staff or patients. It does seem to be a “good news factory”. The NHS appears to have “lost its way” and its focus/purpose as an institution. The dysfunctional organisational behaviours manifest in the NHS need to be addressed urgently as there is a detrimental, sometimes devastating, impact on the wellbeing of both staff and patients. The NHS needs to embrace an identity of being a listening, learning and honest organisation, with a culture of respect.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institution of learning.

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Dedication

This thesis is dedicated to all those in the NHS who care about the wellbeing of patients and staff and who have the courage to speak on their behalf, as their voices come up against the *heart of darkness* and hierarchical power of the NHS.

Acknowledgements

Thank you to the participants and all those people who have supported me in trying to find some answers to the bizarre and irrational behaviour I couldn’t understand.
Chapter 1. Introduction

1.1 Definition of negative behaviour

For the purpose of this thesis negative behaviour is defined as: “Any behaviour that is disrespectful and undermines/violates the value/dignity of an individual. It is behaviour that harms individuals and organisations” (Burnes and Pope, 2007, p.300). It includes incivility, aggression, bullying, harassment or abuse.

1.2 Researcher profile

The researcher Rachael Pope qualified as a physiotherapist in 1977. She has undertaken various clinical roles in the NHS until April 2012. Latterly she was a physiotherapist specialising in Women’s Health. Through trade union representative and health and safety roles, she has had many years’ experience of different situations where negative behaviours have been exhibited between staff, causing huge damage to individuals and teams. The researcher has had a particular interest in implementing preventative measures for such behaviours, and providing support for individuals. In 2003, she and a human resource (HR) colleague in another trust set up and supervised a harassment advisor service for the two trusts. From 2001-2004 the researcher was the allied health professions representative on the Professional Executive Committee and a board member. In 2005 she obtained an MSc in Human Resource Leadership, awarded with distinction, at Manchester Business School.

1.3 Research background

The MSc research looked at the effects of workplace incivility, aggression and the perception of ‘bullying’ linked to these negative behaviours, as well as researching the effects of low and higher frequency behaviour within two Primary Care Trusts. This work was published in the International Journal of Public Sector Management (Burnes and Pope, 2007) and the Nursing Times (Pope and Burnes, 2009). It was concluded that negative behaviour between employees had a damaging impact on the wellbeing of staff and the effectiveness of the NHS. “Even tolerating low levels of incivility can cause problems and leave teams and organisations dysfunctional with implications for quality of
patient care” (Pope and Burnes, 2009, p.23). Some recommendations for action were made in the three areas of leadership, policy and practice.

In 2005 the MSc research findings on negative behaviour were about to be shared with a small group of directors, trade union representatives, the harassment advisor and research coordinator, when the directors unexpectedly walked out of the room. They had never been seen to behave in such a manner before. The presentation continued without them. The people who were present were shocked by the behaviour. The researcher was left extremely puzzled and deeply concerned at the way a very important issue appeared to be not taken seriously.

A colleague of the researcher wanted to write a short article about the research for the Trust News; this was blocked by the HR director. There was resistance to a brief summary being placed on the research section of the Trusts website. A letter critical of the research was received from the HR director. A year later in 2006, an offer was made to share the research findings with the Board; the offer was refused.

Through the assistance of trade union personnel at the Chartered Society of Physiotherapists a meeting was arranged at NHS Employers to discuss the research findings. A number of commitments were made regarding actions, but these were not fulfilled. There was no response to enquiring e-mails. Following the publication of Burnes and Pope (2007) a person who was linked to the leadership programme at regional level was contacted. They made suggestions on how the work could inform the leadership programme. Again there were words indicating action, but again nothing actually materialised.

A contact was made with the Department of Health (DH). It was suggested that NHS Employers were approached. When it was explained that this had already been done and what the result was, the DH stopped communicating.

These experiences were the catalyst for beginning doctorate studies in 2008, to gain understanding of the behaviour, which appeared to the researcher to be completely irrational and bizarre. At many levels of the NHS there appeared to be a lack of interest in, and resistance to, taking action to address the problem of negative behaviour between staff in the NHS. These seemingly avoidant behaviours and resistance to knowledge had implications for staff welfare and ultimately patient care.
As well as the desire for understanding, the motivation for the doctoral research was to see a change in the culture of the NHS. Ten inquiries have been conducted following major failings in health care in the NHS between 1969 and 2001 (Walshe and Higgins, 2002). “The consistency with which inquiries highlight similar causes suggests that their recommendations are either misdirected or not properly implemented” (p.899), and that “...lessons are not always learnt” (p.895). There are few “...formal mechanisms for following up the findings and recommendations” (p.899). It is recognised that “...many of the problems identified...are cultural and demand changes in attitudes, values, beliefs, and behaviours - which are difficult to prescribe in any set of recommendations” (p.899).

Walshe and Higgins (2002, p.899, italics in original) identify some common themes in the inquiries: 1) “Organisational and geographical isolation – which inhibits the transfer of innovation and hinders peer review and constructive critical exchange”; 2) “Inadequate leadership – lacking vision and unwilling to tackle known problems”; 3) “System and process failure – in which organisational systems and processes are either not present at all or not working properly”; 4) “Poor communication – both within the NHS organisation and between it and patients or clients, which means that problems are not picked up”; and 5) “Disempowerment of staff and patients – which means that those who might have raised concerns were discouraged or prevented from doing so”.

Walshe and Shortell (2004) reviewed failures within international health systems, including the UK. They believe that “...major failures in health care are, more than anything else, a product of the distinctive culture of the organizations, the health care professions, and the health system”, which is “...of great international concern” (p.110). That

“...despite much rhetoric about the primacy of patients’ interests it seems that when it matters most, those interests are too often subordinated to the needs and interests of health care organizations and professionals” (p.110).

They consider that most effective actions to prevent failures will be those that “...help to create a more open, transparent, equitable, and accountable health care culture”, including “...a more principled clinical and managerial leadership of health care organizations” (p.110).
The report into the failings at the Bristol Royal Infirmary (BRI) identified problems in the culture of the NHS (Kennedy, 2001). It was described as complex and ‘tribal’, and there was a “…culture of uncertainty” (p.273) and a lack of accountability. There was an old style paternalism which was evident “…in the adherence to the idea of hierarchy” (p.268). This was considered a “…significant cultural weakness”, and many nurses “…still do not feel valued by their medical colleagues or by managers” (pp.268-269). There was friction between “…clinicians on one hand and managers on the other, akin, in places, to a type of guerrilla warfare” (p.270). The culture of the NHS also tends to be “…defensive and secretive” (p.271). Staff “…cannot discuss openly matters of concern relating to care of patients and the conduct of fellow workers” (p.273). These negative cultural aspects “…have acted, and continue to act, as a barrier to improving care for patients” (p.264).

The author of the report had no doubt that the NHS as an organisation, and those who work within it, “…must embrace a culture of openness” (p.271) and that “Openness must be valued and rewarded”. This meant an “…abandonment of the easy language of blame, in favour of a commitment to understand and learn”, and called for “…significant leadership” (p.272).

From the original transcripts of the BRI inquiry document Kewell (2006) identifies seven themes and ‘language games’. The third is that of “… staff bullying and whistle blowing” (p.365). The seventh, however, is said to underpin all other themes and “…functioned at a deeper level than all the others” (p.365); that of ‘reputation’. “…with the exception of victim’s parents and carers, most witnesses spoke from a defensive position and sought to shield their reputation, the reputation of colleagues, or the image of an organization to which they felt some degree of loyalty” (Kewell, 2006, p.365).

Very sadly, the reports of Francis (2010 and 2013) in response to the Mid Staffordshire disaster draw out similar cultural themes. “…two inquiries into the Mid Staffordshire Foundation Trust suggest nothing changed at all” following the BRI report (Newdick and Danbury (2013, p.1). Francis writes that “The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed” (2013, p.5). The report by Berwick and the National Advisory Group on the Safety of Patients in England (2013) also concluded there is a “…need for wide systemic change” (p.4) and for the NHS to become a ‘learning organisation’. Linking this with the other literature in this thesis it appears that little has changed or been learnt in the NHS in the intervening years.
The UK needs an NHS which respects both staff and patients, so that the highest quality of care can be provided in a positive and safe working environment. NHS staff should be able to raise concerns about patient or staff harm without fear of intimidation. The welfare of both staff and patients should be the priority and focus of the NHS. It is the view of the researcher that high quality of care is only achievable if serious regard is given to the welfare and wellbeing of staff. A radical change in the culture is required.

The researcher considers that unless we more fully understand what is happening in the NHS behaviourally, little can be done to change outcomes. If the NHS continues to be culturally dysfunctional, it is extremely likely there will be further health care disasters and failings.

No literature was found detailing an exact study to what has been undertaken for this doctorate. The nearest however, regarding similarity to the research objectives, is the qualitative work of Peirce et al (1998). This work looked at the reasons for the managerial inertia and ‘deaf ear’ responses of large companies in the USA to the complaints of sexual harassment. Nothing similar has been found relating to healthcare.

In an article by Hutchinson et al (2009) about research in two Australian public sector health organisations the management of workplace bullying is seen as a “...serious and corrupt activity” (p.213). “...much of bullying is corrupt conduct” (p.226). Within the article they make reference to the main elements of this thesis literature review: negative behaviour, resistance to voice and silence, corruption, and protection of image/reputation, as well as the selective moral disengagement and rationalisation of unethical behaviour. No similar work was found relating to healthcare.

There are a number of gaps in the research literature. Firstly, the reasons for the culture in the NHS, and the ongoing problems of negative behaviour towards staff over many years (section 2.3). Secondly, the reasons and motivations for the often inadequate organisational responses to negative behaviour (section 2.3). Thirdly, none of the literature explores the role of selective moral disengagement in the perpetuation of the dysfunctional culture of the NHS (section 2.4). Fourthly, only a limited amount of relevant literature was found relating to corruption in the NHS (section 2.6). Fifthly, no literature, other than Pope and Burnes (2013), draws together the well-known and recognised concepts of organisational silence, normalised organisational corruption and protection of image in a model to explain organisational dysfunction (section 3.6 Summary).
1.4 Research purpose

The overall purpose of the doctorate research is to understand the reasons and motivations for the behaviours in the specific scenario described in the Research Background section. It is also to consider more generally the organisational responses to negative behaviour between and towards staff and to understand more fully the broader cultural context and the possible causal drivers of such behaviour.

1.5 Research objectives

The research objectives are:

1) To assess the organisational responses to negative behaviours between staff in the NHS

2) To assess and analyse the motivations/reasons for the organisational responses

3) To increase understanding of why some NHS organisations do not take action to address the problems of negative behaviour between staff

4) To contribute to changes of policy and practice within the NHS

1.6 Structure and outline of the doctorate thesis

The research thesis is structured in seven chapters including this introduction:

Chapter 1. Introduction

Defines the term negative behaviour. Provides a profile of the researcher and the background to the research. Describes the overall research purpose, research objectives, the overall structure and outline of this doctorate thesis.
Chapter 2. Literature review

Chapter 2 provides a review of literature in five main areas starting with negative behaviour in the workplace with particular emphasis on the NHS, and the theory of selective moral disengagement. The review then considers the three concepts of organisational silence, normalised organisational corruption and protection of image. These three overlapping concepts, supported and enabled by the mechanisms of selective moral disengagement, are considered to provide a possible explanation for dysfunctional behaviour in the NHS. A model of organisational dysfunction has been proposed (Pope and Burnes, 2013), and is detailed in section 2.8 (Summary). The final section of the literature review also summarises gaps in the literature.

Chapter 4. Research methodology

Restates the research objectives and describes the ontology and epistemology of the research. Within a qualitative approach the chosen research methods, and the method of analysis are detailed. The terms ‘reliability’ and ‘validity’ used to assess the quality of qualitative research are explored, as is ‘generalisation’. Ethical considerations are discussed. The research design and process is described, as is the data gathering, and the process of analysis using the Framework Method. The limitations and difficulties encountered in the research process are outlined.

Chapter 5. Research findings

Findings from the ‘3 word summary’ responses to describe the culture in the NHS are presented. Findings from the forty three interviews and six focus groups under fourteen analytical Framework Themes are also presented in descriptive format. Data is analysed into Categories and Lower and Higher Level Framework Classes (see appendices). Interesting descriptive words, phrases and metaphors are also identified.

There is further analysis of references to ‘fear’ and other similar words indicating fear, possible rationalisations/justifications, specific references to the culture, what people don’t want, and possible underlying assumptions/beliefs in the NHS. Further
observations on power and behaviour are made. Feedback from the article “A model of organisational dysfunction in the NHS” (Pope and Burnes, 2013) is included.

Chapter 6. Analysis and discussion

Comparisons are made between the proposed model of organisational dysfunction (Pope and Burnes, 2013) and the research findings. An extended and developed model is suggested, as are causal drivers. Further models are offered to increase understanding of the dysfunctional behaviour exhibited in the NHS. Perverse manager characteristics which are valued and rewarded are proposed.

Chapter 7. Conclusions and implications

There is an examination of the extent the original overall purpose, and research objectives have been achieved. Some conclusions are made. Representative, inferential and theoretical generalisations are proposed. Implications for practice/the organisation and implications for theory/academic knowledge are detailed. Some recommendations for policy change are made, as are suggestions for future research.
Chapter 2. Literature review

2.1 Introduction

Chapter 2 provides an extensive review of literature in five main areas. The review starts with negative behaviour in the workplace with a particular emphasis on the NHS, and the theory of selective moral disengagement. The review then considers the three concepts of organisational silence, normalised organisational corruption and protection of image. As mentioned in Chapter 1, a model has been proposed (Pope and Burnes, 2013). The three overlapping concepts, supported and enabled by the mechanisms of selective moral disengagement, are considered to provide a possible explanation for dysfunctional behaviour in the NHS. The model is detailed in section 2.8 (Summary). Other relevant and key literature is also included in the review. It is recognised that in the different sections of the review there is an overlap between the behaviours described.

The main headings are:

2.1 Introduction
2.2 Methodology of literature review
2.3 Negative behaviour in the workplace
2.4 Selective moral disengagement
2.5 Organisational silence
2.6 Normalised organisational corruption
2.7 Protection of image
2.8 Summary

2.2 Methodology of literature review

Following the experiences and observations outlined in the introduction chapter, a systematic and extensive investigative literature review was conducted drawing material from different academic disciplines. There are contributions from nursing and medicine, management, organisational behaviour, safety and risk, psychology, sociology and anthropology. Databases such as Web of Knowledge, Google and Google Scholar were
used. The review predominately took place in 2009-2011, although it has been ongoing. Only English language documents were considered.

As detailed in Pope and Burnes (2013) based upon Cooper’s taxonomy (1988), the focus of this review was firstly on previous research outcomes, practices and behaviours in the workplace. Secondly, the goal of the review was to identify central and key issues to find possible answers and explanations to the scenario described in the research background section. The behaviour appeared to be irrational and inexplicable to those directly involved. Thirdly, the perspective was that of neutrality in the quest to find those answers. Fourthly, an attempt was made to be exhaustive. Some key literature such as Brodsky (1976) and Leape et al (2012, Part 1 and 2), plus others, are cited selectively.

Initially, the focus was upon the topic of negative behaviour within the NHS and workplace negative behaviour literature more generally. This included different types of articles, journals, minor and major survey data, DH documents and academic literature. This review was then broadened, and ultimately focused around the theory of selective moral disengagement, and the concepts of organisational silence, normalised organisational corruption and protection of image. This literature was considered to provide possible explanations for the described dysfunctional behaviour and formed the basis for the proposed model of organisational dysfunction in the NHS (Pope and Burnes, 2013).

There are five pieces of literature that particularly helped to set the direction for the final content of the literature review. The researcher was given an article on selective moral disengagement (Bandura, 2002) by their first supervisor. The researcher was made aware of the book ‘How institutions think’ by Douglas (1986), when a lecturer on discourse analysis suddenly made a statement that “organisations always protect themselves”, citing the book. This statement and book resulted in a significant shift in the thinking of the researcher.

No literature was found of a similar study to what has been undertaken for this doctorate. The nearest however, regarding similarity to the research objectives is the qualitative work of Peirce et al (1998) “Why sexual harassment complaints fall on deaf ears”. This work looked at the reasons for the managerial complacency, inertia and ‘deaf ear’ responses of large companies in the USA, to the complaints of sexual harassment. They identified three themes associated with the organisational inaction:
“1) inadequate organizational policies and procedures for managing sexual harassment complaints, 2) managerial reactions and rationalizations for failing to act in the face of such complaints, and 3) organizational features contributing to inertial tendencies or deafness” (p.43).

In the second theme of “Managerial reactions and rationalizations” the reactions included “...denying the claims; blaming the victim; minimising the seriousness of the offense; protecting a valued employee; ignoring a chronic harasser; retaliating against the victim” (p.45).

They note the similarities regarding retaliatory responses towards the victim of sexual harassment, to the responses towards whistleblowers more generally. They make the link between the lack of action and organisational narcissistic and ego-defensive behaviour as described by Brown (1997).

It is the view of Brown (1997) that “Just as individuals seek to regulate their self-esteem through such ego-defense mechanisms as denial, rationalization, attributional egotism, sense of entitlement, and ego aggrandizement, which ameliorate anxiety, so too do groups and organizations” (p.643).

In an article by Hutchinson et al (2009) about research in two Australian public sector health organisations the management of workplace bullying is seen as a “...serious and corrupt activity” (p.213). “...much of bullying is corrupt conduct” (p.226). Within the article they make reference to the main elements of this dissertation literature review: negative behaviour, resistance to voice and silence, corruption, and protection of image/reputation, as well as the selective moral disengagement and rationalisation of unethical behaviour.

The work by these five authors confirmed the final direction of the literature review.

Key words used to search included: Organisational silence, deafness, blindness, mindlessness, corruption, abuse and image; suppression/denial of voice; moral silence, blindness and deafness; protection/restoration of image; rationalisations, denial and selective moral disengagement; destructive/laissez-faire leadership; workplace bullying and other words to describe any negative behaviour such as incivility, aggression, harassment and intimidation. The number of articles and books generated from the search was in excess of four hundred.
2.3 Negative behaviour in the workplace

Section 2.3 firstly identifies some relevant literature relating to negative behaviour in the general workplace. The second part considers negative behaviour in health care generally. The third part covers negative behaviour between staff in the NHS.

2.3.1 Negative behaviour in the general workplace

Negative behaviour in the workplace across many different work sectors is an international problem (Zaph et al, 2003; Keashly and Jagatic, 2003; Pryor and Fitzgerald, 2003; Marais-Steinman, 2003). Zapf et al reviewed studies in Europe and concluded that “...a converging picture emerges showing that between 1 and 4 percent of employees may experience serious bullying, and between 8 and 10 per cent occasional bullying. Between 10 and 20 percent (or even higher) of employees may occasionally be confronted with negative social behaviour at work which does not correspond to definitions of bullying but which is stressful for the persons concerned nevertheless” (Zaph et al, 2003, p.121).

They also conclude that “In most countries, there seems to be a tendency for bullying to occur more often in the public sector” (p.121). More recently Fevre et al (2012) highlighted that the “…public sector as a whole exhibited a greater propensity towards bullying” (p.14).

A key work is by Brodsky (1976) who considered that “…harassment is a basic mechanism in human interaction” (p.vii), a “…social instinct” (p.4), and “…an informal mechanism for achieving change” (p.146). What was striking was that harassment was described as a privilege and a benefit, that “Harassment signifies status…” (p.7), coming down through all levels of an organisation. He assumes that organisations could tackle such behaviour if they chose to do so, implying that behaviour is only there if “…permission to harass” is given (Brodsky, 1976, p.84).

Harlos and Pinder (1999) when researching organisational injustice write that “… an implicit, if not explicit, sense of entitlement to mistreat others pervaded participants’ descriptions of unjust treatment by bosses” (p.111).
The sense of benefit is also seen in a paper by Salin (2003) which argues that “...workplace bullying can in some cases be a form of organisational politics, that is, a deliberate competitive strategy” (p.35). One of the items on the organisational politics scale is “Some build up themselves by tearing others down” (Salin, 2003, p.46).

“Bullying ranks highly as a workplace problem, as do its more specific forms found in sexual and racial harassment” (Long, 2008, p.143). “...authorities - senior managers, board members and regulators” can ‘turn a blind eye’. “They may know of the existence of a bullying culture, but choose to ignore it” (p.144).

Doctoral research in the private and public sector, but not the NHS, considers the responses of HR professionals to the problems of negative behaviour (Harrington, 2010). The HR professionals consistently supported and protected the line manager and the organisation. They used a range of mechanisms to interpret the claim which serves to attribute blame to the target. In the case of the manager as alleged perpetrator, they sought to legitimise and rationalise the manager’s behaviour. Peer to peer negative behaviour was constructed as work related interpersonal conflict and manager to employee claims seen as a problem of employee underperformance. None of the manager to employee claims were labelled as bullying (Harrington et al, 2012). The HR professionals rationalised the behaviours “…as manager incompetence, over promotion, a lack of training or having the wrong ‘tools in their manager’s box’” (p.401). Words were used such as inappropriate or counterproductive to describe the behaviours; behaviour was repackaged. Underpinning everything was the protection of the relationship between the manager and the HR professional.

They suggest that it is untenable to expect them [HR] to “…service policies concerning manager-employee conflict with equity and neutrality” (Harrington et al, 2012, p.405). HR personnel “…favoured management with considerable negative implications for employees, and currently, the employee voice appears denied” (p.405).

“The main challenge to working with dignity is the continuation of unilateral management power in many sectors of the economy and the resulting patterns of mismanagement and abuse” (Hodson, 2001, p.259). “The workplace is an arena suffused by power relations” (Hodson et al, 2006, p.385). It is suggested that “…the interplay of relational powerlessness and organisational chaos gives rise to bullying” and chaos creates openings
for the abuse of power (p.382). They consider that a bureaucracy can be facilitative or coercive.

2.3.2 Negative behaviour in health care

“The nursing world is rife with aggressive and destructive behaviours, known as horizontal violence” (Duffy, 1995, p.16). “Horizontal violence, oppression and their effects have been reported in the nursing literature for more than than 20 years” (Dunn, 2003, p.979).

A number of studies report high levels of bullying in the health sector (Zapf et al, 2003). “Workplace bullying, or lateral/horizontal violence, is an international problem for nursing” (Johnson, 2009, p.340), and they list studies conducted in Canada, Britain, USA, Australia, New Zealand, and Turkey. The report by Milczarek (2010) considering Europe showed that health care was one of the sectors showing the highest risk of experiencing bullying. The UK was the second highest compared to other EU countries for nurses being subjected to bullying by their supervisors at least once a week (5.6%).

“...uninvited, unwelcome behaviour of a sexual nature in the health care workplace is not uncommon” for registered nurses (Madison and Minichiello, 2004, p.8). Their study with sixteen nurses from a variety of healthcare settings in Australia identified that sexual harassment was a problem. Hutchinson et al (2006a) write that “A plethora of literature suggests that bullying is widespread in nursing, and that it can render the workplace a harmful, fearful and abusive environment” (p.118). The literature however fails to “...acknowledge some of the wider environmental and organisational issues that contribute to an occupational milieu in which bullying becomes (almost) normalised and acceptable... almost invisible” (p.118). The qualitative research work by Hutchinson et al, (2006b) in two large Australian health organisations showed there were “...power structures that normalised bullying as an accepted way of getting work done” (p.235).

“Interpersonal conflict among nurses (traditionally called ‘horizontal violence’ or ‘bullying’) is a significant issue confronting the nursing profession” (McKenna et al, 2003, p. 90). A survey with 551 responses showed there were problems of horizontal violence for first year graduates in New Zealand. Jackson et al, Australian researchers, consider that “...violence and hostility is a part of the day-to-day lives of most nurses” (p.13) and
“The overwhelming evidence is that nurses in many countries are exposed to unacceptably high levels of violent and abusive actions” (p.19). This violence takes many forms, “…such as aggression, harassment, bullying, intimidation and assault” (p.13) and comes from a variety of sources such as patients, relatives, other nurses, other professional groups and nurse managers.

Two important articles have been published by Leape et al (2012, Part 1 and 2) regarding healthcare in the United States. These relate to the widespread culture of disrespectful behaviour and its extremely detrimental impact on individuals and patient care. They consider that “A culture of respect is a “precondition” for the changes needed to make healthcare safe” (Part 2, p.1).

2.3.3 Negative behaviour in the NHS

In 1992, Andrea Adams the journalist who did much to raise the profile of bullying in the workplace, identified problems within the nursing profession. Four years later Ball wrote that “Bullying is thought to be a significant problem within the National Health Service”, asking the question “So why is so little being done about it?” (Ball, 1996, p.114).

In 1998, it was stated that “Harassment and bullying in the health service is a wide spread and serious problem” and that recent research findings provide “…a glimpse of the darker side of organisational life” (Oakley, 1998, p.18). Brennan considers it particularly concerning that “…bullying is tacitly and even overtly condoned” (Brennan, 1999, p.20) and that “Some organisations promote a culture that almost rewards bullying” (p.17).

Quine (1999) researching within an NHS Community Trust, asked staff to indicate the behaviours they had experienced, rather than self-label as bullying. It was stated that 38% of staff had been subjected to one or more forms of bullying behaviour in the previous year and 42% had witnessed such behaviours.

Describing the experiences of doctors, “Bullying remains a familiar part of the health professional culture, despite the caring nature of doctors’ work.” (Hicks, 2000, p.428). “Unhappy units are bad for carers and those being cared for. These are serious issues for quality assurance and clinical governance” (p.431). Cusack writes in the Lancet, “Of concern is the evidence that is accumulating of bullying among health-care workers and
of its effect on them”, and that “Health care organisations ought to recognise that bullying is an issue for them and place themselves in the vanguard of cultural reform” (Cusack, 2000, p.2118).

“The Bullying Culture” written by two midwives (Hadikin and O’Driscoll, 2000) describes a bullying culture that is deeply entrenched in the NHS as a whole and is extremely damaging to both staff and patients. In the British Medical Journal (BMJ) an anonymous junior doctor details being intimidated and traumatised by the behaviour of their surgical consultant. They describe themselves as disillusioned and wrote “I don’t know why bullying still has to be part of medical training” (BMJ, 2001, p.60). The ‘Opinion’ section of the Nursing Times asked the question “Why is bullying in the workplace such an intractable problem in the ‘caring’ professions?” (Chan, 2002, p.18).

The Amicus MSF research work (CPHVA/MHNA, 2003) involved health visitors, school nurses and community nurses across the UK, and showed that 45% considered they had been bullied under a set definition, in their current workplace by other staff.

A three-year longitudinal study of a cohort of pre-registration students was conducted in England primarily looking at the self-esteem of students. “Bullying emerged as an important theme in the qualitative interviews conducted” (Randle, 2003, p.395). There was the view that bullying was commonplace, and that students witnessed bullying of patients by qualified nurses, that qualified nurses bully them and as a result, students bullied others. A link was identified between the behaviour of staff and negative behaviour towards patients. A link with ill treatment of patients is also detailed in Hadikin and O’Driscoll (2000), Hume et al (2006) and Randle et al (2007).

In the Triple Helix it was stated that bullying is “…alive and well, an integral part of NHS culture” and expresses the view that “…it’s high time we confronted it” (Cheesman, 2004, p.8). The Royal College of Nursing (RCN) undertook surveys in 2000 and 2005 of 6000 members across England, Wales, Scotland and Northern Ireland. Nurses were asked whether they had been “bullied/harassed by a member of staff in the last 12 months” (RCN, 2006, App. 4, p.111) against two set definitions for ‘bullying’ and ‘harassment’. Most of the respondents worked in the NHS (82%). The results showed an increase of negative behaviour from 17% in 2000 to 23% in 2005 (RCN, 2002 and 2006).
Another question is asked within the title of a short article “Why is Bullying still Rife?” The opinion was that “…it is clear that, despite years of initiatives and zero tolerance policies, that the NHS and nursing – the caring profession – still has a serious problem” (Paton, 2006, p.20). These statements are supported by a survey at an HR in the NHS conference by Consult GEE (2006).

The literature also highlights the less than positive responses to the problem of negative behaviour within the NHS. The qualitative research work of Lewis considered “…nurse managers’ and nurses’ constructions of bullying in the NHS” (2006a, p.25). He described a permeating climate of silence and fear and of keeping “…bullying quiet and low profile, of it being nebulous and hidden” (p.42). People were fearful of retribution particularly in cases where an individual highlights examples of poor clinical practice and patient care. There is pretence that negative behaviour is not taking place, a reluctance to admit, and “Bullying is openly justified by some managers” (p.40). Managers know what is happening, but prefer to ignore the issue. “Bullying is embedded in the act of ‘management’” (p.40). The need for getting work done is seen as justification and the more “…senior you are the more appropriate it may be to use such an option” (Lewis, 2006a, p.39).

A quote from one interviewee (Mary)

“We give no support to the bullied. We have a policy, which nobody hopes will be used….I think it’s a paper exercise. It’s tick in the box. Trusts don’t want the confrontation of it unless it gets into the union bracket. Unless it’s actively pushed into their face and it has to be dealt with, they would rather people on the ground floor deal with it and it doesn’t get through to the top so we can shield the Board from these issues” (Lewis, 2006a, p.42).

It was also the view of Lewis (2006b) that human resource departments often failed to support targets and that if people try to get redress they can be made more of a target. The overall perception “…is that management as a whole handles bullying situations very poorly” (Lewis, 2006a, p.42).

Randle et al (2007) support these findings stating that environments can be created where bullying is allowed and seen as acceptable, behaviours are not challenged and “…staff pretend that bullying is not taking place” (p.53). Also, many individuals, managers
and NHS Trusts are choosing to ignore bullying or deny that it happens, “...hoping it will go away” (Randle, 2006, p.1). Randle considers this has repercussions for individual health and the functioning of teams, systems and structures. She considers that “Bullying does not only affect the individual, but it goes to the heart and purpose of the NHS” (Randle, 2006, p.1).

“Bullying is rife in the health care sector” (Edwards and O’Connell, 2007, p.27) and there are also difficulties for educators, which they consider has been transferred into the health educational sector from the NHS. Another anonymous person, in a senior NHS position described being bullied by people at the top of the organisation and again of bullying being “...rife in the health service’ (BMJ, 2009, p.177). They considered that human resource personnel were implicated in that process and used the phrase ‘institutional bullying’.

The research in two primary care trusts in 2005 (Burnes and Pope, 2007; Pope and Burnes, 2009) showed that 63% and 52.8% of the respondents had experienced and/or witnessed negative behaviour from staff in the previous year. The findings showed that behaviour perceived as incivility (whether or not it was classed as bullying by the individual) and aggression (this was always described as bullying and had higher levels of effect than incivility) was damaging to the individual and the organisation. Lower frequency behaviour appears to have similar effects to high frequency behaviour. They consider that the full range of negative behaviours experienced and/or witnessed in the workplace need to be addressed.

In an online survey in 2007/8 trainee doctors were asked whether they had been subjected to persistent behaviour in their post that undermined their professional confidence and self-esteem, and 9.7% responded ‘yes’. This was linked to an increased reporting of making medical errors. It was considered that “...bullying is a patient safety issue, and should be taken seriously” (Paice and Smith, 2009, p.17).

A website survey of 5,428 RCN members was conducted in 2009 looking at attitudes towards reporting worries about patient safety. A press release (11th May, 2009) indicated that 78% of nurses responded “…they would be concerned about victimisation, personal reprisals or a negative effect on their career if they were to report concerns to their employers”.
The Health and Wellbeing Review refers to the need to address “…some of the deep rooted cultural issues that are endemic in the NHS, such as a culture of long hours and high levels of bullying and harassment” (Department of Health, 2009, p.23). From over 11,000 responses 13% of staff considered they had been bullied/harassed by a manager and over 17% by ‘Other colleagues’ in the previous 12 months.

On retirement from the Health Care Commission, Sir Ian Kennedy gave “…a sombre warning about the “corrosive” impact of bullying among NHS staff” and stated it was “…permeating the delivery of care”, (Santry, 2009, April 23). That bullying is “…one of the biggest untalked about problems in the delivery of good care to patients” (2009, April 1). Santry asks the question, “…but why is bullying so widespread in an institution devoted to caring?” (2009, April 23).

In the book “Intelligent kindness: Reforming the culture of healthcare” Ballatt and Campling make comments about leadership behaviour in the NHS.

“The there are many anxious, ambitious and reactive managers and leaders, some of whom are simply ineffectual, some of whom place healthcare secondary to organisational and personal success, and some of whom attempt to drive their staff towards achieving targets in ways that often include silencing or bullying them” (Ballatt and Campling, 2011, p.183).

They consider that some of this behaviour stems from personality but “…much stems from a culture of competition, punitive responses, confused accountability and unrealistic expectations” (p.183).

“It is clear from the reports into many of the recent NHS scandals that the management culture has set the frame for much of the staff’s behaviour, and that such a culture, especially in the Mid-Staffordshire NHS Trust, was toxic in the extreme” (Ballatt and Campling, 2011, p.185).

A national study of ill treatment in the workplace included a case study within a large NHS trust with some 30,000 staff. Fevre et al (2011) observed that

“The working environment of much of the organisation seemed to function as a ‘pressure cooker’ where tempers fray, insults are traded and intimidation is practiced. Employees of all ages and backgrounds appeared to be on the receiving
end of ill-treatment with aggressive behaviour being seen as commonplace” (p.27).

“...tension between clinicians and administrators/managers seemed to be a fact of life” (Fevre et al, 2011, p.27). The trust is referred to as Westshire in Fevre et al (2012) “Trouble at work”, and the ill-treatment as “…incivility and disrespect” (p. 157). Shouting and loss of temper was widely reported and “…swearing, screaming and aggressive gestures seemed to be a common occurrence for many staff both in face-to-face meeting and on the phone” (p.157).

Fevre et al (2012) suggested the key predictor of a troubled workplace was that “...individuals did not matter there” (p.52). From their survey they concluded that three statements were “…most important to the diagnosis of workplace problems” (p.53). One of the statements was “Where I work, the needs of the organisation always comes before the needs of people”. The second was “Where I work, you have to compromise your principles”. “…employees in health and social work were more likely than those in most other industries to feel they had to compromise their principles”. The third diagnostic statement was “Where I work, people are treated as individuals” (p.52). These statements are described as the “…FARE questions, standing for FAirness and REspect” (p.53).

Mandelstam (2011) describes the NHS as a “…pyramidal, command and control structure”, where “…targets and other imperatives emanate from the centre” (p.232). A culture that has removed local initiative and judgement and “…created a culture of dangerous, indiscriminate obsequiousness and servility”. Of there being a “…mindlessness that can spread to frontline staff as well” (p.236). Others have retained the virtue of questionning and initiative, but are “…afraid to exercise it because of two key lubricants needed to ensure that priorities and targets are hit, come what may and no matter how detrimental: fear and bullying” (p.231). When trusts are pursuing actions and “…ruthless policies that are detrimental to the dignity and welfare of patients, these two “special ingredients’ of fear and bullying are required to keep the “Thinking and conscientious senior managers and staff... on board” (p.237).

In 2012, allegations of waiting list manipulation and distortions and inappropriate managerial behaviour were made about the NHS Lothian Health Board in Scotland. An independent report described
“...an organisation where being bullied, whilst not representing the daily experiences of the majority of staff, is common at certain levels...staff feel intimidated and anecdotes of bullying behaviour are common...This has pervaded the culture of the organisation so that staff feel under-valued and they have little faith that the organisation will handle them in a fair manner, should they need to raise an issue about bullying by a senior manager” (Bowles and Associates, 2012, p.22).

There was “...a fairly consistent theme from all parts of the workforce and at all levels of either an inability to challenge inappropriate behaviour or an apparent acceptance or “developed” tolerance of these behaviours” (p.26).

The public inquiry report into the appalling care provided by Mid Staffordshire hospital, where so many people died unnecessarily, was published on 6 February 2013 (Francis, 2013). It describes the “...appalling suffering of many patients” (p.3). It also describes a negative workplace culture of fear of adverse repercussions, bullying, target-driven priorities, disengagement from management and leadership responsibilities, low staff morale, isolation, lack of openness and candour, tolerance of poor standards, acceptance of poor behaviours and denial of concerns. It is considered that “...these negative aspects of culturally driven behaviours are not restricted to Stafford”, and that

“Unfortunately, echoes of the cultural issues found in Stafford can be found throughout the NHS system. It is not possible to say that such deficiencies permeate to all organisations all of the time, but aspects of this negative culture have emerged throughout the system” (Francis, 2013, p.1361).

Research on negative behaviour has been conducted by Carter et al (2013) in seven trusts in the North East of England. There were 2,950 participants (46% response) for the cross sectional questionnaire, of whom 43 took part in a telephone interview. They were researching the prevalence and impact of bullying behaviours between staff in the NHS and exploring the barriers to reporting bullying. Twenty percent of staff reported being bullied by other staff to some degree, and 43% reported witnessing bullying in the last 6 months. For most of those the source was a supervisor or manager at 51.1%, and from peers, 31.1%. Workplace culture was also highlighted as a source of bullying by 18.3% of bullied staff. The perception of bullying was assessed against quite a restrictive
definition. The behaviour had to be persistent over a length of time and there was a difficulty defending oneself. A one off event was not classed as bullying.

They concluded that negative behaviours and bullying were a persistent and significant problem in healthcare organisations and that they were underreported. There were particular problems for male employees and those with a disability. Exposure to negative behaviours both experienced and witnessed were associated with higher levels of psychological distress, increased intention to leave, lower job satisfaction and higher sickness absence.

The main reasons for non-reporting were given as the perception that nothing would change, not wanting to be seen as a troublemaker, the seniority of the person they would be complaining about, and uncertainty how cases would be managed and policies implemented. It was indicated that “...managers often failed to act when staff reported bullying, resulting in no change or a worsening situation” (p.7). “Workplace cultures in which bullying behaviours remained unchecked were also described which relayed the message that bullying was acceptable” (p.7).

Experiences of physiotherapy students of bullying on clinical internships are considered by Stubbs and Soundy (2013). This exploratory study was a cross sectional survey at the University of West Midlands, with responses from fifty two final year students. The students experienced incivility and various bullying behaviours which had a negative impact on their wellbeing. The perpetrator of this behaviour was mostly the clinical educator (62%) and most (84%) did not report the behaviours to the university.

A qualitative study was also undertaken (Whiteside et al, 2013) with eight final year students who had experienced at least one incident of bullying behaviours during their clinical internship. Through thematic analysis of the data the study found that “…bullying can have profound and adverse effects on the health of the students” (p. 6). The behaviours also affected the security and confidence in their ability as a physiotherapist. They consider that steps are needed to better protect students from bullying behaviours. It was also their view that highly performing individuals are often the target of a bully.

According to Drew (2013) “Bullying is rife in the NHS, as staff surveys show. Bullying and coercion are seen as ways of getting things done. It comes all the way down the line”.
To conclude this literature review on negative behaviour in the NHS the most recent results of the UK staff attitude/employee surveys are considered.

The first English NHS Staff Survey in 2003 gave the overall figure as 7% from a manager, and 11% from a colleague for bullying and harassment between staff in the previous year. This was 16% of the total number of staff (Care Quality Commission, 2004). The figure for 2011 is around 15% (National NHS Staff Survey Coordination Centre, 2012). Over the intervening years the figures changed little.

In great contrast, using a different question, “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?” the figure for 2012 was 24% (National NHS Staff Survey Coordination Centre, 2013). This figure obviously cannot be directly compared, but there has been a significant increase and is the highest it has ever been. Using the same question as for 2012, a similar figure of twenty-three percent of staff reported they had experienced bullying, harassment or abuse in 2013 (National NHS Staff Survey Coordination Centre, 2014). Twenty-four percent of staff reported they had experienced bullying, harassment or abuse from either their line manager or other colleagues for 2014 (National NHS Staff Survey Coordination Centre, 2015).

The surveys and questions in Scotland are not comparable, but in the NHSScotland Staff Survey report for 2010, 22% of staff considered they had experienced bullying and harassment from various sources in the previous 12 months. Of that 22%, 43% stated a manager/team leader as a source and 60% ‘other colleagues’ (Bacon and Hoque, n.d). The figures for the NHS in Scotland for 2013 identify that 11% of respondents reported that they had experienced bullying/harassment in the past 12 months from their manager and/or from other colleagues (15%). In 2014, 9% of staff said they had experienced bullying/harassment from their manager. The percentage indicating they experienced harassment or bullying from colleagues is again 15% (NHSScotland, 2014).

In Northern Ireland in 2009, 8% of staff said they had experienced harassment, bullying or abuse from their manager/team leader and 11% from other colleagues in the previous 12 months (Business Services Organisations, 2010). In 2012 the figures were 7% from manager/team leader and 11% other colleagues (Health and Social Care Northern Ireland, 2013).
The NHS in Wales 1000 Lives Plus online survey in spring 2011 showed that in response to the statement “I am treated with dignity & respect in this organisation”, 19% strongly disagreed/tended to disagree; 57% agreed (Opinion Research Services, 2011). In the 2012 Welsh NHS staff survey, 18% of staff have personally experienced harassment, bullying or abuse at work from manager/team leader or other colleagues (NHS Wales, 2013).

This review on negative behaviour in the workplace has identified some key themes (Pope and Burnes, 2013):

- The NHS appears to have a widespread and persistent problem with negative behaviour between staff. This is despite various initiatives over the years such as Improving Working Lives and guidelines around bullying and harassment issued from the Department of Health.
- Negative behaviour can be accepted, ignored and denied.
- The responses to, and management of negative behaviour in the workplace can be inadequate.
- Negative behaviour between staff can have a detrimental impact on patient care.
- Questions are asked and calls for action are present, but there is little evidence of NHS organisations taking effective action.

The above literature informs us about the culture and the behavioural problems within the NHS, and some of the organisational responses to negative behaviour such as avoidance and denial of problems. What it does not do is provide any explanations as to why there is such behaviour and what are the reasons and motivations underlying the behaviour.

The literature review will now consider the theory of selective moral disengagement.

2.4 Selective moral disengagement

Section 2.4 firstly provides a literature review on selective moral disengagement within a range of different situations and organisational settings. The second part considers selective moral disengagement in healthcare generally. The third part covers selective moral disengagement within the NHS.
2.4.1 Selective moral disengagement

Albert Bandura has written prolifically on the topic of selective moral disengagement. Most of his work has been on national political, military situations, terrorism and counter-terrorism (e.g. Bandura, 1990a, 1999, 2004a; McAlister et al, 2006). There is also research and literature on moral disengagement linked to executions (Osofsky et al, 2005), predicting aggressive and delinquent behaviour in children and adolescents (Bandura et al, 1996; Bandura et al, 2001) and corporate transgressions (Bandura et al, 2000). A more recent work is White et al (2009) writing on collective “…systematic moral disengagement” (p.66) within tobacco, lead, vinyl chloride and silicosis producing industries.

Human beings have the inhibitive power to withhold from inhumane actions and the power to proactively behave positively, humanely and morally (Bandura e.g. 1990b, 1991, 1996, 1999, 2002, 2004b). We have the power to make that choice. We do things that give us self-worth and satisfaction and normally avoid things that go against our personal moral standards as this provides condemnation, guilt and self-censure. “In the development of a moral self individuals adopt standards of right and wrong that serve as guides and deterrents for conducts” (2002, p.102).

“In the face of situational inducements to behave in inhumane ways, people can choose to behave otherwise by exerting self influence. Self-sanctions keep conduct in line with internal standards. It is through the ongoing exercise of evaluative self influence that moral conduct is motivated and regulated” (Bandura, 2002, p.102).

“Self-sanctions mark the presence of moral oughts” (Bandura, 1999, p.194).

Personal standards are established from rules of conduct being taught, social evaluation and modelling and Bandura (1986) considers that most human behaviour is learned through modelling. He also considers that social learning and moral development is a continuous process in which many societal influences, institutional standards and the media affect us. Personal standards are continually elaborated, modified and adopted (Bandura, 1991).

We are also affected by social sanctions where we anticipate that certain conduct will bring social censure and possibly, some form of punishment. We therefore self-regulate
our conduct accordingly. However, self regulation mechanisms do not come into play unless activated and “...there are many psychosocial mechanisms by which moral self-sanctions are selectively disengaged from inhumane conduct” (Bandura, 2002, p.101).

The theory of selective moral disengagement (Bandura, 2002) assists in explaining the process and psychological mechanisms by which moral self sanctions are selectively disengaged from inhumane and reprehensible conduct. The inhumane conduct is cognitively restructured into “…a benign or worthy one” (p.101). Mechanisms are described that cognitively redefine our actions to lessen and remove feelings of guilt and self-censure. In other words, selective moral disengagement is how we can all do bad things more comfortably.

This includes moral justification, palliative/advantageous comparisons, euphemistic language, displaced and diffused responsibility, minimising, ignoring, or misconstruing the consequences of actions, denial, and dehumanisation of, and blaming the victim for our damaging actions. Figure 2.1 identifies the points “...in the process of moral control at which moral self censure can be disengaged from reprehensible conduct” (2002, p.102).

![Diagram of Moral Disengagement](image)

Figure 2.1 Mechanism through which moral self sanctions are selectively activated and disengaged from detrimental behaviour at different points in the self-regulatory process (Bandura, 1986 in Bandura, 2002, p.103)
Selective moral disengagement features “...most prominently in patterns of behavior that serve the user in some way, but injure others” (Bandura, 1986, p.375). The mechanisms operate not only in extraordinary circumstances of inhumanity to others, but in everyday situations where there are personal benefits to be gained which cause detriment to others (Bandura, 1990b).

People can also act in ways to keep themselves intentionally uninformed.

“People’s values and beliefs affect what information they seek and how they interpret what they see and hear. Most strive to maintain or enhance their positive self-regard. Therefore they do not go looking for evidence of their culpability or adverse effects of their actions” (Bandura, 1991, p.94).

There is individual pretence and “…public pretence is designed to head off social reproof”. When people are in the same situation there can be “...a lot of collective public pretense” (p.95).

In the context of the corporate arena of large industries White et al (2009) alter the wording (in italics) to reflect the inclusion of the opponents to the unethical actions and the denial regarding effects of the damaging substances produced by the organisations (Figure 2.2). These industries produced substances harmful to human health i.e. tobacco, lead, vinyl chloride and silicosis producing substances.

In this research study all but one of the modes of moral disengagement were used by each of the industries. The patterns were very similar. The most frequently used mode was minimisation and denial of harmful effects. Social, moral and economic justifications were also widely used. There were no examples of displacement of responsibility to others, as all the industries persistently denied that their products and practices were harmful.
a) Moral Justification, palliative/advantageous comparison and euphemistic labelling

It is considered that “Cognitive restructuring of harmful conduct through moral justifications, sanitising language and exonerating comparisons is the most effective set of psychological mechanisms for disengaging moral control” (Bandura, 2002, p.106).

People do not usually engage in harmful conduct until they have justified to themselves the morality of their actions. The example of military action is given where soldiers cognitively redefine the morality of killing so that it can be done free from self-censure. “Moral justifications sanctify the violent means” (Bandura, 2002, p.103).

Palliative or advantageous comparison is where people compare their actions with other worse behaviour to justify their own. “...another way of making harmful conduct look good” (Bandura, 1999, p.195). This is considered to be heavily reliant on utilitarian arguments of why non-violent means will not be effective. Firstly non-violent options are judged to be ineffective which removes them from consideration and secondly utilitarian
analyses “…affirm that one’s injurious actions will prevent more suffering than they cause” (Bandura, 2002, p.106).

Euphemistic labelling changes our thought patterns and hides the actual reality of what is happening. It is the language of “…non responsibility” (Bandura, 1999, p.195). An example would be the use by military personnel of words such as ‘collateral damage’ relating to civilian deaths or bombing as ‘servicing the target’. Bandura describes euphemising as an “…injurious weapon” (p.195). “Euphemistic practices through the sanitizing and convoluted language mask detrimental activities rather than justify them” (White et al, 2009, p.66).

b) Displacement and diffusion of responsibility

Moral control is said to operate most strongly when people acknowledge they are contributors to harmful outcomes. However, people will do things they would normally consider wrong if an authority accepts responsibility (Bandura, 2004b).

“Because they are not the actual agent of their actions they are spared self-condemning reactions” and the “…greater the legitimisation and closeness of authority issuing injurious commands, the higher the obedient aggression” (Bandura, 2002, p.106).

There is therefore a conflict between duty to one’s superiors and accountability for the effects of one’s actions. Examples are given of Nazi prison guards and the My Lai massacre of civilians in the Vietnam War.

Authorities keep themselves intentionally uninformed. They

“…do not go looking for evidence of wrongdoing. Obvious questions that would reveal incriminating information remain unasked, so that officials do not find out what they do not want to know. Implicit agreements and insulating social arrangements are created that leave the higher echelons unblamable” (Bandura, 2002, p.107).

When people go looking for people to be found accountable they only find elusive “…arrangements of non-responsibility” (p.107). When problems and harmful practices
are identified and publicised “...they are officially dismissed as only isolated incidents” and “...efforts are made to limit any blame to subordinates, who are portrayed as misguided or overzealous” (p.107).

There is also a problem around diffusion of responsibility either by division of labour where people shift their attention to their specific job, rather than looking at the meaning of what they do, or by being part of a group decision-making process. “Where everyone is responsible no one really feels responsible” (Bandura, 2002, p.107). Collective action which assists in providing anonymity also weakens moral control as any harm done by a group “…can always be attributed largely to the behaviour of others” (p.107).

c) Minimising, ignoring or misconstruing the consequences/*Denying, distorting, disputing harmful effects*

Minimising, disregarding, denying and distortion regarding consequences and the effect on the victim is another way of weakening moral control. Effects are minimised, ignored and misconstrued and the evidence of harm can be discredited. “As long as the harmful results of one’s conduct are ignored, minimised, distorted or disbelieved there is little reason for self censure to be activated” (Bandura, 2002, p.108).

It is also easier to harm others if we do not see their suffering. If we do not see the harmful effects of what we have done, there is less impact. Considering organisations with “…hierarchical chains of command” (Bandura, 2002, p.108), superiors formulate plans and intermediaries transmit them to ‘functionaries’ who carry them out. “The further removed individuals are from the destructive end results, the weaker is the restraining power of injurious effects” (p.108). Disengagement of moral control is easiest for the intermediary in a hierarchical system.

d) Dehumanisation and attribution of blame/*Disparaging victims and opponents*

The final mechanisms are those of dehumanising and blaming/disparaging the victim and opponents. Dehumanisation has been shown to result in greater cruelty.
“In the studies of the perniciousness of dehumanization, people who are given power treat dehumanized people more ruthlessly than those who have been invested with human qualities. Combining diffused responsibility with dehumanization greatly escalates the level of punitiveness” (Bandura, 2002, p.109).

In contrast, “To perceive another as human activates reactions through perceived similarity” (p.108) and “The combining effect of personalising responsibility and humanizing others together has a powerful self-restraining effect” (p.109). A moral disengager can quickly change to a moral engager through the “...transformation power of humanization” (Bandura, 2004b, p. 38).

The power of dehumanisation is also described by Zimbardo in “The Lucifer effect: How good people turn evil” (2007) as he writes about the mock prison experiment they conducted in 1971 when students behaved very brutally towards each other. He also describes the more recent horrific situation of the abuse of prisoners by soldiers at the Abu Ghraib prison in 2004.

“Dehumanization is one of the central processes in the transformation of ordinary, normal people into indifferent or even wanton perpetrators of evil. Dehumanization is like a cortical cataract that clouds one’s thinking and fosters the perception that other people are less than human. It makes some people come to see others as enemies deserving of torment, torture and annihilation” (p.xii).

Discrimination acts within our social and political environment and this affects the prevalence of moral disengagement. As in the situation of the Nazi soldiers “Cultural hatreds create low thresholds for the disengagement of moral self-sanctions” (Bandura, 1999, p.198). Another more recent example would be the appallingly brutal Rwandan genocide in 1994 when one group of people were persistently devalued and demeaned (Zimbardo, 2007). The Tutsis were called ‘cockroaches’ who needed to be ‘exterminated’.

Bandura also considers that situations in our present society and culture are conducive to impersonalisation. “Bureaucratisation, automation, urbanisation and high mobility lead people to relate to each other in anonymous impersonal ways” and social practices that divide people into “…ingroup and outgroup members produce human estrangement that
fosters dehumanization” (2002, p.109). Under certain conditions “...wielding institutional power changes the power holders in ways that is conducive to dehumanization” (1999, p.200). This happens when people in positions of authority have “...coercive power over others with few safeguards to constrain their behaviour” (p.200). Having power can result in the devaluing of those we control.

“Blaming ones adversaries or circumstances is another expedient that serves self exonerating purposes” (Bandura, 2002, p.110). As well as being dehumanized victims can be blamed for bringing suffering on themselves. “By fixing the blame on others or on compelling circumstances one’s own injurious actions are excusable but one can even feel self-righteous in the process” (Bandura, 2002, p.110).

e) The process is gradual

The process of increasing disengagement is a gradual one (Bandura, 1999 and 2002). People do not suddenly become an inhumane person. Self-censure is decreased through repetition of increasing severity of aggressive acts and the person may not recognize what is happening. “Inhumane practices become thoughtlessly routinized” (1999, p. 203). The example is given of a prison guard putting people to death by gassing and the way he disengaged from the seriousness of his action. A further example is of terrorists becoming more radical again involving a gradual “...disengagement of moral sanctions from violent conduct” (p.204). “Conducive social conditions rather than monstrous people are required to produce heinous deeds. Given appropriate social conditions, decent, ordinary people can be led to do extraordinarily cruel things” (Bandura, 2004a, p.137).

f) “Everybody does it”

Bandura (1999) considers that the disengagements of moral self-sanctions from inhumane conduct are a growing human problem at both individual and collective levels. As already mentioned moral disengagement is not just occurring within the domain of the extraordinary and the most inhumane events, but these mechanisms also operate in “...everyday situations in which decent people routinely perform activities that bring
them profits and other benefits at injurious costs to others” (p.205). Bandura et al (2000) also consider that corporate transgression is a “…well-known phenomena in today’s business world” (p.57) and describes the moral disengagement strategies of organisations involved in corporate transgressions.

Gabor (1994) supports that in “Everybody does it! Crime by the public”. People frequently use the justification of “Everybody does it” for a wide range of criminal behaviour and he describes it as a global justification. He uses words such as rationalisation, justifications and excuses for criminal behaviour and writes that “The mental gymnastics involved in justifying or excusing one’s behaviour, I will argue, are an integral part of law violation and other antisocial behaviour” (p.167). He makes it clear that he considers that ordinary people use justifications similar to more hardened criminals. He cites at length the work of Sykes and Matza in “Techniques of neutralization: A theory of delinquency” (1957). These sociologists identified five main “…neutralization and coping techniques through which delinquents could deal with their own behaviour”. These were: denial of responsibility, denial of injury, denial of the victim, condemning the condemners, and appeal to higher loyalties. There are obviously similarities to the categories of disengagement as described by Bandura. Gabor considers that these neutralizations “…are not merely hypothetical: they are encountered in everyday life by those working with defendants and convicted persons, and used in everyday life by ‘respectable’ citizens confronted with their failures or transgressions” (p.170).

In the book “Wilful Blindness: Why we ignore the obvious at our peril” (Heffernan, 2011) details are given of an interview with Bandura.

“People are highly driven to do things that build self-worth; you can’t transgress and think of yourself as bad. You need to protect your sense of yourself as good. And so people transform harmful practices into worthy ones, by coming up with social justifications, by distorting themselves with euphemisms, by ignoring the long term consequences of their actions” (pp.258-259).

In the context of attitudes and damage to the environment, what is harmful has to become seen as good. People have to
“...vindicate harmful practices that take such a heavy toll on the environment and the quality of human life – they have to make out that what’s harmful is, in fact, good. And one way they do that is to use the notion of nature as, in fact, an economic commodity. So they see nature in terms of its market value rather than its inherent value” (p.259).

2.4.2 Selective moral disengagement in healthcare

Reviewing failures within international health systems Walshe and Shortell (2004) identify that “The culture of secrecy, professional protectionism, defensiveness, and deference to authority is central to such major failures” (p.103). They consider that “...some health care organization leaders act defensively to protect the institution rather than its patients” (p.107).

“...the capacity of individuals and organizations for self-deception and post-hoc rationalization in the face of unwelcome information often plays a part in their inaction. It is easier to disbelieve the data than to believe the unwelcome truth, and so problems go unaddressed until the evidence is quite incontrovertible” (Walshe and Shortell, 2004, p.107).

2.4.3 Selective moral disengagement in the NHS

Regarding the Bristol Royal Infirmary (BRI) tragedy, Weick and Sutcliffe (2003) identified socially acceptable rationalisations and justifications as critical to reinforcing and confirming the actions of a failing health system. They identify a health system which was unable to learn, describing this as ‘cultural entrapment’. “Cultural blind spots can lead an organization down the wrong path, sometimes with dire performance consequences” (Weick and Sutcliffe, 2003, p.73).

In “Betraying the NHS: Health Abandoned” Mandelstam (2007) refers to the

“...excessive use of emotive but empty language to try to explain new policies, both at national and local level. When more detail has to be mastered, and awkward cracks plastered over, then the language of euphemism takes hold.
When that is itself inadequate, and ‘less’ has to be passed off as ‘more’, then the realms of doublethink or double speak are sometimes entered into. Misrepresentations may come into it. Evidence may be lacking or used highly selectively. And logic and facts are sometimes dispensed with” (p.166).

In the context of cuts in services, Mandelstam describes the ‘stardust’ of the brightness and jollity of the websites and the use of mantras (e.g. “changing for the better”; new models of care would “develop and thrive” and be “dynamic” (p.168). “Modernisation” seemed to be the key word (p.170). Lots of positive terms were used. “Such mantras are of course inadequate substitutes for true substance and evidence” (p.170). He refers to George Orwell’s definition of doublethink as being applicable for what is happening.

Mandelstam’s view is that history is altered and rewritten and information manipulated. Evidence is ignored or selectively used. Problems and obstacles are over simplified and NHS bodies indulge in wishful thinking. Politicians would say one thing but the exact opposite would be happening in reality. NHS decision makers were detached and in “…parallel worlds” (p.184).

In “How we treat the sick: Neglect and abuse in our health services” Mandelstam (2011) warns readers they should be “…mindful of the degree of denial and euphemism sometimes emanating from NHS Trusts in order to deflect criticism” (p.54). There is a gap that can open up between “…obligatory incantation and what actually goes on in practice” (p.60); a chasm between the “…official line and the real world” (p.70). Euphemism has become “…an art form in the language of the NHS”. He refers again to the ‘Orwellian doublethink’ and ‘outrageous spin’, which can be highly damaging to patients (p.250). The NHS has difficulty with ‘straight talk’.

In the context of the seriousness of inadequate care being able to be concealed, ‘suboptimal care’ is used instead of neglect, ‘systems failure’ instead of recklessness, and ‘clinical error’ instead of clinical incompetence. ‘Busy ward’ instead of dangerous practice, ‘learning collective lessons’ instead of taking and accepting personal responsibility and ‘isolated incident’ instead of pattern of behaviour. Storerooms and cupboards can be called ‘treatment rooms’. Organisations such as Mid Staffordshire can become caught up in promoting the organisation and its reputation. When it was found to have very high mortality figures it was excused as having problems with ‘data capture’.
The stripped down language is described by Mandelstam as ‘pure inanity’. Use of such language is however sinister when “...used to persuade managers, staff and public to believe the words but not their own eyes; when it is used to create a rarefied, managerial, verbal and essentially ‘virtual’ world of health care – rather than the actual thing” (p.254). The world of the NHS Boards can be marvellous in “...their world of make believe” (p.254).

An example is given of a CEO doing whatever is asked of them by the NHS hierarchy. They will support any cause, even if it changes daily “... and believe in it”; totally obedient with no independent belief or thought (p.253). The modern chief executive tends to “...fly a flag of convenience” (p.253).

In the concluding postscript he writes

“Nor should we underestimate the immense harm inflicted by the deniers, the concealers of facts, the spinners of tall tales and of seductive words – and, sometimes, the outright deceivers. If you deny a problem you cannot talk about it; if you do not talk about it you cannot even begin to solve it” (p. 360).

“The Hospital Revolution: Doctors reveal the crisis engulfing Britain’s health service”, is written by Riddington Young et al (2008). The three authors are all consultants. One is anonymous due to fear of retribution and suspension. They use the term of ‘Stasi’, referring to managers, who they prefer to call administrators. They liken the NHS to East Germany with the security police, the Stasi, and they refer to their use of “...euphemisms, double speak and downright lies” (p.14).

They consider that “...rules are very useful for those who seek refuge behind them. Blind to their inner reason, they can then justify their actions by ‘I was only following orders’” (p.130). The attempts to curb expenditure while avoiding a public backlash is accomplished by “...a combination of double-talk and stifling informed criticism” (p.181).

Bailey in “From Ward to Whitehall: The disaster at Mid-Staffs” (2012) as well as describing denial of problems, refers to defensive and justifying statements made by some of the Mid Staffs Governors. ““It is the system,” “It’s the coding,” or “Mid Staffs is no different from any other hospital”” (p.263).
Taylor (2013) refers to the ‘big lies’. The first lie is that a uniform NHS service is provided across the country and it would provide a consistent standard of care. “That big lie has been thoroughly examined and exposed over the last decade” (p.181). The second, “...new “big lie””, is that “...variations in standards occur but the problem is under control...This is not true. And the reluctance to acknowledge this is directly contributing to the problem” (pp.181-182).

“The big lie requires that the NHS maintain the line that most of the time, in most places, things are under control and quality is being ensured. By implication, that also means that failures to implement standards must be defined as exceptional events. If it is generally true that patients can “expect to be safe” it must also be true that Mid-Staffordshire is grotesque exception to the normal state of affairs. The reality is rather different” (p.186).

A report “More complaints please!” was published by the Public Administrations Select Committee (2014).

“The shocking collapse of care at Mid Staffordshire Hospital, and the exposure of the failure of the Mid Staffordshire NHS Foundation Trust and NHS leadership to hear both the complaints of patients and their families, and the complaints of their own staff, led to the unspeakable disaster at that hospital. The Francis Report gave no comfort that a culture of denial did not exist across the NHS as a whole” (p.5).

They consider that

“An integrated approach to administrative justice is lacking, and this is reflected in the confusion in the language. A complaint is a complaint. Whenever a citizen experiences dissatisfaction with a public service, nobody should be shy of the term “complaint”, particularly where a complainant is seeking restitution or to alert management of a service’s shortcomings. Other euphemistic terms for “complaint” should be banned” (p.36).
It is proposed that the mechanisms of selective moral disengagement may enable the persistence of a dysfunctional culture within the NHS. It is an integral part of the proposed model of organisational dysfunction in the NHS in section 2.8 (Summary).

The review is now broken into two further areas of literature; the concepts of organisational silence and normalised organisational corruption.

2.5 Organisational silence

Section 2.5 firstly provides a literature review on organisational silence and resistance to voice within a range of different organisational settings. The second part considers organisational silence in healthcare generally. The third part covers organisational silence within the NHS.

2.5.1 Organisational silence

Blackman and Sadler-Smith (2009) explore the concept of silence in organisational settings and describe different forms of silence including suppression of voice. A person can choose to “...construct silence through the repression or withholding of voice; similarly, an institution may suppress the voices of its members” (p.570). This silence is “...not only a power-invested process, but also has ramifications for knowing, learning and organizing”. They consider that “Research on silence within organizations is sparse” (p.570) and refer to the work of Morrison and Milliken (2000).

A conceptual model has been detailed by Morrison and Milliken (2000) looking at the organisational characteristics and beliefs resulting in a climate of silence (Figure 2.3). Employees know the truth about problems, but they “...dare not speak that truth to their superiors” (p.706). The outcome is ‘organisational silence’ and an inability to learn and change. There are implicit managerial beliefs of “...employees are self interested”, “...management know best” and “...unity is good and dissent is bad” (p.709). Managers fear and reject negative feedback and tend to respond negatively to dissent. There is centralised decision-making with a lack of informal and formal upward feedback.
This, for the employee, results in feelings of not being valued, a lack of trust, decreased motivation and satisfaction, withdrawal and turnover, as well as ‘Sabotage/deviance’ and stress (Morrison and Milliken, 2000, p.718). The organisational outcome is less effective organisational decision-making and decreased error detection and correction (Figure 2.4).

Others are also concerned about the lack of voice and silence within organisations. Perlow and Williams (2003) look at the cost of silence to individuals and organisations. They conclude that “…silence is not only ubiquitous and expected in organizations but extremely costly to both the firm and the individual” (p.53).

Milliken et al (2003) considered issues employees don’t communicate upward and the reasons. Following forty interviews they discovered that the most common things people felt unable to raise were: “Concerns about a colleague’s or supervisors competence or performance” and secondly “Problems with organisational processes or performance and/or suggestions for improvement” (p.1460). The most common reasons for not raising concerns were given as “Fear of being labelled or viewed negatively”, “Fear of damaging a relationship” and “Feelings of futility” i.e. speaking up will not make a difference or the recipient will not be responsive (p.1462). People tend to be silent about ‘bad news’, therefore “… positive information is likely to flow up organizational hierarchies much more readily than negative information” (p.1473), which has serious implications for the organisation. “… silence about important issues can compromise an organization’s ability to detect errors and engage in learning. Employee silence can also create stress, dissatisfaction, cynicism and disengagement amongst employees” (p. 1473).

Park and Keil (2009) explore organizational silence and whistle blowing on IT projects using a role play experiment. They integrate key elements of the organisational silence model of Morrison and Milliken (2000) in their research. The three elements were 1) Organisational structures and policies (e.g. “centralisation of decision making and lack of formal upward feedback mechanisms”); 2) Managerial practices (e.g. “tendency to reject or respond negatively to dissent or negative feedback and lack of informal solicitation of negative feedback”); and 3) Degree of demographic dissimilarity between employees and top managers (e.g. “differences in terms of gender, race, ethnicity and age”) (p. 902).

They concluded that all three factors had a significant effect on the perceived climate of silence. Managerial practices had the strongest effect.
Figure 2.3 Dynamics giving rise to organisational silence (Morrison and Milliken, 2000, p.709)
Figure 2.4 Effects of organisational silence (Morrison and Milliken, 2000, p.718)
“...employees will feel a greater climate of silence when their managers respond negatively to bad news and do not informally seek negative feedback from subordinates” (p.910). They consider that the findings are consistent with the Morrison and Milliken (2000) theoretical model and provides strong empirical support for the core elements.

Vakola and Bouradas (2005) conducted research to measure organisational silence as a continuum between silence and voice and also to explain silence behaviour through the organisational dimensions as described by Morrison and Milliken (2000). The research was conducted in an organisation about to undertake large scale change with 677 respondents (above 88% response rate). The findings showed that supervisors’ attitudes to silence, top management attitudes to silence and communication opportunities are associated with, and predict, employees silence behaviour. The supervisors attitudes to silence were the strongest predictor of employee silence behaviour.

The study also found that employee silence behaviour can be responsible for low commitment and satisfaction. The strongest predictor of organisational commitment is communication opportunities. The supervisors’ attitudes to silence is the strongest predictor of job satisfaction. The findings support the Morrison and Milliken theoretical model. One of their conclusions is that “Silence climate has an impact on organizations’s ability to detect errors and learn and therefore, organizational effectiveness is negatively affected” (p.453).

“A cycle of silence about problems or issues” is created when staff perceive that managers will ignore or punish their attempts to speak about problems (Milliken and Lam, 2009, p.240). In this situation sharing positive information may increase in frequency to reduce employees anxiety. This can lead to a “...skewed transfer of information” and a “...misleading “rosy” outlook” (p.240), resulting in a distorted picture of how the organisation is functioning. “When silence about organizational issues or problems is pervasive, an organization’s ability to learn about the effects of its actions can be severely disabled” (p.242).

The conceptual article of Morrison and Rothman (2009) consider “Silence and the dynamics of power” (p.111). Their view is that the theme of power has been an undercurrent in the silence literature, but there has not been an indepth discussion or study of the relationship between power and silence. Power is such a strong driver of social behaviour that “...the power imbalance inherent in organizational roles is perhaps
the most important factor that makes employee silence such a common experience” (p.112). They argue that a position of relative power will cause managers to be less open to input, and increase the tendency for subordinates to see “...voice as futile” (p.113). It will also reduce the extent to which managers “...monitor and censor their behavior, which may lead them to behave in ways that violate social norms and hence appear rude or intimidating” (p.113). In turn, this causes people to fear that raising concerns is dangerous. It is also proposed that being in a position of low power activates a state of inhibition. Silence “...results from the combined effects” (p.113) of a position of high power and someone’s position of low power (Figure 2.5).

Manager's position of high power

Activated approach and reduced inhibition

Activated inhibition and reduced approach

Subordinate's position of low power

Subordinates belief that voice is futile

Subordinate's fear of speaking up

Less openness to input

Less self-censoring

Likelihood of subordinate remaining silent

Figure 2.5 How power contributes to silence within hierarchical relationships: An overview (Morrison and Rothman 2009, p.114).

There are many factors that contribute to this model including the power holders tendency towards having a very positive view of themselves. They will have “... an overly positive assessment of their current effectiveness and future likelihood of success. They will be likely to feel that “all is well”. As a result they will be “...disinclined to see value in, to seek out, or to listen to negative feedback” (p.118).
A study was undertaken examining official documents and conducting focus groups in one organisation (Mackenzie Davey and Liefhooghe, 2003). The right to speak was linked to organisational status and power. The perceptions of bullying related more to “...organisational systems of discipline and surveillance” (p.450), which rendered them voiceless, rather than individual interpersonal issues. Employees were very aware that speaking out “...may be recorded as offensive behaviour” (p.450). “Speaking out is presented as a dangerous and almost heroic activity” (p.451). “Employees described organizational power systems as operating unfairly by denying them voice” (p.452). Denial of voice was perceived as bullying by the employees. Generally silence was seen as a safer and easier option.

Alford (2001) studied the behaviour of whistleblowers and the organisational responses to them. He writes in “Whistleblowers: Broken lives and organizational power” that whistleblowers offer truths which are “...experienced as a threat to power” (p.3). To “...run up against the organization is to risk obliteration” (p.4). He considers that organisations are “...not just undemocratic” they are also “...the enemy of individual morality” (p.35).

Another item on the already mentioned organisational politics scale is “Don't speak up for fear of retaliation” (Salin, 2003, p.46).

2.5.2 Organisational silence in healthcare

A letter written by a staff nurse in New Jersey was discovered entitled “Organizational silence: The threat to nurse empowerment” (Hascup, 2003, p.562). She writes

“We have more power than ever..., yet the fear of nurses to speak out and stand up for patient care and nursing standards is as strong as ever before. Why? Because nurses who do are labeled and punished. This is organizational silence: most organizations do not want nor do they value nurses who speak out”.

She refers to the article by Perlow and Williams (2003), who ask the question “Is silence killing your company?” (p.52)

The professional consequences of whistleblowing by nurses in Western Australia are considered by McDonald and Ahern (2000). The nurses described many serious examples
of misconduct with detrimental outcomes for patients. There were official reprisals for 28% of the whistleblowers consisting of “...reprimand (verbal and written), demotion, suspension, and referral to a psychiatrist” (p.318). All of the whistleblowers reported unofficial reprisals which were consistent with other studies.

“Incredibly, the form of the punishment (threats, isolation, ostracism, and pressure to resign) followed the same blueprint; managers in many different settings used identical tactics to silence whistleblowers” (p.318).

Whistleblowing had a devastating impact upon the nurses, and they suffered “...profound professional effects”’. In contrast nonwhistleblowers “...reported few professional reprisals and their employment was not threatened” (p.319). Both the whistleblowers and the nonwhistleblowers “...described the fear, anxiety, and intimidation they felt in the face of their institutions’ attempts to silence them” (p.319). Constraint is placed on nurses “...by bureaucratic forces” (p.320).

“The reality is that hospital power structures limit the moral authority of nurses and require obedience and loyalty to group norms that are often in conflict with patient advocacy issues. Furthermore, nurses risk extreme consequences if they make independent decisions regarding patient advocacy issues” (p.320).

Speedy (2006) writes about workplace violence, which they consider is common in the nursing profession, and the silence that results.

“Workplace violence creates fear. When mobbing and bullying occurs, targets and witnesses become fearful, which gives power to the bully. Sometimes that power is silence. An environment in which there are issues that are not discussable is created when fear of retribution keeps targets and witnesses silent” (p.247).

Henriksen and Dayton (2006) consider organisational silence and the hidden threats to patient safety referring to “...a collective-level phenomenon of saying or doing very little in response to significant problems that face an organisation” (p.1539). They look at some of the underlying factors that “...serve to shape and sustain organizational silence” (p.1539). These include the use of psychological coping mechanisms which prevent dwelling on difficult events. “...coping mechanisms that psychologically serve to protect the individual also serve to maintain the status quo, and in return, may impede organizational efforts to improve patient safety (p.1544). There is also “Diffusion of
“responsibility” with the tendency for people to take on less responsibility when “...efforts are pooled in pursuit of a shared goal” (p.1546, italics in original), and “Micro climates of distrust” (p.1547, italics in original) when local unit managers are prone to be blame seeking. “…it is suspected that fear of reprisal leads to few errors that get reported” (p.1548).

2.5.3 Organisational silence in the NHS

In the staff survey findings in England for 2011 only 26% said that communication between senior managers and staff was effective and less than a third (30%) said that senior managers act on their feedback (National NHS Staff Survey Coordination Centre, 2012). For 2012, “Only 35% said that communication between senior managers and staff is effective, this figure is the lowest for ambulance staff (20%), and less than a third of all NHS staff (26%) reported that senior manager’s act on feedback from staff” (National NHS Staff Survey Coordination Centre, 2013, p.2). In 2013 “Only 36% said that communication between senior managers and staff is effective - this figure is the lowest for ambulance staff (19%) - and less than a third of all NHS staff (28%) reported that senior managers act on feedback from staff” (p.2). In the 2014 survey “Only 37% said that communication between senior managers and staff is effective” (p.2). Less than a third of all NHS staff (29%) reported that senior managers act on feedback from staff. Despite this, 74% said that they are able to make suggestions on how they could improve the work of their team or department, the same as in 2013 (National NHS Staff Survey Coordination Centre, 2015).

Across the four years the survey figures for England, though still low, show an 11% increase, from 26% to 37%, regarding effective communication between senior managers and staff. The figures however, for action in response to feedback from staff, remain at less than a third.

The NHS Scotland survey for 2010 (Bacon and Hoque, n.d) identified that 27% considered they were always consulted about changes at work, and 40% were confident that their ideas or suggestions would be listened to. For the survey for 2013 (NHSScotland, 2013) 26% agreed that staff are always consulted about changes at work. Thirty seven percent agreed they are confident their ideas or suggestions would be listened to. For 2014, 29%
thought that staff are always consulted about changes at work. Forty two percent were confident their ideas or suggestions would be listened to (NHSScotland, 2014). Again both figures are still low, but there has been an increase of 2% over the five years.

In Northern Ireland in 2009 (Business Services Organisations, 2010) 38% of staff agreed that communication between senior managers and staff was effective. Thirty two percent agreed that senior managers try to involve staff in important decisions and 36% agreed that senior managers encourage staff to suggest new ideas for improving services. “A third of staff (33%) agree that senior managers act on staff feedback” (p.31). In 2012 (Health and Social Care Northern Ireland, 2012), 27% felt that communication between senior management and staff was effective. Twenty-four percent agreed senior managers try to involve staff in important decisions and 27% agreed that senior managers encourage staff to suggest new ideas for improving services. These figures are substantially decreased compared to 2009. Twenty-nine percent agreed that senior managers act on staff feedback, which is a decrease of 4%.

In the Welsh 1000 Lives Plus survey (Opinion Research Services, 2011) the response to the statement “This organization’s leaders listen to me and care about my concerns” was that 35% strongly agreed/tended to agree. In the latest survey for 2012 (NHS Wales, 2013) with very different statements, 22% of employees agreed that senior managers try to involve staff in important decisions. Twenty-five percent agreed that senior managers encourage staff to suggest ideas for improving services. “These results seem to suggest a perceived remoteness between the upper levels of the NHS organisations and employees in their day to day roles, which crucially may suppress upward flow of ideas and innovation to the detriment of service improvement” (p.18). “Only 19% of employees agreed that senior managers will act on the results of this survey...This is a further indicator of a lack of trust in senior managers” (p.18). Only 21% agreed that communication between senior management and staff was effective and only 24% agreed that senior managers act on staff feedback.

A number of academics have reviewed the Bristol Royal Infirmary (BRI) tragedy where many babies and children had died after heart surgery. Alaszewski (2002), Weick and Sutcliffe (2003), and Kewell (2006) identified a culture where there was a resistance to the raising of concerns and identification of problems, as well as a culture of fear. “Most frontline staff conceal their concerns from key decision makers because of fears of
victimisation” (Alaszewski, 2002, p. 372). Warnings were persistently disregarded and those who did raise concerns were viewed as trouble makers and marginalised.

In 2002, in the article “Valuing voices from below”, Faugier and Woolnough identify that the Commission for Health Improvement reports revealed that employees attempted to “…blow the whistle on abuse, corruption or malpractice but were largely ignored” (p.315). They conclude that “…too many bosses ‘need to know’ only good news. In many cases managers are reluctant to admit there is a problem” (p.319).

“The government has pledged to create an ‘open culture’ in the NHS to encourage staff with genuine concerns to speak out” (p. 315). They considered that this could only be achieved “…if the current leadership culture characterized by conflict avoidance, blame and hierarchical control is replaced with openness and accountability”. “…the NHS needs strong leaders capable of challenging the existing social equilibrium” (p.315).

Sheaff and Pilgrim (2006) concluded that due to the “…complexity of the NHS and the contradictory processes of marketisation and bureaucratisation characterising it, it cannot as a whole system, become a learning organisation”. It is however possible that the constituent organisations “…may achieve this status to varying degrees. Constraints upon NHS managers to speak their minds freely place an ultimate limit on learning organisational development”. The current NHS encourages learning “…but not too openly and not too much” (p.1).

The public inquiry report into the disaster at Mid Staffordshire hospital (Francis, 2013) identified that people did try to raise concerns about the poor patient care. One nurse in particular, Helene Donnelly, was a whistleblower in 2007 regarding the accident and emergency services. In the earlier independent inquiry report in 2010 Francis wrote in his letter to the Secretary of State, “…it has become apparent that many staff during the period under investigation, did express concerns about the standard of care being provided. The tragedy was that they were ignored” (Francis, 2010, p.3). The management of the trust also did not respond positively to the many concerns raised by patients and their relatives over a number of years.

One of the relatives at Mid Staffordshire (Bailey, 2012) outlines the horrendous battle they had trying to get acknowledgement of the appalling care people had received at this hospital, and their attempts to achieve change. She writes
“From what I learnt whenever anyone started to question the management or the board of directors they were ostracized. A picture was starting to emerge of a deep-rooted culture of silence where any dissenting voices were cruelly dealt with” (p.145).

Their raising of concerns and complaints were met with great resistance and rejection.

Mandelstam (2011) considers that the different layers of the NHS from the clinical frontline to NHS Boards should respond to prevent poor care. These people should all be “...fighting the cause of basic humane care” (p.256). “...What we have instead, when things go off the rails, is a health care world of mostly muted, not raised voices. And, too often, silence.” (p.256). Numerous possible reasons are given for this silence including being numb to poor care, being afraid and lacking confidence, as well as uncritical obedience and a lack of professional integrity.

Some professionals however, do voice concern. He gives several examples of failures in trusts where people did raise concerns but “Their words fell on deaf ears” (p.258). The information about failures was resisted, deflected and ignored. He describes closeted boards, who go on to express “...denial and shock when daylight floods in” (p. 259). He refers to institutional mistreatment of patients and of “...systemic neglectful care in the health service” (p.265).

“If all else fails whistles are meant to be blown” (Mandelstam, 2011, p.267). He considers that fear and bullying, are “...weapons of last moral resort but employed all too frequently”. Weapons designed to make sure “...health professionals go with the flow, and also to deter them from spilling the beans, that is, from blowing the whistle” (p.267). Evidence suggests that clinical staff regularly either take part in or witness unacceptable care. “Some staff protest to no avail; others become ground down and inured to such care; still others remain unhappy but are reluctant, or fear, to speak out” (p.269). This is particularly so in NHS trusts where “...boards and senior management wish to hear only good news” (p.269).

Referring to the NHS, “Individuals raising concerns - or ideas - face high anxiety and vulnerability to being ignored, or even punished” (Ballatt and Campling, 2011, p.186). Cultures of silence and cultural censorship in the NHS are considered by Hart and Hazelgrove (2001). They describe the paradox of “...a characteristic feature of cultural
censorship – that adverse events can be widely known about yet simultaneously concealed” (p.261).

A book was published by Pink (2013) with the title “Time to speak: Diary of an NHS whistleblower”. Pink actually prefers the title of ‘truth teller’. Pink was a charge nurse at Stepping Hill Hospital, Stockport. He started writing letters in August of 1989 expressing his concerns about the lack of appropriate care for elderly patients and the lack of staff on the wards. Prior to writing letters he had previously had conversations with senior staff about his concerns. He wrote to a multitude of people including various politicians, and the then current health secretary, but to no avail. No one responded to his concerns. He was dismissed and his appeals failed. He went however to an industrial tribunal and won his case. The outcome in June 1993 was that the health authority had acted unfairly when they dismissed him.

Trying to talk to someone about his concerns was like “...speaking to the deaf” (Pink, 2013, p.98). He describes a resistance to listening, accepting his concerns and taking action. He was up against a “...wall of silence and indifference” (p.64).

“The practice of exposing wrongdoing in hospitals, which has a long and depressing history has one common factor running through it – the persecution and punishment of the exposers” (p.258). He draws attention to the work of Beardshaw (1981) who wrote the report “Conscientious Objectors at Work: Mental Hospital Nurses – A case study”. She looked at the experiences of student nurses and others raising concerns about the ill treatment of mental health patients. The people who raised concerns in this situation suffered much detriment, as did Pink. Beardshaw in a Health Service Journal article is reported as saying that in the world of the NHS “...whistleblowers could only look forward to a Kafkaesque chain of events” (Pink, 2013, p.258).

In one of his letters Pink writes “But sadly, and to their everlasting shame, managers just do not want to know. All that matters is to silence and get rid of me” (p.222). He considers that “If my case established anything, it is that there is no freedom to speak the truth in the NHS. I believe that remains true today as it did then” (p.241).

In another letter he wrote “Administrators, managers, consultants, NHS Executives listen but do not hear. They do not want to know, do not I suspect care” (p.55).
Self-interest and desire for reward can have an impact on whether people raise concerns. Regarding discretionary awards for doctors according to Riddington Young et al (2008)

“If you want one of these awards, you clearly need to toe the line and keep your mouth tightly shut. But if you choose to do this the financial reward for sycophancy is high. Many have not considered it derogatory to their dignity to exchange their self respect for a brown nose and the consideration of quite a few thousand pounds per annum (or should it be anum?)” (p.127).

A paediatric consultant, raised multiple concerns about the services provided by a particular hospital, including circumstances around the death of a child (Drew, 2014). In “Little stories of life and death @NHSwhistleblower” he writes that his story is “…about the dark side of the NHS”. He recognises that he is but one doctor in one hospital, but he thinks “…it’s a story that will resonate with many other healthcare professionals.” (p.4). In the preface he tells of his purpose that of hastening “…the advent of an NHS culture in which frontline staff are treated with respect they deserve” (xii). He considers that “This culture already prevails in the best of our hospitals, but in others disrespect, bullying and dishonesty are still the all too common day-to-day experience of many” (p.4).

There are trusts where

“…doctors, nurses, managers and others are actively discouraged from exercising their professional responsibility to their patients: when they report poor care, patient harm, wrongdoing and even fraud they are often ignored. If they persist, senior managers are likely to perceive a threat to the organization’s reputation and their own position. The whistleblower is then pursued with bullying and threats, exclusion, allegations of mental instability, disciplinary investigations and hearings, vexatious referral to the GMC and, ultimately, as in my own case, dismissal” (p.4).

On 24 January 2014 the House of Commons Public Accounts Committee (2014a) published a report on confidentiality clauses and special severance payments within the public sector. Part of the summary statement, and quote, indicates how the NHS is able to suppress the voices of employees in the NHS when they raise concerns about patient care and other issues.
“We are deeply concerned about the use of compromise agreements and special severance payments to terminate employment contracts in the public sector. The lack of transparency, oversight and proper accountability over their use has allowed taxpayers’ money to be used to reward failure and to avoid management action, disciplinary processes, unwelcome publicity and reputational damage. Confidentiality clauses within these compromise agreements may be appropriate in some circumstances, but they have been used inappropriately to deter former employees from speaking out about serious and systematic failures within the public sector, for example, in patient care or child safety” (p.3).

On the parliamentary website (http://www.publications.parliament.uk/) Margaret Hodge the chair of the committee is quoted as saying:

“It is clear that confidentiality clauses may have been used in compromise agreements to cover up failure, and this is simply outrageous. We heard evidence of shocking examples of using taxpayers’ money to ‘pay-off’ individuals who have flagged up concerns about patient or child safety”.

“It is vital that people feel free to speak out to help prevent terrible tragedies or even deaths, and protecting the reputation of an organization, such as the NHS, at the expense of public safety is unacceptable”.

A further report on whistleblowing was published on 1 August 2014 by the Public Accounts Committee (2014b). One of the conclusions was that “The treatment of some whistleblowers has been shocking and departments have sometimes failed to protect some whistleblowers from being victimised” (p.5). The committee welcomed the “…Secretary of State’s recent announcement that Sir Robert Francis QC will lead an independent policy review into whistleblowing and creating a culture of openness and honesty in the NHS” (2014b, p.3).


“Sir David accepted that the “toxic cocktail” exists within the NHS: a reluctance on the part of citizens “to express their concerns or complaints” and a defensiveness on the part of services “to hear and address concerns”, and he said that there is a
“real issue” about defensiveness and a lack of transparency...He accepted that it comes down to leadership and culture” (pp.19-20).

The report concludes that

“Sir David Nicholson acknowledged shortcomings in NHS attitudes and behaviour in respect of complaints. He adopted encouraging language, but we are far from convinced that the NHS leadership knows how to change attitude and behaviour throughout the NHS. This is a huge challenge for the NHS leadership” (p.21).

A further report is published by the Health Select Committee (2015) on “Complaints and Raising Concerns” in the NHS.

“The treatment of whistleblowers remains a stain on the reputation of the NHS and has led to unwarranted and inexcusable pain for a number of individuals. The treatment of those whistleblowers has not only caused them direct harm but has also undermined the willingness of others to come forward and this has ongoing implications for patient safety” (p. 3).

The committee also refers to the independent review “Freedom to speak up” (Francis, 2015). This review identified that people were reluctant to speak up because of “…fear of the repercussions” on them as an individual and their career. Raising concerns was also seen as futile “…because nothing would be done about it” (Francis, 2015, p.9). There is a “…remarkable consistency in the pattern of reactions described by staff who told of bad experiences” (p.8).

“Whistleblowers have provided convincing evidence that they raised serious concerns which were not only rejected but were met with a response which focused on disciplinary action against them rather than any effective attempt to address the issue they raised…I have concluded that there is a culture within many parts of the NHS which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them” (p.8).

Many described “…a harrowing and isolating process with reprisals including counter allegations, disciplinary action and victimisation” (p.10). “Bullying and oppressive
behaviour was mentioned frequently, both as a subject of concern and as a consequence of speaking up” (p.10). There were

“...more references to bullying in the written contributions than to any other problem. These included staff raising concerns about bullying, or being afraid to do so, bullying of people who had raised concerns and frustration that no-one ever appeared to be held to account for bullying” (p.12).

There were also “...attempts to cover up allegations of bullying” (p.103).

M.D. in the Private Eye (20 February – 6 March, 2015) “With friends like the BMA...” makes the following observation on the Freedom to Speak Up report.

“The Commons health committee and Robert Francis are to be congratulated for acknowledging so publically the suffering of whistleblowers. But without unions and lawyers on their side, they will never win. In MD’s view, it is still not safe to blow the whistle in the NHS. Patients suffer as a result” (p.13).

A number of reports have been published on the abusive behaviour of Jimmy Savile. In the Lampard and Marsden report (2015) regarding raising concerns, “A few of Savile’s victims did report what had happened to them to members of staff, their relations or to senior colleagues. Mostly those reports were either not believed or were brushed aside or ignored” (p.34).

“Our visits to hospitals showed us that organisations continued to face a challenge in empowering staff to feel able to raise concerns. People do not feel comfortable challenging those they see as in positions of authority and hierarchies within hospitals are a barrier to staff raising concerns. It is important in encouraging hospital staff to overcome or question the behaviour of others that managers are present within the hospital and approachable. Managers need to be trained to deal positively and appropriately when matters of concern are reported to them” (p.20).

A further report on Saviles activities over two decades at Stoke Mandeville Hospital identified that “When interviewed by the Investigation, several witnesses felt that, even today, they would be reluctant to raise concerns if they pertained to staff performance, in case of reprisals” (Johnstone and Dent, 2015, p.249).
It is proposed that the concept of organisational silence with the resistance to, and suppression of voice and upward feedback forms one of the aspects of the NHS culture. It provides some possible reasons for lack of action and response to problems, forming part of the proposed model of organisational dysfunctional in the NHS in section 2.8 (Summary).

2.6 Normalised organisational corruption

Section 2.6 firstly provides a literature review on normalised organisational corruption within a range of different organisational settings. The second part considers normalised organisational corruption in healthcare generally. The third part covers the limited amount of relevant literature found relating to corruption in the NHS.

2.6.1 Normalised organisational corruption

“Corruption is a persistent feature of human societies” (Pinto et al, 2008, p.685). “Indeed, systemic and persistent corruption appears to be a common reality of organizational life in both developing and developed economies” (Misangyi et al, 2008, p.750). Corruption is considered by Ashforth et al (2008) to be seemingly “…everywhere, afflicting for-profit, not-for-profit, governmental, and to the dismay of many, even religious organizations” (p.670). Not only are individuals being seen as corrupt, but organizations themselves “…are increasingly being construed as corrupt entities” (p.670).

Corrupt behaviour is defined as “…aggregate wrongdoing”, which is explicitly or implicitly “…officially sanctioned” (Brief et al, 2001, p. 472). The “…misuse of authority for personal, subunit and/or organizational gain” (Ashforth and Anand, 2003, p.2). “…illegal, unethical, or socially irresponsible” behaviour (Palmer, 2008, p.107). Lange (2008) defines it as “…the pursuit of individual interests by one or more organizational actors through the intentional misdirection of organizational resources or perversion of organizational routines” (p.710). Ashforth et al (2008) consider that unethical, antisocial, dysfunctional and deviant behaviour overlap somewhat with the “…notion of corrupt behavior” (p.671).
Blaug (2014) writing on how power corrupts considers that the understanding of the term corruption has changed. Now it seems to denote “…personal financial gain, kick-back and nepotism” (p.2). He refers to the more ancient conception

“…one in which ‘corruption’ signifies a general failure to orient to the common good, a crisis of moral judgement and an aggrandised and hubristic distortion of individual thinking. Mad autocrats are thus corrupted by power in this ancient sense, for they have suffered nothing short of a moral collapse and a failure of virtue that has impoverished their thought and judgement” (p.2, italics in original).

Corruption by power is a “…dangerous and destructive condition: a disorder of meaning, a mixing of self and organisations, a madness that is in part collective” (Blaug, 2014, p.7).

The concept of corruption through power has to consider both leaders and subordinates. Blaug (2014) writes that “…we are all variously corrupted by power – if not as leaders, then as subordinates” (p.4). “Whereas for leaders, corruption manifests itself as aggrandisement and insularity; for subordinates and citizens, common symptoms are dependence, apathy and blind obedience” (p.4).

“Self-interest is always a strong driving force of behaviour, as is the tendency to justify its pursuit” (Gabor, 1994, p.336). Ashforth and Anand (2003) describe a theoretical model of the three pillars of institutionalisation, rationalisation and socialisation, producing normalised corruption (Figure 2.6).

Institutionalisation is where an initial corrupt decision or act becomes embedded in structures and processes in an organisation and therefore routine. A permissive ethical climate and leadership are key to the intitiation and the behaviour, once routine, becomes normative. Rationalisation is where justifications are made to serve self-interests. “…self serving ideologies develop to justify and perhaps even valorize corruption” (p.1). Rationalisations “…acting as a sedative” (p.36). Behaviours are described such as, denial of the victim and denial of injury and responsibility, which are very similar to those of selective moral disengagement. Socialisation is where new employees are induced by rewards to view corruption as “…permissible if not desirable” (p.1). “Rewards induce newcomers to change their attitude to the corrupt behaviour” (p.28) leading to a gradual escalation.
They describe how the three pillars of institutionalisation, rationalisation and socialisation are “...mutually reinforcing and reciprocally interdependent”. Once established, they create a situation where “...corruption is practiced collectively by employees and may endure indefinitely” (p.3).

Figure 2.6 The three pillars of normalisation (Ashforth and Anand, 2003, p.3)

Ashforth and Anand give the example of institutionalised corruption at Mitsubishi Motors in the US in the 1990s, where sexual harassment pervaded “...multiple subunits and levels” of the organisation (p.4). The company strongly rejected and refuted the claims of over 700 women.

They consider that “...just as corruption is insinuated into the fiber and being of the organization through the process of institutionalization, so is it insinuated into the role behaviour of individuals through socialisation and the sedative of rationalization” (p.36). “Once corruption sets in, the mutually reinforcing processes...create an unholy trinity that actively resists change” (p.37).

Using different terminolgy Maclean (2001) outlines the mechanisms of diffusion and facilitation embedded in the relationships between managers and employees resulting in widespread rule breaking. Qualitative research had been conducted with former employees of a large mutinational life insurance company where there had been corrupt practices. In this model the rule breaking produced an increase in productivity or ‘benefit’, which promoted more bad behaviour. People were then rewarded by being
promoted. They in turn assist in perpetuating bad behaviour, including affecting new employees. There is a cycle of rule breaking (Figure 2.7).

![Diagram of the proliferation and persistence process of organisational rule breaking](image)

Figure 2.7 The proliferation and persistence process of organisational rule breaking (Maclean, 2001, p.189)

The mechanisms of diffusion and facilitation are described as ‘greasing the wheel’ of the “...larger iterative process of proliferation and persistence” (p.190). Diffusion and facilitation practices were “...embedded in the relationships” between managers, superiors and their subordinates (p.190). To consistently break rules people needed the support from those above them.

“The embedded processes of diffusion and facilitation...enable rule breaking to persist and proliferate by diffusing techniques needed to beat the system of monitoring and by facilitating rule breaking by either passively ignoring it or more actively protecting rule breakers from the consequences of their actions” (p.190).

Beenen and Pinto (2009) interviewed Sherron Watkins who had worked at Enron in their exploration of the mechanisms that resulted in “...corruption becoming pervasive across the organization” (p.275). She said that Enron was a place where people who hid wrongdoing were “...getting promotions and big bonuses” while a person who challenged the behaviour was “...forced out”. “So I think that’s how values were sustained at Enron. Bad behavior was subtly rewarded, and good behavior was punished” (p.280). “...Evil becomes good, and good becomes evil” (p.281).
The concept of normalised organisational corruption is further explored in “Business as usual: The acceptance and perpetuation of corruption in organizations” by Anand et al (2004). Drawing upon the information in Ashforth and Anand (2003) they identified six rationalisation tactics used by employees they believe are the most commonly used in organisations. Table 2.1 provides details and examples of the rationalisations.

<table>
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<th>Strategy</th>
<th>Description</th>
<th>Examples</th>
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| Denial of responsibility | The actors engaged in corrupt behaviours perceive that they have no other choice than to participate in such activities. | “What can I do? My arm is being twisted.”
|                        |                                                                            | “It is none of my business what the corporation does in overseas bribery.”                          |
| Denial of injury       | The actors are convinced that no one is harmed by their action; hence the actions are not really corrupt. | “No one was really harmed.”                                                                        |
|                        |                                                                            | “It could have been worse.”                                                                        |
| Denial of victim       | The actors counter any blame for their actions by arguing that the violated party deserved whatever happened. | “They deserved it.”                                                                                |
|                        |                                                                            | “They chose to participate.”                                                                      |
| Social weighting       | The actors assume two practices that moderate the salience of corrupt behaviours: 1. Condemn the condemner, 2. Selective social comparison. | “You have no right to criticize us.”                                                               |
|                        |                                                                            | “Others are worse than we are.”                                                                   |
| Appeal to higher loyalties | The actors argue that their violation of norms is due to their attempt to realize a higher-order value. | “We answered to a more important cause.”                                                           |
|                        |                                                                            | “I would not report it because of my loyalty to my boss.”                                          |
| Metaphor of the ledger | The actors rationalize that they are entitled to indulge in deviant behaviour because of their accrued credits (time and effort) in their jobs. | “We’ve earned the right.”                                                                          |
|                        |                                                                            | “It’s all right for me to use the Internet for personal reasons at work. After all I do work overtime.” |

Table 2.1 Rationalising Corruption (Anand et al, 2004, p.41)

They also describe a model (Figure 2.8) which shows how “…rationalization and socialization, in conjunction with certain facilitating factors, allow for the acceptance and perpetuation of corruption in the organizations” (p.40).
Facilitating Factors

**Rationalization Tactics**
- Denial of responsibility
- Denial of injury
- Denial of victim
- Social weighting
- Appeal to higher loyalties
- Balancing the ledger

**Socialization Processes**
- Cooptation
- Incrementalism
- Compromise

Euphemistic Language  
Social Cocoon and Group Attractiveness

Ongoing Organisational Corruption

Figure 2.8 Facilitating rationalisation/socialisation in organisations (Anand et al, 2004, p.40)

“Taken together, rationalizations and socialization practices allow perpetrators of unethical activities to believe that they are moral and ethical individuals, thereby allowing them to continue engaging in these practices without feelings pangs of conscience” (p.40). The three facilitating factors they consider are especially important are:

1) Group attractiveness and a social cocoon

Where there is a strong sense of identity and belonging, and perhaps a sense of being special, it increases the likelihood of “…blind acceptance of norms” (p.46). There is disparity between norms of the cocoon and those of society generally. There is
acceptance due to compartmentalism “...by psychologically separating life inside the cocoon from life outside the cocoon” (p.46).

2) Mutual support of rationalisation and socialisation

The processes of rationalisation and socialisation support each other and are mutually reinforcing. There is a progression from minor unethical/corrupt behaviour to more major acts with people becoming more accepting over time.

3) Euphemistic language

Euphemistic language is one of the most important factors facilitating the rationalisation and socialisation. This “...enables individuals engaging in corruption to describe their acts in ways that make them appear inoffensive” (p.47). They give examples of the doctors in Auschwitz. Doctors never used the word death. People going to the gas chambers were described as “...going on a transport back to camp” (p.47). The use of phenol injections to kill were referred to as euthanasia or as ‘preventative medicine’. “Euphemistic language enabled the doctors to engage in denial of the victim and of responsibility because gassing and death were words that were never used” (p.47).

They also consider that rationalisation and socialisation are facilitated if top management are perceived as being unethical. “Rationalization tactics receive a tremendous boost if they are also being used by top management” (p.49). When unethical acts are uncovered there is often a “...strong resistance to accepting the facts, no matter how strong the evidence” (p.50). This is because rationalisation “...fosters a belief there has been no wrongdoing” (p.50). This article again refers to the Mitsubishi situation which actively resisted acknowledgement and taking action. When wrong doing is acknowledged senior executives often tend to blame rogue individuals or isolated groups, “...arguing that they do not represent the otherwise pristine organization” (p.50). Anand et al (2004) consider however, that “...bad apples can be the product of bad barrels” (p.50).

Pinto et al (2008) describe two types of corruption. An organisation of corrupt individuals (OCI) where a significant number of its individuals act in a corrupt manner “...primarily for their personal benefit” (p.688). This is a bottom up phenomenon. They describe the corruption threshold which is the point where “...corruption has become so widespread that it characterizes the organization as a whole” (p.688). They consider this is similar to the point where incivility in an organisation spirals to a level where the organisation
becomes ‘uncivil’, referring to the work of Andersson and Pearson (1999). The concept of organisation silence of widespread withholding of information (Morrison and Milliken, 2000) is also considered as similar. The second type is the corrupt organisation (CO) where a group acts in a corrupt manner for the benefit of the organisation. This is usually a top down phenomenon. “...typically, the dominant coalition, organizational elites, or top management team - undertake, directly or through their subordinates, collective and coordinated corrupt actions that primarily benefit the organisation” (p.689).

The link between corrupt behaviour and selective moral disengagement is discussed by Moore (2008). It is proposed that moral disengagement plays an important role in the intitiation, facilitation and perpetuation of corruption in organisations. If the corruption is to the benefit of the organisation, she also suggests that the promotion and advancement of individuals who practice some form of corruption assists in the perpetuation of the behaviour.

Hodson et al (2013), highlight four prevalent features of “...contemporary bureaucracies – divergent goals, patrimonialism, unwritten rules and chaos” which they contend “...constitute an organizational logic more compatible with a Kafkan vision of bureaucracy” (p.256). From their research their core claim is that these four features of bureaucracy “...are concrete manifestation of the importance and prevalence of personal power and domination within organizations” (p.272). They “...centrally arise from, or are responses to, the exercise of domination by powerful actors in organizations” (p.272). Hodson et al contend that the “...centrality of power and the abuse of power for personal gain...serves as the unifying theoretical foundation upon which these four informal elements of bureaucracy rest” (p.262). The features are widespread, not anomalies, “...more typical than atypical” (p.272, italics in original).

They consider there is a need to have a revised theory capable of understanding “...bureaucracy’s power laden and often dystrophic features” (p.257). A need to have a more realistic model of organisational functioning which “...fully incorporates Kafka’s darker vision of uncertainty, deceit, informal agreements and personal power” (p.272). “The Kafkaesque aspects of bureaucracy...exert strong pressures on organizational behaviour that produce deceit, duplicity, bad faith and non-accountability...these problems...reflect its inherent nature” (p.273).
At the extreme end of a spectrum of negative human behaviour, Bauman (1989) considers the abuse and cruelty of the Holocaust was able to take place because it was the outcome of a rational bureaucracy. He refers to, and analyses in depth, the work of Milgram (1971 and 1974) which showed how easily people can inflict pain when under authority.

Bauman identifies the “‘...moral sleeping pills’ made available by modern bureaucracy and modern technology” (p.26) and how “...formal and ethically blind is the bureaucratic pursuit of efficiency” (p.15). He describes an organisation where “…the organisation as a whole is an instrument to obliterate responsibility” (p.163, italics in original). He uses the term “…free floating responsibility”, of buck passing, and a situation where “…responsibility is essentially ‘unpinnable’, while every participant of these acts is convinced that it does reside with some ‘proper’ authority” (p.163).

He also refers to research conducted by Philip Zimbardo in Haney (1973), which is also now detailed in Zimbardo (2007). This research showed how easily and quickly ordinary people can act destructively to others when placed in a particular situation. The study had to be halted. “…the orgy of cruelty that took Zimbardo and his colleagues by surprise, stemmed from a vicious social arrangement, and not from the viciousness of the participants” (Bauman, 1989, p.167). “The most poignant point, it seems, is the easiness with which most people slip into the role requiring cruelty or at least moral blindness – if only the role has been duly fortified and legitimised by superior authority” (p.168).

“The lesson of the Holocaust is the facility with which most people put into a situation that does not contain a good choice, or renders such a good choice very costly, argue themselves away from the issue of moral duty (or fail to argue themselves towards it), adopting instead the precepts of rational interest and self-preservation. In a system where rationality and ethics point in opposite directions, humanity is the main loser” (Bauman, 1989, p.206, italics in original).

“At the core of modern organisations there is a heart of darkness” (Clegg et al, 2006, p.29, italics in original). They argue that “…the heart of organization is power and at the heart of power is a darkness that has been bleached out of contemporary accounts of power in organizations” (pp.29-30). Twenty techniques of “…constructing total institutional power relations” are listed (p.177).
1) “Construct an organizational politics premised on identity/non-identity
2) Concentrate and marshal bodies on the basis of clearly inscribed identities in a specific space
3) Delegate authorities to enact centrally conceived power projects
4) Use expert knowledge to render power efficiently
5) Strip members of markers of individual identity
6) Pay systematic attention to means while accepting ends
7) Apply intrinsically instrumental and value free science
8) Construct a factory flow of power – with efficiencies of scale in processing inputs and creating outputs
9) Have the highest authority sanction the organizational action in question
10) Routinize the actions that enact organizational power
11) Dehumanize those subject to power
12) Be selective in your mercies
13) Maintain a distance between the designated exercisers and subjects of power: divisions of labor in complex chains of power enable elites to maintain distance from power’s effects
14) Make technique paramount in the dispatch of power
15) Obedience to power is encouraged where organization work is a ceaseless round of activity with little room for reflection
16) Make those who are subjects of power complicit in its exercise
17) Be convinced that the regime of the total institution is the best for all concerned, both those in and those outwith; wrap its purpose in the rhetoric of being in the ‘real’ interests of both the other and the society at large
18) Minimize the possibilities of escape attempts, by spying on everyone and making everyone aware that they may be being spied upon and informed about
19) Lock members inside, keep insiders outside, and systematically misrepresent the reality of the situation
20) Reward the institution’s keeper with perks and benefits and keep them secret from other members” (Clegg et al, 2006, pp.177-179).

Extreme examples of total organisations are also listed e.g. Magdalene Laundries, the Holocaust, German Democratic Republic and Abu Ghraib.
“What these extreme cases do is throw everyday power practices into sharp relief. Any one of the techniques listed...is a significant and subtle power practice; combined they are a formidable weapon against ethical rectitude in everyday life” (p.176).

The techniques and attributes of total institutional power

“...are deliberate acts of domination. By this we refer not to the violence but to the ordering, the social organization of ethical horror, in such a way that it is domesticated, tamed, made normal. If such horrors and monstrosities can be tamed, how much easier is it to enact the many lesser calumnies and sins of everyday power in ordinary organizational life?” (p.180).

They also observe that

“What is most sobering is that such domination is not necessarily done in the name of evil, violence or terror: sometimes it is clothed in moral authority, religious piety, or ideological legitimacy. Why, it even comes disguised as moral organization, authority or leadership” (p.183)

There are costs to adopting “...hierarchic relations of power” (Blaug, 2014, p.105).

“Among them are the excessive concentration of power, chronic exclusion and a sclerotic inability to learn. Hierarchy incurs significant health costs for its participants, enforcement costs and a range of deleterious psychological effects including dehumanisation, learned helplessness and, of course, corruption by power” (p.21).

The hierarchical organisational form is in his view dangerous. He gives a list of costs often incurred by the “…hierarchic organisational form” (p.106).

- “Cognitive separation
- Subordinate self-debilitation and alienation
- Wasted subordinate knowledge
- Degeneration of elite knowledge
- Communication breakdown
- Mission drift
- Invisibility of other organisational forms
• General failure of organisational learning
• Tyranny and terror” (Blaug, 2014, p.106)

“When power corrupts, dominants are unable to empathise with subordinates, and so are more likely to harm them with moral impunity” (p.52).

The list of clinical indicators for corruption by power is provided in Appendix 1.

It is the view of Whyte (2015) in “How corrupt is Britain?” that

“The idea that British institutions are fair and democratic is one of the foundation stones of our self-imagined national heritage...Yet the almost daily reporting of all manner of corruption cases in our most prominent and powerful institutions is beginning to unravel the idea the British establishment is predicated on civilised values of ‘fairness’, ‘openness’ and transparency”” (p.1).

Evidence also shows that

“...corruption is not merely a minor accidental flaw of the political and economic systems that we live in, but is actually a routine practice that is used for maintaining and extending the power of corporations, governments and public institutions” (p.5).

There is the “...‘revolving door’ that often facilitates the movement of personnel between public and private sectors, and provides the social networks that are ultimately used to concentrate power in social elites” (p.12). “...corruption appears not merely as an effect of power, but is a means by which institutions maintain and concentrate power” (p.27, italics in original).

There are individual benefits from taking part in corruption but the “...British corruption problem...is much bigger than this: it is the pursuit of institutional interests that characterises British corruption” (p.4). He describes the “Structures of impunity” (p.20, italics in original) and the widespread failure to address corruption and hold people to account. There are “...clear indications of a politics of impunity that pervades British government” (p.22).

In the preface of the same book McMahon (2015) writes that “How corrupt is Britain? demonstrates that rather than an aberration, corruption is endemic in powerful
institutions in contemporary Britain, both public and private, and is sustained by a culture of impunity that has emerged over generations” (p.vii, italics in original). In the view of Miller (2015) “The United Kingdom is institutionally corrupt” (p.67).

2.6.2 Normalised organisational corruption in healthcare

In 2002, Ibrahim and Majoor wrote their paper “Corruption in the health care system: the circumstantial evidence” (p.20). They use the definition of the word corrupt as literally meaning “…rotten, depraved, wicked. Corruption refers to decomposition, moral deterioration; perversion from its original state” (p.21). They use the words ‘ailing’ and ‘rotten’ to describe health systems and view the problem as “…an organisation or corporation that has deviated from the core goal of delivering health.” (p.20). Health systems “…throughout the developed world are performing at sub-optimal levels” (p.20). An example given for that is the inquiry into the deaths at the Bristol Royal Infirmary.

They conclude that

“…there is a strong case based on the circumstantial evidence that the current health system is rotten. The evidence includes the level of under-use, over-use and mis-use of health care services, the new standards asking for respect, dignity, honesty and transparency from health services, the corporatisation of health and the existing inequalities in power and health outcomes” (p.24).

A “Study on corruption in the health care sector” was published by the European Commission in 2013. Six dimensions of corruption were identified: bribery in medical service delivery; procurement corruption; improper marketing relations; misuse of (high) level positions; undue reimbursement claims; and fraud and embezzlement of medicines and medical devices. They concluded that “… corruption in the health sector occurs in all EU MSs, and that the nature and the prevalence of corruption typologies differ across the MSs”. “A general acceptance, or at least tolerance, of corruption is considered one of the main drivers behind widespread corruption in healthcare” (p.9).

From narrative qualitative research conducted in two Australian public sector health organisations (Hutchinson et al, 2009) a link is made between bullying and corruption in organisations. They consider that the study offers “...implications for the management of
bullying as a serious and corrupt activity’ (p.213). “...participants described bullying, and the organizational systems and processes that perpetuated or condoned the behavior as unethical, corrupt or evil” (p.217).

They describe five aspects of “...bullying as organizational corruption” (p.217, italics in original).

Firstly, there is “...silence and censorship: the institutional backdrop”, of “...secrecy and cover up in which corrupt conduct was able to flourish” (p.217). There was an emphasis on meeting performance targets and the maintenance of the public image of the organisation in line with external standards and expectations. The actual reality was very different. People were fearful of raising concerns and those who did were punished. “Unethical behaviour was rationalized and even valorised, serving to sustain a spiral of deviance which permeated both institutions” (p.218).

Secondly, there are “...networks of predatory alliances” of established informal networks, “...between those who engaged in bullying as corrupt conduct” (p.217). The alliances were powerful. The type of bullying perpetrated were not isolated acts, but a “...persistent, organised, clandestine, and systematic form of conduct, enabled through the relatively stable network of relationships between perpetrators” (pp.218-219). There was a “...bullying hierarchy” with junior people being supported by higher ranking people (p.219).

Thirdly, there is “...corrupting legitimate routines and processes” for personal gain (p.219). While maintaining a facade of legitimacy and due process they perpetrated “...extensive abuse on a number of targets” (p.220). Meetings were used as opportunities for abusive behaviour “...hidden from the view of others” including “...unsubstantiated allegations about poor performance, threats, humiliation, and intimidation” (p.220). People were denied access to justice and due process.

Fourthly, “...reward and promotion” was where career prospects were advanced within the alliances. “The network of alliances between bullies provided extensive opportunities for co-operative, planned forms of bullying, as well as the mechanisms that rewarded the behaviour” (p.221). People identified that when
“...individuals who engage in corrupt conduct are promoted into management, in spite of their behaviour, corruption then becomes a tolerated means of ensuring personal “success”; it becomes normalised behaviour” (p.221).

“Social relationships and ties of loyalty within “alliances” of bullies were an important vehicle for career progression” (p.21).

Fifthly, there is the “...protection from detection” within these groups (p.222). Within the authority structures and systems

“...mechanisms conducive to moral disengagement facilitated the abuse of institutional power for the purpose of protecting perpetrators in the alliances...legitimate reports of bullying were minimised, ignored and denied...this included the falsification of records” (p. 222).

The protection resulted in repeated bullying situations. People who were whistleblowers suffered mistreatment, further ensuring protection within the alliances. There was “...swift and brutal retaliation that silenced individuals who attempted to speak out about conduct deemed inappropriate or corrupt” (p.224). Careers were destroyed.

They conclude their findings “... shed light on what happens in institutions where corrupt conduct through bullying becomes a form of institutionalised, habituated behaviour that goes formally unrecognised and unchecked” (p.226). People misused their position and their access to organisational resources for “...personal power and political gain” (p.226).

The research also highlighted how “...cliques facilitate forms of professional misconduct” (p.226).

It is the view that "The worse you behave, the more you seem, to be rewarded" (p.213). Of concern was the “...apparent inability of those organisations to constrain the behaviour when it was identified, or even make it visible” (p.226). This work of Hutchinson et al (2009) makes reference to the main elements of this thesis literature review, that of negative behaviour, resistance to voice and silence, corruption and protection of image/reputation, as well as the selective moral disengagement and rationalisation of unethical behaviour.
2.6.3 Normalised organisational corruption in the NHS

Ballatt and Campling (2011) consider “There is a strong argument that there are worrying perverse incentives operating within the NHS that undermine its ethical intention. These are known about on many levels, but a blind eye is deliberately turned” (p.187). They refer to the work of Long (2008) and her book “The perverse organisation and its deadly sins” and “The pull towards perversion” (Ballatt and Campling, 2011, p.139). Though Long is writing about large private sector corporations they consider the work is “...relevant to the modern NHS”. “Perversion is about seeking individual gain and pleasure at the expense of the common good, often to the extent of not recognising the existence of others or their rights” (Ballatt and Campling, 2011, p.139). “Perversion flourishes where instrumental relations have dominance – in other words, where people are used as a means to an end, as tools and commodities rather than respected citizens” (p.139, italics in original).

“A fundamental aspect of perversion is the process of **turning a blind eye** and, with this, the development of perverse certainty, the denial of a reality that continues to be encountered and the consequent self deception that seduces accomplices and breeds corruption” (p.140, italics in original).

They describe “...powerful forces” that “...seem often to be striving actively to prevent acknowledgement of problems, especially where they may be consequences of key elements of the ‘reform agenda’ of whatever government is in power” (p.140). They refer to the “...quite explicitly perverse and corrupting – manifestations of this enforced ‘blind eye’” (p.141). Detailing the situation of deaths of “...400-1200” people at Mid Staffordshire hospital as a result of “...cost cutting, target driven behaviour and poor management”, they draw attention to a “...far more sinister process”(p.141).

“The trust knew about these dangers and of the increasingly obvious effect. Managers and leaders appear to have ignored, or even silenced, feedback from staff at all levels that would have alerted them to the problem” (p.41, italics in original).

They consider that the story of Mid Staffordshire “...illustrates directly what is meant by the ‘pull towards perversion’” (p.141).
“It is clear from the reports into many of the recent NHS scandals that the management culture has set the frame for much of the staff’s behaviour, and that such a culture, especially in the Mid-Staffordshire Trust, was toxic in the extreme” (p.185).

They comment on the suspension and silencing of the collective conscience in that situation.

They also refer to “Corrupting forces?” (p.142), and these are: the active promotion of a competitive market economy; industrialising health care with a “...mechanical delivery of processes and systems”; and the “...framework and currency of specification, regulation and performance management” (p.142). They consider that it is crucial that the potential of these interrelated forces and processes “...to skew, even actively pervert, the delivery of healthcare is recognised and managed” (p.142).

“NHS ‘targets’ may have a blunting effect on compassion” (Newdick and Danbury, 2013, p.3). There are unintended and dysfunctional consequences of performance management in the NHS (Mannion and Braithwaite, 2012, p.569). They describe this dysfunction under the four headings of poor measurement, misplaced incentives and sanctions, breach of trust (“misrepresentation, gaming, misinterpretation, bullying, erosion of trust and reduced staff morale”) and politicisation of performance systems (“political grandstanding and creating a diversion”). Data has been required for the “..purposes of tightening the corset of central accountability and control” (p.570) and “Political grandstanding is an omnipresent risk” (p.573). It has been used all too often to “...point score by governments, opposition parties, the media and other stakeholders” (p.573) and also to create a diversion and distraction by governments under pressure.

Goddard (2008) considers that there has been a “Severing of power from responsibility”. “...modern management and government are purposely ignoring the union of power and responsibility and that they have spent the best part of the last decade (or more) trying to sever the ties between the two” (p.205). “It has become the norm to see accretion of power to the management whilst they demand increased answerability, productivity and output from ‘pit face’ workers such as doctors and nurses” (p.205). Power is held by managers, but responsibility has been devolved.
One of the extreme examples of total organisations given by Clegg et al (2006) is the German Democratic Republic (GDR). Riddington Young et al (2008) term managers as the GDR security police, the Stasi, referring to their use of “...euphemisms, double speak and downright lies” (p.14). They are described as tyrannical. People have to ‘watch their backs’. “Big brother (in the Orwellian... sense) is always watching you and eager to find fault and throw you out of the place!” (p.xxii). The growth of the administration is likened to a ‘cancer’, the problems in the NHS as a ‘disease’. The NHS is “…definitely very sick” and the “…malignant mass is the Management System”, which is “…sapping it of all its strength” (p.219). The NHS in their view has “…already reached serious levels of incipient totalitarianism” (p.177).

“Shroud waving is a dismissive term invented by the Stasi for professional warnings of hazards to patients that are unpalatable (i.e. have cost implications). The suppression of criticism, muzzling the professions, and institutional disregard of the law, are well-known symptoms to those familiar with the history of the evolution of Nazi Germany and Soviet Russia, to name but two” (p.177).

Details are shared in Riddington et al (2008) of many negative personal experiences of a range of staff from across the country. One nurses experience was described as a “…witch-hunt” (p.102). She had raised concerns about patient care. Another’s experience entitled “Spite and malice in South Molton” (p.103) “…would not be out of place in Kafka’s The Trial. It is difficult to believe that these events did not occur in some police state” (p.105, italics in original). In the case of a radiologist, “They opened his mail; they tapped his phone without the authority of the Home Office; they destroyed evidence required by the police...; they suspended him...; they damaged his health and destroyed his career” (p.109). The Trust Chairman “…burned the tape!”, and there was “…the alarming disclosure of the installing engineer of the bugging device; he claimed that this was a regular feature of his work in NHS hospitals!” (p.109).

Goddard (2008) refers to the “…dictatorial style” of the Blair and Brown governments, where “…the management are the “police” of the government trying to force clinical staff...to do the will of the prime minister” (p.204). Managers are also described as the “…managerial agents” of the state (Traynor et al, 2014). “The rise of managerialism within public services and particularly healthcare systems has been noted globally” and
there has been a “...profound shift in the distribution of power between professional and managerial groups in many health systems” (p.51).

The rise of the ‘new public management’ offered managers

“...an explicit mandate to redraw the frontiers of control between themselves and health professionals. Instead of working alongside them - or even supporting their work - managers were invited to believe that they should have the power to manage them” (Traynor et al., 2014, p.52).

Traynor et al. (2014) consider disciplinary processes and the management of poor performance among UK nurses. They ask the question whether these people are bad apples or whether there are systemic failures. They suggest there is an overuse of disciplinary procedures by managers and a tendency towards punishment. Poor performance is managed in “...an unsatisfactory and costly way” (p.56). There is also evidence of “...poor managerial practice and managerial action designed to conceal processes” (p.56).

In the context of increased central government pressure

“...the management of poor performance can be seen both as a sanction that management can exercise over recalcitrant staff, for example, whistleblowers, and as a recourse in the face of bad publicity over patient dignity issues, a way to demonstrate that such issues are being handled strongly” (Traynor et al., 2014, p.56).

They also argue that “...as members of a relatively weak group, nurses who are disciplined carry the individualised blame for organisational failings such as poor resources, poor training or target-driven cultures” (p.56). Nurses can be “...scapegoated for system failures” (p.56). They conclude that the management of poor performance can act as “...a mechanism to control the traditional autonomy of clinical professionals” (p.57), and that nurses are rendered “...vulnerable to less than optimal employment practice” (p.57).

“...individual nurses can become the focus for chronic or widespread problems in a way that may enable organisations to continue to function without addressing complex systemic problems. The element of concealment within managerial practice and the exercise over relatively weak members of the workforce can be
seen as the ‘shadow side’ of NPM practice that presents itself as rational, benign and free from vested interest” (p.57).

Whyte (2015) makes reference to corrupt practices linked to the NHS. There is the influence over health policy from people such as peers and other politicians who have interests in private health companies e.g. owning shares and sitting on boards. Also, inappropriate relationships and lobbying of politicians to affect parliamentary decision making and further private concerns e.g. private finance initiatives. He also refers to the key performance indicators and the pressures on the “...hospital managements to massage the figures” (p.15). Examples are given from Scottish health boards where many people were removed from lists for very dubious reasons and marked as ‘unavailable for treatment’ simply to reduce the waiting lists.

It is proposed that the concept of normalised organisational corruption, where there is a persistent engrained high tolerance of negative behaviour, forms a second aspect of the NHS culture. It provides further possible reasons for lack of action and response to problems, forming part of the proposed model of organisational dysfunction in the NHS in section 2.8 (Summary).

2.7 Protection of image

Section 2.7 firstly provides a literature review on protection of image within a range of situations and organisational settings. The second part considers protection of image within healthcare generally. The third part covers protection of image in the NHS.

2.7.1 Protection of image

The anthropologist Douglas (1986) considers that institutions promote their “...righteous image” (p.112), and “...endow themselves with rightness” (p.92). Any institution “...starts to control the memory of its members; it causes them to forget experiences incompatible with its righteous image, and it brings to mind events which sustain the view of nature that is complimentary to itself” (p.112). “Institutions have the pathetic megalomania of the computer whose whole vision of the world is its own programme” (p.92) and also “...create shadowed places in which nothing can be seen and no questions asked” (p.69).
As already described in section 2.2 the qualitative research work of Peirce et al (1998) looked at the reasons for the managerial inertia, ‘deaf ear’ responses to sexual harassment in large companies in the United States. Denial was often the response to the sexual harassment complaints. “The founders, owners, or managers become defensive in the face of any information that might prove damaging to the reputations of their companies. They often refuse to accept that reported incidents constitute sexual harassment” (p.46). Peirce et al considered the research findings reflected the work of Brown (1997) on organisational narcissistic behaviour; the need to maintain a positive self-image, and the ego-defensive behaviours required to preserve self-esteem, both individually and organisationally.

Brown (1997) interprets the shadowed places described by Douglas (1986) as relating to the pervasiveness of rationalisations. He argues that groups and organisations, “…literally have needs for self-esteem that are regulated narcissistically” (p.649).

“Just as individuals seek to regulate their self-esteem through such ego-defense mechanisms as denial, rationalization, attributional egotism, sense of entitlement, and ego aggrandizement, which ameliorate anxiety, so too do groups and organizations” (Brown, 1997, p.643).

Idealisation and fantasy are other collective ego-defences (Brown and Starkey, 2000).

People are extremely sensitive to their organisations external image and promoting a positive image becomes very important when individual self-esteem is so closely linked to that of the organisation’s identity and sense of legitimacy. Information that threatens an organisation’s collective self-esteem is “…ignored, rejected, reinterpreted, hidden or lost” (Brown and Starkey, 2000, p. 103). They contend that organisations fail to learn due to the ego-defences that maintain collective self-esteem.

There is a healthy level of ego-defences and self-esteem in any individual or organisation. However, there are extremes in either direction, of either too low or too high defence of self-esteem and image, which is pathological (Brown and Starkey, 2000). In the organisation that over protects its self-esteem there is a retreat from reality and an inability to learn and change.

Blaug (2014) writes that we are individuals, but our “…identities and thoughts are also the product of social and organisational processes” (p.4, italics in original). When we join...
organisations “...we become like centaurs: part human; part organisation” (p.4). There can be a point where people are corrupted by power to such an extent that the organisation can exist for “...one overriding purpose” (p.9) and that is to meet those people’s needs.

According to Blaug, with increased status there is a blurring of the boundary between the person and the organisation and an increased defensiveness.

“Increasingly, you identify with the organisation; you bring it into yourself and meld its interests with your own. Slowly but surely, you are becoming a centaur: part individual, part organisation. Any slight against the organisation is now one against your very self” (Blaug, 2014, p.94, italics in original).

Schwartz (1987a) also considers

“...to the extent that the individual’s identity is an organizational identity, threats to the organization are experienced as threats to the individual. Thus, defense of the organization becomes self-defense...it is not only real threats to the organization that are seen as reprehensible acts of aggression. It can even be mere threats to the image of the organization as perfect. Thus, in a similar fashion, ‘slander against the State’ is considered a crime in the Soviet Union” (pp.333-334, italics in original).

In a totalitarian organisation it appears that “...productive work comes to be less important than the maintenance of narcissistic fantasy”. “Totalitarianism represents a turning away from reality” and this has consequences for the organisation’s productivity (Schwartz, 1987b, p.52).

Duchon and Burns (2008) also describe extreme narcissism where an organisation loses sight of reality and employs “…denial, aggrandizement, and a sense of entitlement to prop up its damaged sense of identity” (p.355).

Organisations can however have a healthy level of narcissism.

“Such organizations are reality-based and, overtime, show themselves to be worthy of trust and reliance. An organization with a healthy, authentic sense of self-values, knowledge and awareness rather than denial, seeks justice and fair
play rather than entitlement, and encourages self confidence rather than self-aggrandizement” (Duchon and Burns, 2008, pp.360-361).

A reality based organisation is also one where people “...face the facts of their situation and accept responsibility. It does not enable the use of denial to avoid the facts or evade responsibility” (p.362).

Brown (1997) suggests a number of questions that could be used to assess an organisation's level of denial. “Do people admit responsibility for their errors? Are important issues dodged around here? Does the organization refuse to acknowledge problems?” (p.669). It is suggested that ego-defences can be mitigated by embracing the identity of a learning organisation, of becoming a ‘wise’ organisation (Brown and Starkey, 2000).

Other literature explores image restoration (Brinson and Benoit, 1999; King, 2006). Benson and Benoit considered the image restoration strategies used by Texaco following allegations of racism. The image restoration strategies earlier proposed by Benoit are described. It is stated “...there are five general options available for self defence, some with subdivisions: denial, evading responsibility, reducing offensiveness, corrective action, and mortification” (p.486). Denial can be simple denial of involvement or shifting the blame. Evading responsibility can be the defences of provocation, defeasibility (lack of information or ability), it was an accident or there were good intentions (meant well). The third option is that of reducing the offensiveness of the event. This includes bolstering (stress good traits), minimisation (act is not serious), differentiation (act is less offensive than similar acts), transcendence (there are more important values), the accuser can be attacked to reduce the credibility of the accuser, and compensation is paid to reimburse the victim. The fourth category is corrective action with a plan to solve/prevent a recurrence of the action. Fifthly, there is mortification where an apology is made.

King (2006) examined the various response strategies a particular tobacco company employed after a whistle blowing incident of allegations of wrong doing. The organisation used a defensive strategy to protect its image. King concludes that a defensive strategy was more likely because the company was accused of a serious wrongdoing. In this case, the organisation “...focused on attacking the accuser” (p.134). They also used denial as a response strategy, minimisation of the seriousness of the
wrongdoing, and victimisation. They claimed the organisation was a victim, of
information that “...was being presented to destroy the image and reputation of the
company” (pp. 134-135). The organisation also used the strategy of claiming some
degree of provocation by the whistleblower.

Though different language is used there are obviously similarities regarding ego-defences,
to the Bandura and other work previously described in this literature review.

In “The perverse organisation and its deadly sins”, Long (2008) is looking at “…perversity
as a social phenomenon, as a cultural pattern” and the “…seeming madness” within
various organisations (p.x). “The ideas that organisations are sites of collective defences
against anxiety, depression, guilt and other emotions and that these defences
unconsciously structure the organisation, threw light on a multitude of experiences” (p.x).

The second half of the twentieth century, in developed countries, has produced an
increasingly “…narcissistic or egotistical society” (p.28).

“The heir to such a culture of narcissism may well be a perverse society. This is
because cultural narcissism allows the development of a blind eye to perverse and
exploitive behaviour, through increased privatisation and withdrawal of checks
and balances from the public sphere” (p.28).

She suspects there is the potential for all organisations to have perverse cultures. Five
main indicators of a perverse state of mind are outlined.

1) “The perverse state of mind is not simply a deviation from normative reality. It
has to do with individual pleasure at the expense of a more general good. It
reflects a state of primary narcissism.

2) The perverse state of mind acknowledges the reality concerned, but also denies it.

3) The perverse state of mind engages others as accomplices in the perversion.

4) The perverse state of mind may flourish where instrumental relations have
dominance in the society. This is because instrumentality ignores the more
extreme issue of abuse. It is a societal state of mind that turns a blind eye.

5) Perversion begets perversion. Abusive cycles are hard to break. Corruption
breeds corruption because of the complicity of the accomplices and their
subsequent denial and self-deception” (p.34).
Perversion “...indicates an exploitive attitude”. It “...reveals the “...more autistic position of primary narcissism” (p.29). There is a culture of private consumerism based upon instrumental relatedness. “...people use one another to gain their own particular ends or fulfil their own specific agendas with little attention to mutual aims or to the quality of the relationship per se” (p.29).

A distinction is drawn between perversity and conscious organised corporate corruption. “...organised corporate corruption is a conscious manifestation, the iceberg tip of an unconscious perverse societal structure and dynamic. Corruption builds on an underlying social fabric of perversity” (p.3); the two are linked. An example is given where leaders may take conscious steps to cover up a financial failing or problem in an organisation. “The denial involved in turning a blind eye can become a conscious attempt to disguise a reality all too evident” (p.2).

“There are many signs that currently the perverse is alive and well. Stories of abuse and their cover up are constantly surfacing, whether perpetrated by individuals or more insidiously within institutions. Increasing numbers of stories of child abuse within the Church have surfaced. There is also increasing evidence of abuse within work organisations” (p.29).

The “...stark contradiction between avowed social values” and certain practices “...is evident and accepted. Avowed values and practices are split apart” (p.30).

In “Wilful Blindness: Why we ignore the obvious at our peril” Heffernan (2011) discusses numerous situations, some with devastating consequences, where human beings choose not to see and to know. Historically a number of phrases have been used to describe choosing not to know or see.

“...deliberate or wilful ignorance, conscious avoidance and deliberate indifference. What they all have in common is the idea that there is an opportunity for knowledge, and a responsibility to be informed, but both are shirked” (p.3).

She considers that wilful blindness is very pervasive, but not inevitable. There are examples where people have chosen to see and know. One example given was that of Steve Bolsin, the anaesthetist at the Bristol Royal Infirmary who raised concerns about the deaths of children following heart surgery which led to the major inquiry (Kennedy, 2001). This was a situation where “Many doctors, managers, clinicians and nurses had
known what was going on for years”, but had done nothing (p.173). He was unable to get a job in the UK and eventually, “Frustrated, ostracised and convinced his reputation as a troublemaker would prevent him getting any other appointment within the NHS, Bolsin emigrated to Australia” (Heffernan, 2011, p.172).

Silence and denial is brought together in “The elephant in the room: Silence and denial in everyday life” (Zerubavel, 2006). “...the most public form of denial is silence” (p.4).

“Like silence, denial involves active avoidance. Rather than simply failing to notice something, it entails a deliberate effort to refrain from noticing it. Furthermore, it usually involves refusing to acknowledge the presence of things that actually beg for attention, thereby reminding us that conspiracies of silence revolve not around those largely unnoticeable matters we simply overlook but, on the contrary, around those highly conspicuous matters we deliberately try to avoid” (Zerubavel, 2006, p.9).

Denial itself is also denied. “In other words, the very act of avoiding the elephant is itself an elephant!” (Zerubavel, 2006, p.53). He refers to the work of Alford (2001) and not discussing, the ‘not discussing’.

“”The best way to disrupt moral behavior” notes political theorist C. Fred Alford, “is not to discuss it and not to discuss not discussing it.” “Don’t talk about ethical issues,” he facetiously proposes, “and don’t talk about our not talking about ethical issues”” (p.16).

Zerubavel considers that “As moral beings we cannot keep on non-discussing “undiscussables”” (p.16). There is a need to break the “...insidious cycle of denial” (p.16). The concept of ‘silence breaking’ and the negative responses to the breaking of silence are identified. Silence breakers are not received positively.

It is interesting to note that the report published in 2009 on the Catholic Church child abuse scandal provides interesting comparative material. Both the Church and the NHS have concern for protecting the reputation and external image. The conclusions of the report stated that “The desire to protect the reputation of the congregation and institution was paramount” (Commission to inquire into child abuse, 2009, p.454).
In contrast to more recent literature, ancient writings detailing the story of ‘The Tower of Babel’ identify that people are building the tower so that “...we may make a name for ourselves” (The Holy Bible NIV, 1980, Genesis 11, v 4). In the New Century Version (1993) this is translated as “We will become famous”.

2.7.2 Protection of image in healthcare

As already outlined in section 2.4.2 reviewing failures within international health systems Walshe and Shortell (2004) identify that “The culture of secrecy, professional protectionism, defensiveness, and deference to authority is central to such major failures” (p.103). They consider that “…some health care organization leaders act defensively to protect the institution rather than its patients” (p.107).

2.7.3 Protection of image in the NHS

In the first inquiry report on Mid Staffordshire hospital, there is a section on denial (Francis, 2010, pp.179-184). In the final comments it is written “This culture is characterised by introspection, lack of insight or sufficient self criticism, rejection of external criticism, reliance on external praise and above all, fear” (p.184). Senior managers were unable to accept that the service was as bad as described. They also failed to accept responsibility. “Such a position, held in the teeth of external adverse opinion, suggests an entrenched attitude of denial and dissociation from the issues that beset the hospital and its patients” (p.182). “This reluctance to accept the scale of the problem or responsibility for it extended to lower echelons of the organisation” (p.184).

These findings are further reinforced in the latest report (Francis, 2013). There was “An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern” (p.4). There was a “…lack of openness to criticism”, “…lack of consideration for patients”, and a “…defensiveness” (p.65). The trust looked inward rather than outwards, and was secretive. There was an acceptance of poor standards, and a failure to put the patient first in everything that was done. There was a culture of “…self promotion rather than critical analysis” (p.44). Francis observes that
“...for all the fine words printed and spoken about candour, and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism” (p.184).

Kewell (2006) brings an interesting qualitative focus to the BRI events, of what themes of discourse and ‘language games’ were used within that situation. They identify from the original transcripts seven main language games. The third is “...about staff bullying and whistle blowing” (p.365) the seventh, however, is said to underpin all other themes and “...functioned at a deeper level than all the others” (p.365); that of ‘reputation’.

“...with the exception of victim’s parents and carers, most witnesses spoke from a defensive position and sought to shield their reputation, the reputation of colleagues, or the image of an organization to which they felt some degree of loyalty” (Kewell, 2006, p.365).

The report on the Scottish Health Board (Bowles and Associates, 2012) identified a culture of a requirement for ‘gloss’ and positive ‘spin’, where “A generally consistent pattern emerged of a reluctance to pass bad news too far up the management chain” (p.24). “...at times, creating the right image or gloss was just as, if not more important than, seeking to obtain a full understanding of some of the substantive issues or risks” (p.24).

A range of behaviours within the NHS are discussed by Ballatt and Campling (2011). These include the presence of denial driven by the need to dispel anxiety, which they consider is common in healthcare. They describe denial as “…a step on from repression and involves active distortion of the truth and consequent distortion of relationships. Denial frequently involves omnipotence, grandiosity and triumphalism” (p.75). Problems are ignored or “…rationalised away’” (p.76).

As already detailed in 2.6.3 they describe the “The Pull towards to perversion” and corruption referring to the work of Long (2008). Ballatt and Campling identify that “A fundamental aspect of perversion is the process of turning a blind eye” (p.140). They believe that the active resistance to ‘knowing’ and acknowledgement “...is at the core of the ‘pull towards perversion’” (p.141). “Knowing and not knowing at one and the same time is central to the concept of perversion” (p.140).
They recognise that the situation at the Mid Staffordshire hospital was extreme, however they consider that the dynamics that produced it “...are everywhere in the NHS, and there is the risk that they could tip into such outcomes at any time, anywhere” (Ballatt and Campling, 2011, p.176, italics in original).

A chapter in Mandelstam (2011) is titled “Misinformation, concealment and spin” (p.242). He describes that when things go wrong, which are “...politically unacceptable”, managers in the NHS “...look for face saving measures” (p.243). Concealment is one of those measures and comes in many forms.

“It can include outright lies and deception, withholding of information from the public, giving of partial information – and the operating of systems of clinical governance or incident reporting which have the effect of suppressing the evidence of substandard care, including neglect and abuse” (p.243).

The use of euphemism and wishful thing are other forms of concealment, which sometimes qualifies as Orwellian doublethink, or maybe spin. He states that “These types of concealment are located above all in management circles and are rife throughout the hierarchy – local, regional, central – of the National Health Service” (p.243). Codes and guidance are frequently disregarded. There is a ‘polished veneer’, but underneath the wood is sometimes rotten.

He considers that paperwork and its electronic equivalent

“...plays a key role in facilitating concealment, deliberate or otherwise. A closed and secretive culture of leadership and senior management tends to build up a parallel universe, in which everyone pretends that all is well. Ultimately, everyone comes to believe it. Boxes are ticked, soothing and selective and anaemic reports are written. Overall, reassurance is stamped” (p.244).

There can be a huge gap between the rhetoric and the reality of situations.

Denial and concealment is described in “Who cares? One family’s shocking story of ‘care’ in today’s NHS” (Steane, 2007). Steane describes an appalling catalogue of repeated mistakes and neglect which ultimately resulted in the death of her husband through suicide. “The NHS tried to avoid responsibility for what was happening to Paul – letters were ‘mislaid’, promises were ‘forgotten’, and key medical records were ‘lost’”
(Introduction). She writes “I couldn’t understand how someone could look at a person who had been injured as much as Paul had and care more about protecting their own careers than about trying to care for him and taking responsibility for what had gone wrong” (p.191).

Bailey (2012) refers to being on the receiving end of spin on many occasions. At a particular meeting, “…on and on went the spin” (p.177). She describes her first exposure to the “…hospital spin team” (p.176). There was a huge gulf between what was being spoken and the reality of the situation. At the same time as the hospital management were being given negative feedback they were promoting the trust as being high performing. “…the hospital hated the bad publicity and they always tried to counteract our press coverage with their spin” (p.223). Meetings were described as scams and charades.

People were in denial at all levels about the harm that was caused and sometimes she felt that talking to managers was like talking to robots. “I feel that I am talking to a robot, this woman has no feelings” (p.133). Notes and records were “…distorted and altered” (p.168) and “The patients’ notes were nothing but a long list of lies” (p. 176). The written responses to complaints were all the same. “Identical, in the fact that they just didn’t care and they also didn’t care if they were dishonest” (p.286). This dishonesty, they at first found difficult to believe.

Bailey highlights the relationship of the general public to the NHS. “Criticism of the NHS is difficult for many to take”. The fact it played a part in the Olympic ceremony in 2012 indicates “…how deeply it is engrained in the national consciousness” (p.295). Her view is that the NHS “…has become a dangerous Sacred Cow, above criticism for many despite its obvious failings” (p.295). Also, the NHS “…appears to be pathologically unable to improve” (p.295). She and others of Cure the NHS have been victims of intimidation and abusive behaviour from members of the public because of their views and stand.

The defensive attitude towards the NHS by the public is also explored by Taylor (2013) in “God bless the NHS”. In relation to the NHS being part of the 2012 Olympic ceremony, he writes that the British “…do believe the NHS is an organisation of global significance” (p.7) and is unique. It is “…part of our national story. It is part of our national myth. We think it says something important about who we are. We love our health service” (p.7). He considers that people do not want to hear a word said against the NHS. That, “Criticism
can quickly become blasphemy. And the praise at times becomes daft” (p.8). Britons hold the institution of the NHS “…in a peculiar reverence”, and “…pious regard” (p.9).

Eric Pickles MP, speaking on Radio 4 ‘Any Questions?’ (5 December 2014), said “The NHS is in our DNA”. Again, on ‘Any Questions?’ (30 January 2015) a contributor said the NHS is “a national treasure, a national asset”. The NHS is also “…the envy of the world” (Evans, 2014). David Cameron is quoted as saying the NHS is “…our most treasured national asset”” (Taylor, 2013, p.12). “Politicians understand the place of the NHS in people’s hearts. They fall over each other protesting their love for it” (pp.12-13).

Pink (2013) describes his experiences of raising concerns and ‘truth telling’ in the NHS. It was clear to him that appearances were more important than whether the patients were ill-treated. “While he seemed concerned about appearances and public perception, I wanted to talk about what was going on at the bedside night after night, but it was like speaking to the deaf” (p.98). Concerning a health authority meeting in 1990 he learned that “…it was the publicity rather than the quality of care that exercised members’ minds. Mr Caldwell expressed the belief that harm was being done to the hospital by the publicity” (p.99).

It is a very risky business to talk about any matter “…that managers believe will dent the shiny corporate image that they are so keen to promote” (p.3). People “…accept nothing and admit nothing” (p.25). “The greater the evidence that something was wrong, the more unresponsive and less open to reason they became” (p.37).

Pink considered that “…managers seemed to have been suddenly struck blind and deaf” and to Pink this was an unexpected and strange response. It “…appeared to be little short of nihilism” (p.39).

He wrote in a letter that when presented with problems, the nurse managers “…seem to have a number of strategies:

1. Deny the problem
2. Ignore it and hope it will go away; failing that
3. Procrastinate
4. Deny responsibility; blame someone else/anyone else. If all else fails
5. Attempt to discredit the problem raiser” (p.53)
This list also could perhaps feature in the literature review for selective moral disengagement such is the similarity. He considers that “There is something seriously wrong with any group of people which is unable to accept its failings and learn from them” (p.223).

The Dixon-Woods et al (2014) study showed inconsistency with “bright spots” regarding patient care and also “dark spots”. They identified behaviours relating to data gathering as “problem-sensing” or “comfort-seeking”. Comfort-seeking is defined as being “…focused on external impression management and seeking reassurance that all is well...Comfort-seeking tended to demonstrate preoccupation with positive news and results from staff, and could lead to concerns and critical comments being dismissed as ‘whining’ or disruptive behaviour” (p.6).

Their work “…found sobering evidence that NHS organisations are not always smart with intelligence, and need to gear more towards problem-sensing rather than comfort-seeking” (p.9).

Drew (2014) believes there are dysfunctional organisations in the NHS and that in his situation the leaders were “…more concerned about their own reputations than the care of the sick children they were ultimately responsible for” (p.5). The lack of care was also shown in the attitudes to staff. Referring to another doctor; “The managers who treated him so shoddily at the end of his working life neither knew nor cared about his history of long and loyal service”.

There was a culture of secrecy around professional failure in this particular hospital which meant that information was not available to enable learning. Drew wrote, “I was always puzzled when management showed a complete lack of interest in what, in my view, would help them improve the department – Hear no evil. See no evil. Speak no evil” (p.107).

He considered that senior managers had built up an “…illusory picture” (p.160). There was also a “…typical management strategy” of shifting blame from senior managers to other staff. “Managers make underlings feel bad about themselves and shift the blame for their own failings” (pp.161-162). There is a “…kind of wilful blindness that enables managers to cope with difficult situations they encounter when things go wrong: to
maintain his ignorance it was important for him to deliberately avoid speaking to me” (p.183).

Regarding the high levels of bullying in the NHS he comments that

“Of course no trust ever admits to this problem. Few that I have heard of deal with it decisively, and in some it is a management tool. In our own department it was sapping energy and destroying morale, but the Chief Executive, whose responsibility it was to enforce the Trust’s bullying policy, could not have cared less. That was the only conclusion we clinicians could reach” (p.177).

There are different perceptions of reality seen in the King’s Fund report (2014) on leadership and culture in the NHS. Responses to the questions varied significantly between job roles. “While 84 per cent of executive directors felt their organisation was characterised by openness, honesty and challenge, only 37 per cent of doctors and only 31 per cent of nurses felt the same” (p.6). The report states

“The most notable feature of this year’s survey results was a consistent discrepancy between the views of executive directors and those of other NHS staff, especially nurses and doctors. Executive directors tended to be much more positive about the working environment and culture within their organisations than other staff, especially nurses. This lack of consensus is a cause for concern” (p.1).

In the journal ‘The Consultant’ (Vincent, Autumn 2014, p.4-8) the article “Failure at the top: Where does transformation drive come from if the leaders themselves don’t see it?” is accompanied by an interesting picture of NHS managers with their heads in the sand. Referring to a recent NHS confederation survey he wrote

“What was far more upsetting was a question asked of NHS Leaders. Addressing the question of whether the NHS needs to make large-scale changes to maintain current levels of care, only 51% responded in the affirmative, meaning a whopping 49%, virtually half, could not see the need for large scale changes. Given that the foremost element of drive for change is the leaders themselves, it invites the question of just what this means for NHS transformation and the individual Trusts and services within our system currently” (p.4).
He also refers to “Leadership Blindness”.

“One of the most vital functions of leadership is that of preparedness for emerging circumstances, part of which is asking and answering the question of whether we need to adapt to remain secure. Failure in this domain affects survival. The commonest reasons for failure in this domain are: Blindness to emerging circumstances; Failure to interpret them intelligently; Denial and defensive reasoning” (p.5).

The “Freedom to speak up” report (Francis, 2015) considers the NHS is unique in that it has a “...very high public and political profile”, is “...intensely complex” and “...heavily regulated” (p.9).

“...the political significance of almost everything the system does means that there is often intense pressure to emphasise the positive achievements of the service, sometimes at the expense of admitting its problems” (p.9).

The Kirkup report was published on 3 March 2015. This report investigated the “...serious failures of clinical care” (p.5) in the maternity unit at Furness General Hospital. The result was “...avoidable harm to mothers and babies, including tragic and unnecessary deaths”.

“What followed was a pattern of failure to recognise the nature and severity of the problem, with, in some cases, denial that any problem existed, and a series of missed opportunities to intervene that involved almost every level of the NHS. Had any of those opportunities been taken, the sequence of failures of care and unnecessary deaths could have been broken. As it is, they were still occurring after 2012, eight years after the initial warning event, and over four years after the dysfunctional nature of the unit should have become obvious” (p.5).

The unit is described as “...seriously dysfunctional” (p.7).

“Clinical competence was substandard, with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives; there was a growing move amongst midwives to pursue normal childbirth ‘at any cost’; there were failures of risk assessment and care planning that resulted in inappropriate and
unsafe care; and the response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons” (p.7).

Five serious Incidents in 2008 signalled “…unmistakably to the Trust executives and Board that all was not well with the unit” (p.8).

“The reactions of maternity unit staff at this stage were shaped by denial that there was a problem...We found clear evidence of distortion of the truth in responses to investigation...events such as the disappearance of records, although capable of innocent explanation, concerned us. We also found evidence of inappropriate distortion of the process of preparation for an inquest, with circulation of what we could only describe as ‘model answers’” (p.8).

Regarding a report in 2010 which was “…given very limited circulation within the Trust” it was “…found on the balance of probability that there was an element of conscious suppression of the report both internally and externally” (p.9).

“...there is a clear sense that neither the Trust nor the wider NHS has yet formally accepted the degree to which things went wrong in the past and admitted it to affected families; until this happens, there is little prospect of those families accepting that progress can be made” (p.5).

In the Press release on 3 March 2015 Dr Kirkup said

“For the first time the full extent of the problems have been laid bare, independently and comprehensively. Those affected by the consequences deserve to see the nature and degree of failures acknowledged, after too long hearing them denied. I am sorry that it has taken so long to happen”.

The Patients Association in their report “Why our NHS should listen and be human” (2015) identify that one of the patient concern themes was “Complaints handling process within the NHS, including a culture of defensiveness and lack of transparency” (p.11). They also referred to their earlier report in October 2014, on complaint handling. “This report highlighted how families who raise concerns are frequently met with barriers and defensiveness from the health and social care provider” (p.3).

The Public Administration Select Committee report (2015) on “Investigating clinical incidents in the NHS” states that “This culture of defensiveness described by many of our
witnesses can make mistakes in clinical practice hard to admit” (p.21). The Secretary of State for Health made the following statement

“It is incredibly difficult for Ministers to admit they ever make a mistake, because they know that they will be on the floor of the House of Commons and be utterly castigated for it. [...] Part of the defensiveness throughout the NHS may come from defensiveness by Ministers and that culture feeds its way down” (p.21)

It is proposed that the concept of protection of image, where there are high levels of ego-defences, denial and rationalisations and an unhealthy focus on the image of organisation or individuals, forms the third aspect of the NHS culture. It provides further possible reasons for lack of action and response to problems, forming part of the proposed model of organisational dysfunctional in the NHS in section 2.8 (Summary).

2.8 Summary

Chapter 2 provides a review of the relevant literature covering negative behaviour in the workplace, with particular emphasis on the NHS, the theory of selective moral disengagement and the concepts of organisational silence, normalised organisational corruption and protection of image. It is proposed that this literature contributes to providing possible explanations for dysfunctional behaviour in the NHS.

The NHS appears to have a persistent, widespread and engrained problem with negative behaviour between its staff, in its different forms. Negative behaviour can be accepted, ignored and denied. It is behaviour that ostensibly has become tolerated and ‘normalised’. Negative behaviour between staff can have a detrimental impact on patient care. The responses to, and management of negative behaviour in the workplace can be inadequate. Within the literature, questions are asked and calls for action are present, but there is little evidence of NHS organisations taking effective action.

Based upon the literature review a model of organisational dysfunction (Figure 2.9) has been proposed (Pope and Burnes, 2013, p.684). The three overlapping concepts, of organisational silence, normalised corruption and protection of image reflect three aspects and perspectives of the NHS culture, providing some possible reasons for lack of action and response to problems. Supported and enabled by the mechanisms of selective
moral disengagement, the model provides a possible explanation for dysfunctional behaviour in the NHS. It is concluded that “…organisational behaviour in the NHS can be dysfunctional, not always rational, and perverse” (p.691). The model goes some way to addressing the research objectives in Chapter 1.

![Figure 2.9 Model of Organisational Dysfunction in the NHS (Pope and Burnes, 2013, p.684).](image)

The three concepts are seen as being entwined/interlocked, each reinforcing the other. Encompassing and integral to this is the tendency to rationalise/morally disengage and to exhibit denial. The mechanisms of selective moral disengagement enable the persistence of this dysfunctional culture. The adaptations to thinking enable people to do bad things more comfortably, so that they can avoid self-censure, keep their self-esteem and avoid anxiety.
Underpinning these concepts is the human requirement for benefits and reward. There is the benefit and privilege of negative behaviour described by Brodsky (1976), rewards for corrupt behaviour, as well as the preservation of self-esteem and avoidance of anxiety with individual or collective narcissistic behaviour (Brown, 1997).

In the scenario described in Chapter 1 (section 1.3), there was a seeming resistance to receiving information. The behaviour appeared not to be rational and there were no signs of any care or concern for the staff, or ultimately for the patient. It could be viewed as an extreme form of organisational silence. It is suggested however, that the protection of the organisational image, and also the image and self-esteem of the individuals involved, was probably the dominant influence. The information about negative behaviour was perhaps perceived as a threat.

As described in Pope and Burnes (2013), over time some NHS colleagues were asked to give their opinion on the possible reasons for this experience. One said ‘fear’, another, “they didn’t want to know” and they were “scared”. Other responses included “protecting their image” and “you were showing them a mirror”. All of these link with the writing on organisational narcissism, which includes the emphasis on denial. Other people suggested it was about exerting control, power and senior managers showing their authority (Clegg et al, 2006; Blaug, 2014).

The actual event when the directors/senior managers walked out of the room was probably about silence breaking (Zerubavel, 2006). They knew, but they had chosen to ignore, and they didn’t want to know. They had chosen not to see and to know (Heffernan, 2011).

It was proposed that

“...the NHS exhibits too high a level of collective ego defences and protection of its image and self-esteem, which distorts its ability to address problems and to learn. Organisations and the individuals within them can hide and retreat from reality and exhibit denial; there is a strong resistance to voice and to ‘knowing’. The persistence and tolerance of negative behaviour is a corruption and is not healthy or desirable. Negative behaviour is one of the ‘elephants in the room’ for the NHS.” (Pope and Burnes, 2013, p.691).
Based upon the literature review and direct observation within NHS organisations, some possible characteristics of an organisation retreating/hiding from reality, exhibiting denial, were also proposed (Figure 2.10).

Centralised decision making/authoritarian leadership  
Suggestions for improvements not received well/active resistance to upward feedback  
Managers choosing to remain uninformed  
Important issues/problems are avoided/deflected  
Organisations refuse to acknowledge/deny problems  
Not admitting responsibility for errors  
Pretence that things are OK when they are not/lack of honest self assessment  
People who raise concerns are marginalised/intimidated  
Organisation acutely sensitive to outside interest by the press or other interested parties/staff talking to the press.  
Staff access to Non-Executives strongly controlled/restricted  
Patient complaints are deflected  
The presence of fear

Regarding negative behaviour:  
Denial that negative behaviour exists in the organisation  
Extreme reluctance to class/label any behaviour as ‘bullying’  
Staff/managers who intimidate people can be protected/promoted

Figure 2.10 Possible characteristics of a dysfunctional organisation which is retreating/hiding from reality (Pope and Burnes, 2013, p.691).

This list of characteristics could be used to encourage honest self-reflection at all levels of the NHS, but particularly at the senior and middle management layers regarding the behaviour in their own organisation. It could also assist in helping them to gather feedback from employees and to respond more positively to that feedback. There is also a place for discussion around the justifications and rationalisations that are used to excuse such negative and dysfunctional behaviour. There could also be utilisation as a diagnostic tool at a regulatory level. The serious implications of not taking these dysfunctional behaviours seriously are repeated failures across the UK NHS, possibly repeated on the scale of Mid Staffordshire.

There needs to be recognition within the NHS that the dysfunctional behaviours described in this thesis are not ‘normal’ or acceptable, and that everything possible
should be done to address these problems. There has got to be a healthy level of individual and collective ego-defences and narcissism.

Qualitative research as described in this thesis, in the form of interviews and focus groups, has been undertaken across the UK. The findings of the research will be utilised to test and develop the conceptual model of organisational dysfunction in the NHS; to more adequately reflect the complexities of the NHS culture. This will hopefully contribute to theory/academic knowledge and impact on policy and practice within the NHS.

It is also suggested that further to the characteristics identified above that in an organisation which reflects the proposed model there would be:

- Resistance to voicing concerns on a range of topics
- Widespread negative behaviour with high levels of toleration and normalisation; a bullying culture
- Reluctance to address problems of negative behaviour
- Reluctance to address problems/concerns generally
- A sensitivity to, and rejection of any information that would put individuals and organisations in a ‘negative light’
- Widespread denial of problems
- Evidence of reframing/redefinition of bullying
- Evidence of rationalisations and justifications providing excuses for actions/non action

As described in section 1.3 (Research background) there are some gaps in the research literature. Firstly, the reasons for the culture in the NHS, and the ongoing problems of negative behaviour towards staff over many years. Secondly, there is a gap regarding the reasons and motivations for the often inadequate organisational responses to negative behaviour. Thirdly, the literature does not explore the role of selective moral disengagement in the perpetuation of the dysfunctional culture of the NHS. Fourthly, only a limited amount of relevant literature was found relating to corruption in the NHS. Fifthly, no literature, other than Pope and Burnes (2013), draws together the concepts of organisational silence, normalised organisational corruption and protection of image in a
model to explain organisational dysfunction. The proposed model of organisational dysfunction is considered to contribute to addressing those gaps within the literature.

Having reviewed the literature in Chapter 2 the thesis now describes the methodological approach and methods employed for this doctorate research in Chapter 3.
Chapter 3. Methodology

3.1 Introduction

This chapter restates the research objectives and describes the ontology and epistemology of the research. Within a qualitative approach the chosen research methods, and the method of analysis are detailed. The terms ‘reliability’ and ‘validity’ used to assess the quality of qualitative research are explored, as is ‘generalisation’. Ethical considerations are discussed. The research design and process is described as is the data gathering and process of analysis using the Framework Method. The limitations and difficulties encountered in the research process are outlined.

The main headings are:

3.1 Introduction
3.2 Research objectives
3.3 Ontology and epistemology
3.4 Research method
3.5 Research design
3.6 Data gathering
3.7 Analysis using the Framework Method
3.8 Research limitations
3.9 Summary

3.2 Research objectives

The research objectives are:

1) To assess the organisational responses to negative behaviours between staff in the NHS
2) To assess and analyse the motivations/reasons for the organisational responses
3) To increase understanding of why some NHS organisations do not take action to address the problems of negative behaviour between staff
3.3 Ontology and epistemology

Crotty (1998, p.1) suggests there is “…bewilderment at the array of methodologies and methods” and confusion arising from terms being used in several different and “…sometimes even contradictory ways”.

Ontology is the set of beliefs adopted in a research study about the nature of the phenomena under study. For Crotty (1998, p.10) “Ontology is the study of being”, “It is concerned with ‘what is’, with the nature of existence, with the structure of reality”. The ontology sits alongside the epistemology in forming the theoretical perspective.

Bryman (2008, p.18) considers that “Questions of social ontology are concerned with the nature of social entities”. There are entities, that could be considered to be objective which have “…a reality external to social actors” or entities considered “…social constructions built up from the perceptions and actions of social actors”.

Snape and Spencer (2003) in Ritchie and Lewis (2003) describe three main ontological positions, that of realism, materialism and idealism. The realist stance assumes there is an “…external reality which exists independently of people’s beliefs and understanding about it” (p.11). Materialism is where there is a real world but “…only material features…hold reality” (p.11) and values, beliefs and experiences do not shape the material world. Idealism “…asserts that reality is only knowable through the human mind and through socially constructed meanings” (p.11). Realism and idealism can be considered as the extremes of a spectrum of ontological stances. An intermediate position is ‘critical realism’, which Snape and Spencer (2003) identify as equivalent to Hammersley (1992)’s ‘subtle realism’. Critical or ‘subtle realism’ holds that an “…external reality exists independent of our beliefs and understanding”, but that “…reality is only knowable through the human mind and socially constructed meanings” (Snape and Spencer, 2003, p.16). Similarly “…the social world does exist independently of individual subjective understanding, but that it is only accessible to us via respondents’ interpretations (which may then be further interpreted by the researcher)” (Snape and Spencer, 2003, p.19).
Building on the ontological stance adopted, a research study requires an epistemological position on how to generate or test theory. Crotty (1998, p.3) considers that “An epistemology...is a way of understanding and explaining how we know what we know”. He outlines the well-known epistemologies of objectivism, constructionism and subjectivism. The researcher has a clinical and scientific background, which might be associated with an objectivist stance. However, as a physiotherapist, it is essential to assess a physical problem both objectively and subjectively; both are essential and equally important. Similarly, the critical/subtle realist ontology appropriate for this research suggests constructionism is an appropriate epistemology:

“...we do not create meaning. We construct meaning. We have something to work with. What we have to work with is the world and the objects in the world...Objectivity and subjectivity need to be brought together and held together indissolubly. Constructionism does precisely that” (Crotty, 1998, pp.43-44).

This thesis focuses on the issue of the high level of negative behaviour and the lack of action to effectively address this within the NHS. As detailed in the Introduction one of the objectives for this research is to contribute to changes of policy and practice within the NHS, and to bring about social change.

One well-known theoretical approach is critical inquiry, as described by Crotty (1998) and Gray (2009). This “…questions currently held values and assumptions and challenges conventional social structures” and “…is not content to interpret the world but also seeks to change it”. “…the task of the researchers is to call the structures and values of society into question” (Gray, 2009, p.25).

Cresswell (2009) considers four world views: postpositivistic, social constructivist, advocacy/participation and pragmatism. Advocacy/participation describes what appears to be a similar approach to critical inquiry: this

“...philosophical world view focuses on the needs of groups and individuals in our society that may be marginalised or disenfranchised...research contains an action agenda for reform that may change the lives of the participants, the institutions in which the individuals work or live, and the researcher’s life” (Cresswell, 2009, p.9).
Also similar is the term critical theory, which “...casts a sceptical eye on the motives and impact of powerful groups and individuals” (Easterby-Smith et al, 2008, p.74).

In summary, an appropriate approach to address the research objectives in this research is a critical/subtle realist ontology, with a constructionist epistemology. In addition a critical theoretical/inquiry perspective will be taken.

3.4 Research method

3.4.1 A qualitative approach

Cresswell (2009) states that the worldview of advocacy/participation is “...typically seen with qualitative research” (p.90). Ritchie (2003) defines qualitative research into contextual, explanatory, evaluative and generative functions. “Contextual research is “...concerned with identifying what exists in the social world and the way it manifests itself” (Ritchie, 2003, p.27). “Explanatory research is concerned with why phenomena occur and the forces and influences that drive their occurrence” (p.28, italics in original).

“Because of its facility to examine subjects in depth, qualitative research provides a unique tool for studying what lies behind, or underpins, a decision, attitude, behaviour or other phenomena”, it “...may indicate some explanatory – even causal – link” (Ritchie, 2003, p.28). While recognising that some would challenge this ability to assess cause, Ritchie considers that “… qualitative methods still have a crucial role in identifying the important influences and in generating explanatory hypotheses” (p.28).

In evaluative research “…qualitative methods are particularly adept at looking at the dynamics of how things operate (Ritchie, 2003, p.29). Generative research can “…develop hypotheses about the nature of the social world” and provide “…new solutions to persistent problems” (Ritchie, 2003, p.31).

A qualitative approach was taken to answer the ‘what’ and ‘why’ aspects of the research objectives. The aim is also to further develop explanatory hypotheses about the nature of the social world within the NHS and provide some possible solutions to the persistent problems of negative behaviour in the NHS.
3.4.2 Semi-structured interviews

The initial chosen method within a qualitative approach was face-to-face semi-structured interviews. Interviews are considered by Denscombe (2007) to be for the “...exploration of more complex and subtle phenomena” (p.174). A suitable method for gaining “...insights into things like people’s opinions, feelings, emotions and experiences” (p.174). Semi-structured interviews in contrast to structured interviews allow the participant greater flexibility to “...develop ideas and speak more widely on the issues raised by the researcher” (p.176).

A main method of collecting ‘natural language data’ in management research is according to Easterby-Smith et al (2008, p.142) the in-depth one-to-one interview. An interview provides the opportunity to explore situations and experiences more deeply and gives opportunity to explore topics that are highly confidential or sensitive. Legard et al (2003) also consider the in-depth interview as one of the main methods of data collection in qualitative research.

Easterby-Smith et al (2008) also note that managers can sometimes prefer telephone interviews as this can give greater flexibility and is less of a demand. Bryman (2008) writes that “There is some evidence that there are few differences in the kind of response that one gets when asking questions by telephone rather than in person” (p.457).

It soon became obvious in the research process that it was very difficult to arrange face-face interviews due to problems of distance and time, and also some people requested to participate by e-mail. Other people wanted a telephone interview and e-mail follow-up if necessary.

The benefit of the e-mail interview was seen initially as ease of access and decreased financial and time cost. There was also the benefit that both researcher and participant had greater time to consider their responses, and less time would be spent in transcribing interviews (Bampton and Cowton, 2002; Meho, 2006; Bryman, 2008; Gibson, 2010). Some other advantages are extending the access to participants with flexibility of picking up lines of inquiry, which was also the case for telephone interviews (Opdenakker, 2006). Gray (2009) considers that with telephone interviews the main advantage is the low cost and such interviews can be conducted more quickly than ones face-to-face.
The experience of the pilot interview had made the researcher very aware of the limitations of the face-to-face situation regarding the difficulty of not leading the person and becoming directive with questioning. The sensitivity of the topic and the difficulty of answering some of the questions, particularly the ‘why’ questions, meant that to have more time to consider a response was positive for both parties. It was also decided that it would be better in the available time to be able to contact more people than would have been achieved with purely face-face interviews.

It was recognised that the e-mail interviews may lack depth due to the lack of visual feedback and interviewee emotional responses, as well as spontaneity (Bampton and Cowton, 2002; Meho, 2006; Bryman, 2008; Gibson, 2010), but it was considered that the advantages far outweighed the disadvantages. Gibson (2010) found that her “…e-mail data was particularly rich, and helpful for analysis” (p.2). Burns (2010) considers that e-mail interviews enriches “…the array of investigatory tools available for social research” (p.1). Meho (2006) writes that e-mail interviews can be a “…viable alternative to face-to-face and telephone interviewing” (p.1284). Face-to-face, telephone and e-mail interviews are all viable options according to Kazmer and Xie (2008). This is despite of the fact they found there was a greater attrition with e-mail interviews and that participants could exit the process at multiple points in comparison to other forms of interview. Morgan and Symon (2004) consider that electronic interviews can be useful particularly in organisations where e-mail is an accepted form of communication, which obviously applies to the NHS.

It was finally decided to do a mixture of face-to-face interviews, e-mail interviews with possible follow-up with telephone, as well as telephone interviews with possible follow-up on e-mail. The focus was on giving the participant as much choice as possible to encourage participation. “…one should let the participants choose as much as possible” (Kazmer and Xie, 2008, p.273).

3.4.3 Focus groups

It was eventually decided that part of the qualitative data collection would be through conducting focus groups with various staff groups in the NHS.
Focus groups are less predictable and provide a broader range of information and trigger new lines of thought not picked up within an interview situation. They can be “...very helpful in the elicitation of a wide variety of different views in relation to a particular issue” (Bryman, 2008, p.475). Bryman also considers that within a focus group individuals challenge each other and argue, which is not present in ordinary interviewing.

“This process of arguing means that the researcher may stand a chance of ending up with more realistic accounts of what people think, because they are forced to think about and possibly revise their views” (p.475).

Focus groups also “...offer the researcher the opportunity to study the ways in which individuals collectively make sense of a phenomenon and construct meanings around it” (Bryman, 2008, p.476).

Denscombe (2007) also considers that focus groups make use of ‘group dynamics’.

“Particular emphasis is placed on the interaction within the group as a means of eliciting information” (p.178). Berg (2006) makes a similar statement and writes that when focus groups are administered properly “...they are extremely dynamic” (p.146). The outcome is that “A far larger number of ideas, issues, topics, and even solutions to a problem can be generated through group discussion than through individual conversations” (p.146).

Focus groups produce data that is “...enriched by the groups interactive discussion” (Lee, 1999, p.51).

The use of focus groups in social research has “...increased considerably in the last two decades of the twentieth century” (Finch and Lewis, 2003, p.171). A key feature is that through interaction the discussion progresses and the “...individual response becomes sharpened and refined, and moves to a deeper and more considered level” (p.171).

Focus groups are more spontaneous and the perspective is “...less influenced by interaction with the researcher than it might have be in a one to one interview” (p.171). The group may take over some of the interviewing role and the researcher is “...at times more in the position of listening in” (p.171).

Berg (2006) refers to a tactic called the ‘extended focus group’ with the use of a questionnaire before a group session on material to be discussed. This is considered to help the participant to “...develop a commitment to a position before any group discussion begins” (p.159). This concept was utilised by asking participants to write down
their opinions on the culture of the NHS and respond to the request for the ‘3 word summary’ of the culture at the beginning of every focus group.

3.4.4 Thematic Framework Method of analysis

After much consideration it was decided to use the thematic Framework Method of analysis as detailed in Ritchie and Spencer (1994), reprinted in Huberman et al (2002); and Ritchie et al (2003). Bryman (2008) makes reference to this method and Gale et al (2013) write that the Framework Method is being increasingly being used in health research and that it is a flexible and systematic approach to qualitative analysis.

The ontology of Ritchie and Lewis (2003) is that of critical/subtle realism. “...there is a ‘reality’ to be captured in terms of the social constructs, beliefs and behaviours that operate, albeit a diverse and multifaceted one” (p.xiv). “...we accept that the social world does exist independently of individual subjective understanding, but that it is only accessible to us via respondents’ interpretations (which may then be further interpreted by the researcher)’ (Snape and Spencer, 2003, p.19).

The Framework Method involves constructing a Thematic Framework or Index “…within which the material can be sifted and sorted” (Ritchie and Spencer, 1994, p.180). “The thematic framework is used to classify and organise data according to key themes, concepts and emergent categories” (Ritchie et al, 2003, p.220). Ritchie et al uses the analogy of forming “…conceptual scaffolding” (p.221) and that “…the process of familiarisation is akin to building the foundation of the structure” (p.221).

“It is a matrix based analytic method which facilitates rigorous and transparent data management such that all stages involved in the ‘analytic hierarchy’ can be systematically conducted. It also allows the analyst to move back and forth between different levels of abstraction without losing sight of the ‘raw’ data” (Ritchie et al, 2003, p.220).

After constructing the initial Thematic Framework structure a process of Indexing or labelling then takes place where every piece of data is labelled as being relevant to one or more of the chosen Themes. “Indexing refers to the process whereby the thematic
framework or index is systematically applied to the data in its textual form” (Ritchie and Spencer, 1994, p.180).

Following the Indexing, the data is then managed through the stages of summarisation, and reduction to its Key Elements/dimensions whilst still retaining the language of the participant. The next stages are to refine the data into perhaps more abstract Categories and Classes of data (Figure 3.1). At the Category stage the choice is made regarding the level of abstraction of the data. The researcher chose to stay close to the sense of meaning in the data, with some abstraction. Every effort was made to retain what was considered critical wording to maintain meaning to be able to provide explanations. The data at the Classes stage became more abstracted but still stayed close to wording used by the participants. The stages of refining the data into the Key Elements, Categories, and Classes provide the descriptive accounts of the analysis.

The use of language for this method of analysis was found to be somewhat confusing. Terms in the literature are used interchangeably, different words used to describe the same, but also different things. There are also some differences between the language used by Ritchie and Spencer (1994) and that used by Spencer et al (2003) and Ritchie et al (2003). From this point for the purpose of this thesis, to avoid confusion, the term ‘Framework’ will be used by the researcher and not ‘index’. The term ‘Theme’ will be used and not ‘concept’ relating to the initial constructed Thematic Framework. Material is ‘Indexed’ rather than ‘labelled’ and the words ‘Key Elements’ used rather than ‘dimensions’. Data is refined into ‘Categories’ and then ‘Lower Level Classes’ and in some Framework Themes, ‘Higher Level Classes’. This terminology is reflected in Figure 3.2.

After producing the descriptive accounts of the Key Elements, Categories and Classes the process moves to the stage of drawing out the explanatory accounts. “The ability to explain, or build explanations, lies at the heart of qualitative research” (Spencer et al, 2003, p.215). The “…explanations may be based on the explicit reasons that are given by participants themselves, or alternatively implicit reasons that are inferred by the analyst” (Ritchie et al, 2003, p.253). For explicit explanatory accounts the evidence is overt in the reasoning within the responses of the participants. For the implicit accounts “…the researcher may deliberately put together different pieces of evidence to develop or construct an explanation” (p.253).
Primary Raw Data: 43 interviews and 6 focus groups were conducted

Identifying initial Framework Themes through ‘familiarisation’ to form the Thematic Framework/index: The 14 chosen Themes were decided based upon the literature review, the words collected under the 'summary of 3 words' to describe the culture of the NHS, and the accumulating research data.

Indexing/labelling of data into Framework Themes: All the research data was indexed using descriptive indexing rather than numerical.

Summarising the data: The Raw Data was summarised on an excel spreadsheet format. Key terms, phrases and expressions of the participants own language were maintained. At this stage interesting descriptive phrases and metaphors used by participants were also marked in italics. Every reference to the word ‘fear’ and other words indicating fear e.g. ‘scared’, ‘anxiety’, were also underlined.

Identifying Key Elements/dimensions: Data was further reduced into the Key Elements. The language of the participant was maintained.

Data refined into Categories: The data was refined into Categories. At this stage a decision was made to stay close to the sense of meaning in the data, with some abstraction. Due to the vast amount of data the summarised data, the Key Elements and the refined Categories were transferred from the spreadsheets into a table format to enable presentation of the data.

Data refined into Classes: Categories were then grouped together to provide more abstract Lower Level Classes of data. Some of the Framework Themes were further refined into Higher Level Classes due to the amount of data collected.

Developing explanations to address the research objectives

Seeking applications to wider theory/policy

Figure 3.1 Depiction of the stages and processes involved in the Thematic Framework analysis method as applied to this research study (Ritchie and Spencer, 1994; Spencer et al, 2003, p.212; Ritchie et al, 2003)
Where reasons are implicit and inferred

“...the process may entail searching for a possible underlying logic within what people have said; using common sense to search for explanations; applying powerful analytic concepts; comparing findings with those of other studies; or relating findings to a more theoretical framework” (Ritchie et al, 2003, p.253).

It is at this stage that the researcher must ensure the explanations do not “...’bully’ the findings to fit preconceived ideas” (p.257).
The final stage of the Framework analysis is that of considering whether the evidence from the data has some wider application. This could be a “...contribution to theory...suggested strategies for the formulation or realignment of a social policy, or recommendations about practices within a public service” (Ritchie et al, 2003, p.257).

The method of template analysis (King, 2004) was also considered, however, it was finally decided to follow the Framework analytical method for the following reasons.

Firstly, the management and process of data in this method appeared to be very systematic and methodical. Secondly, there was the desire for transparency, visibility and clarity of process to provide a clear audit trail that could be accessed by others. It is expected that due to the sensitivity of the data that the research and the researcher will be very open to criticism. There was a need to remove any lack of clarity around the process of analysis.

Thirdly, Framework was chosen for the ease of tracking the data back to the original transcript so there was effective checking for accuracy of text and of meaning. This checking went on throughout the process and was found to be as effective as described by Ritchie et al (2003). It meant that the researcher felt confident about the way the huge amount of data could be managed, corrected and revised.

Fourth, and extremely important was the recognition of the bias and world view of the researcher. This method though rather slow and laborious helped to prevent ‘cherry picking’ of data. Each section of data had to be included into the Framework and assisted in developing thought outside the researcher’s preconceived notions. Some data that was thought initially to be perhaps irrelevant was on further consideration an important part of the bigger picture.

Finally, the use of terminology of ‘Indexing’ was preferred rather than ‘coding’ which seemed to the researcher to better describe what was happening at the early stages of the process and was more meaningful to the researcher.

3.4.5 Reliability and validity in qualitative research

Several authors write about the terms reliability and validity regarding the assessment of the quality of qualitative research (Lewis and Ritchie, 2003; Bryman, 2008; Cresswell,
2009). They all make the observation that these words do not mean the same for qualitative research as quantitative. Despite this it seems that the terms have some relevance in relation to qualitative research. Reference is made to other authors who use different words to assess quality.

Referring to reliability Lewis and Ritchie (2003) consider that reliability is “...generally understood to concern the replicability of research” (p.270) and whether the findings would be repeated if research with the same or similar methods were used. They also highlight words of other authors such as confirmability, trustworthiness, consistency and dependability. They consider that “All of these features lie at the heart of reliability in its broadest sense and are key to appraising the soundness of a study” (p.271). “Confirmability, consistency or dependability...refer to the security and durability of a research finding” (p.285).

Validity is

“...traditionally understood to refer to the correctness or precision of a research reading. In qualitative research it concerns the extent to which the phenomena under study is being accurately reflected, as perceived by the study population” (Lewis and Ritchie, 2003, p.285).

Alternative terms such as credibility and plausibility are sometimes used.

Cresswell (2009) describes reliability as “...examining stability and consistency of responses” (p.190) and that it is not the same as validity. Validity is

“...one of the strengths of qualitative research, and it is based on determining whether the findings are accurate from the standpoint of the researcher, the participant, or the readers of an account” (p.19).

He refers to the other terms of trustworthiness, authenticity and credibility.

Bryman (2008) also refers to replication regarding reliability. Based upon the work of other authors, he suggests that alternative terms to reliability and validity can be used for assessment, that of trustworthiness and authenticity. Trustworthiness is made up of the four aspects of credibility, transferability, dependability and confirmability.
In contrast, Easterby-Smith et al (2008) considering the validity of constructionist research designs and being able to assure the quality of the research, state that ‘...authors rarely use the term ‘validity’” (p.96). They also quote others who use terms such as authenticity, plausibility, criticality and refutability. Their view is that the results of constructionist research “...should be believable, and they should be reached through methods that are transparent” (p.97). It is important to explain how access is gained to organisations, and to participants, how data is created and recorded, how the data is “...transformed into tentative ideas and explanations” (p.97), and how the researcher feels about the research.

The researcher will now detail how she has attempted to address issues of quality under the terms of reliability and validity, but influenced by the broader meaning of the other terms above. The actions described provide reasons why this research study should be considered ‘sound’, ‘believable’ and ‘trustworthy’.

- Recognition of bias

“...qualitative researchers should be very explicit about their biases and personal world views” (Lee, 1999, p.xv). It is necessary to “Clarify the bias the researcher brings to the study” (Cresswell, 2009, p.192, italics in original) and to identify “...personal values, assumptions and biases at the outset” (p.196). The researcher has attempted to do this in the personal profile, and the research background in the introduction.

“A key feature is to be as objective and neutral as possible in the collection, interpretation and presentation of qualitative data” (Snape and Spencer, 2003, p.20). The researcher has aimed to achieve that at every stage of the research. Snape and Spencer also recognise that despite our attempts we cannot be completely objective and neutral as we are personally interpreting the research, referring back to the “...ontological stance of subtle realism” (p.20).

The chosen Framework Method, though rather slow and laborious, is systematic. Every piece of data has to be examined and included in the analysis. It helped to prevent ‘cherry picking’ of data in line with any bias of the researcher.
Only one of the participants was from the researcher’s original organisation to avoid bias. In the researchers trade union role she has interviewed many people at the lower levels of the NHS about their experiences of negative behaviour. Such has been the desire to counteract the bias of the researcher, there has probably been an over compensation. There are more participants at a senior level, than at lower levels in the NHS. If similar research is conducted in the future there should be more contributions from staff at the clinical and operational levels.

When contacting chief executives the researcher only contacted NHS organisations which were completely unknown to the researcher. Trusts that had been in the press in any way were deliberately avoided. The organisations in England, Scotland and Wales were chosen on the basis of ensuring a broad geographical area, different health regions, and to include both rural and more urban areas.

- Accuracy

All the data was transcribed and checked a minimum of three times for any mistakes (Cresswell, 2009). In two interviews some note taking by the researcher was involved. The notes were read back to the participant to check for accuracy and meaning; alterations were made as required. The descriptive Indexing of the data was constantly reviewed, adjusted and alterations were made as required as described earlier in this chapter. The process of working through the Framework Method of analysis was constantly being scrutinised and checked for accuracy, and corrections were made.

- Triangulation

Data was collected from different sources to provide some triangulation of the data (Cresswell, 2009). This included individual interviews using different modes, focus groups and a very broad range of roles, internal and external to the NHS, including external organisations. Participants were from across a large geographical area.

- Looking for contrary information
There is a need to look for “...negative and discrepant information that runs counter to the themes” (Cresswell, 2009, p.192). A very conscious decision was made at the onset of the research that every attempt would be made to look for any information that is contrary to the main thrust of the data. Most of the data has a negative slant to it. No doubt this is partly because the researcher is exploring a negative topic. The researcher was constantly looking for positive information and this is documented under the theme of ‘Positive characteristics’. Despite the overall lack of positive information this heading was placed second in the list of major themes to help maintain the focus. The ‘open’ statement, at the beginning of the interview/focus group requesting participant’s thoughts on the culture, gave opportunities for them to put as much positive information as they wished. The definition of negative behaviour was only given to the participants after they had completed this stage so that their thinking was not affected.

- Transparency of process and audit trail.

To provide the utmost transparency throughout the process has been an overarching aim. Details are given of the process of thought and action, particularly in the preparation stage, as well as the reasons for changes in direction. The problems encountered in gaining ethical approval and in conducting the research process are shared.

The reasons behind the choice of participants are described. Details of how the participants and potential participants were contacted are provided in Table 3.1. Information on the 77 ‘contacts’ who ‘disappeared’ or declined is provided in Appendix 2.

The reason for the choice of the Framework Method was to provide the maximum transparency of analytic process and to provide an audit trail. This was found to be very effective and data could be easily tracked back to the original source. Every step of the analytical process is detailed, including the changes in the Framework Theme structure (section 3.7).

Data in the form of Categories is included in Appendix 3.
Feedback

Cresswell (2009) discusses ‘member checking’. Lewis and Ritchie (2003) refer to “Member or respondent validation” (p.276). It was decided the conceptual article ‘A model of organisational dysfunction in the NHS’ (Pope and Burnes, 2013) would be sent pre and post publication, to individuals to get their opinions, and test the conclusions. The feedback from the individuals is detailed in Appendix 4.

3.4.6 Generalisation from qualitative research

Denscombe (2007) uses the terms “Generalizability (or transferability)”. He describes this topic in qualitative research as a ‘thorny issue’. Transferability is

“...an imaginative process in which the reader of the research uses information about the particular instance that has been studied to arrive at a judgement about how far it would apply to other comparable instances” (p.299).

The researcher is required to supply relevant details and “... information enabling others to infer the relevance and applicability of the findings (to other people, settings, case studies, organisations etc.)” (p.299, italics in original).

Cresswell (2009) defines ‘generalizability’ as the “...external validity of applying results to new settings, people, or samples” (p.190) and considers that ‘generalizability’ is “...a term that is used in a limited way in qualitative research” (p.192).

It is the view of Lewis and Ritchie (2003) that

“...generalisations can be drawn from qualitative data in relation to the parent population from which the sample is drawn (representational generalisation); about other settings in which similar conditions to those studied may exist (inferential generalisation); and as a contribution to generative or enhancing ideas and theories (theoretical generalisation)” (p.277).

There are, however, “...strict limits on what can be generalised”, and also “...variations in the level of certainty that can be attributed to the inference” (p.277). There are important principles which can be “...broadly summarised under four broad headings: full
and appropriate use of the evidential base; display of analytic routes and interpretation; research design and conduct; validation” (p.277, italics in original).

1) Full and appropriate use of the evidential base
   • **Use of the original data.** Generalisation will be strengthened by making “...full use of the original data”.
   • **Encompassing diversity.** “One of the key roles of qualitative research is to identify and display range and diversity” (p.277). They refer back to earlier texts covering diversity of samples and whether they are representative of the larger population. “The selection of participants needs to be monitored carefully to ensure the final sample meets the requirement for diversity and symbolic representation” (p.107).
   • **Nature not number.** “The inference that can be drawn from qualitative data concerns the nature of the phenomenon being studied but not its prevalence or statistical distribution” (p.277).

2) Display of analytic routes and interpretation
   • **Level of classification.** As a general rule “...higher levels of aggregation of categories are more likely to be transferrable in representational terms than more specific or individualised items” (p.278). However, “...the analytic routes to these need to be made explicit (p.278).
   • **Assigning meaning and interpretation.** “...the more a researcher places his/her own meaning or interpretation on a finding as a basis for generalisation, the more open it will be to questioning and review by others” (p.278). The “...display of the meanings and interpretations assigned is important” (p.278).

3) Research design and conduct
   • **Checks on research design and conduct.** The researcher must be “...vigilant about any features of the research design or conduct that might limit the nature and power of the inference drawn” (p.278). Checks need to take place under the terms of ‘reliability’ and ‘validity’.
   • **Display of research methods.** “A full description of the design and conduct of the research will allow others to assess the research methods used and any limitations they hold” (p.278).
• **Noted limitations.** “...it is important for researchers to note any limitations that they themselves encounter or consider” (p.278). This is to apply to both the research and analysis process. “Documentation of these will help the user of the research to understand the boundaries of the evidence in terms of any wider inferences that can be drawn” (p.278).

4) **Validation**

• **Validation of the inference.** “Once a finding appears open to generalisation, then checks against other evidence and corroboration from other sources are highly desirable” (p.278).

All of the principles apply to the three forms of generalisation of ‘representational’, ‘inferential’ and ‘theoretical’.

### 3.4.7 Ethical considerations

Due to the in depth and unstructured nature of qualitative research it is considered that “...ethical considerations have a particular resonance in qualitative research studies” (Lewis, 2003, p.66). The opinion of Gray (2009) is that “The central ethical issue surrounding data collection through interviews is that participants should not be harmed or damaged in any way by the research” (p.391). Also, “A key ethical consideration is that of informed consent” (p.392). Berg (2006) writes that informed consent means “…the knowing consent of individuals to participate as an exercise of their choice, free from any element of fraud, deceit, duress, or similar unfair inducement or manipulation” (p.78). It is the view of Denscombe (2007) that “Social researchers should be ethical” (p.141), and that researchers should respect the “…rights and dignity” of the participants, “…avoid any harm to the participants” and “…operate with honesty and integrity” (p.141).

The researcher has at all stages of the research been open and honest about all aspects of the research study. At no time has deception or manipulation been used to elicit information, and at no time has pressure been applied to force anyone to take part.

It was recognised that the topic of negative behaviour in organisations and the responses was sensitive. Ethical permission was gained from the university prior to the pilot
interview taking place and there was consideration of any risk to the participants and impact on their welfare (Berg, 2006).

Relevant information was provided about the researcher and the study through the formal research letters (Appendix 5). All interview participants were given opportunities to ask questions by e-mail or phone.

Initially it was ensured that the participants taking part in the interviews and the focus groups understood they could withdraw at any point. Regarding the interviews, as stated later in this thesis, they did not need any encouragement to leave, so this was stopped. It was, however, clearly stated for all the focus groups that people didn’t have to take part and could leave at any time, or call a halt to the focus group, if they wished.

All face-to-face interview participants were asked to sign the consent form (Appendix 6). The people undertaking e-mail or phone interviews were asked to simply type their name on the e-mail consent form. They were not asked to send a hard copy back as this may have deterred them from taking part (Denscombe, 2007).

A commitment was made to confidentiality on the consent form (Appendix 6).

“All the information collected will be anonymised and all personal data will be kept confidential to the Chief Investigator (Rachael Pope). The academic supervisors will have access to all of the anonymised data.”

To maintain confidentiality and protect anonymity, the roles of participants are not listed alongside the main data within the thesis. This meant that no particular comparisons could be made between different roles. It was, however, considered that keeping confidentiality was of the utmost importance.

As described by Berg (2006) it is more difficult to maintain confidentiality when other participants are in the same room in a focus group. Berg suggests using a signing of a group agreement for maintaining confidentiality. The researcher chose not to do this as this was completely unenforceable. Instead, at the start of each focus group a request was made for all participants to maintain confidentiality so that people were able to speak freely. The group went forward on the basis of trust.
3.5 Research design

The process of the preparation, planning and conducting the research was extremely lengthy, difficult and frustrating. There was a constant change of research design and plan due to the ongoing practical problems encountered in gaining ethical approval. This particularly related to difficulties regarding contact with the NHS ethics committee, but also trusts wanting large payments for access to staff.

To address and achieve the research objectives the initial intention was to conduct individual interviews with Chief Executive Officers (CEOs), Risk Managers (RMs), Staff Side (SS) Chairs and trade union Full-time Officers (TU FTOs) who had substantial experience of working in, or with the NHS. These were chosen to reflect a range of people from very different backgrounds who may have the knowledge, experience and insight to provide answers to the research questions/requests for information (Appendix 6). They would probably also have very different attitudes, approaches and insights e.g. managerial in contrast to trade unions, to enable a fuller picture of what was happening to be gained. It was considered that the RM role would perhaps reflect a more ‘middle’ position in contrast, and provide balance to the CEO and TU position. It was also expected that they would at least have some interest in organisational risk in relation to negative behaviour between staff as part of their official role. The aim was also to interview some individuals who were external to an NHS organisation, but who had substantial experience of the NHS in some way.

Arrangements were made for a focus group of NHS trade union representatives from different trade unions at a workplace conference in November 2010. The conference was considering workplace health and safety concerns across different work sectors. This focus group was going to be used as a tool to assist in planning future interviews. The aim was also to gain a broader range of information and to trigger new lines of thought not picked up within an interview situation (Bryman, 2008). Permission had been gained from the conference committee to conduct the focus group. Ethical approval was, however, not given by the university (22 October 2010) as the participants were NHS employees, and the focus group due to be held in November of 2010 had to be cancelled.

The initial emphasis on individual interviews was adjusted after conversations with a risk manager (RM). It was suggested that interviews would not be practical and a focus group would be more suitable. It was also considered to meet the needs of the participants, in
that people would gain from hearing the views of others. The opinion was also given that people would not be able to/wish to undergo an interview of 45-90 minutes due to their heavy workloads. A letter was written to the chair of the professional group via a risk manager to assess whether such a focus group would be, in principle, a possibility in the future.

An FTO of one of the main trade unions was also approached to discuss the potential for interviewing an FTO and also an experienced SS Chair from that trade union. They reasoned that they could not possibly undertake an interview of such a length due to work pressures, asking for a questionnaire instead. It was suggested a questionnaire could be completed electronically. The person agreed to this saying they would be happy to follow-up with a phone call if there were any queries to explore. They also considered that a SS Chair would also prefer to complete a questionnaire.

Due to the ongoing problems of getting ethical approval a decision was made to completely withdraw from the NHS, even though this would make it far more difficult to get access to the necessary individuals. The research design was altered to contact Ex/Retired NHS employees, Ex/Retired NHS Trade Union representatives, Trade Union Full-time Officers (TU FTOs) who have had substantial experience of working with the NHS, and people external to the NHS who have had substantial experience of working with the NHS e.g. workforce consultants. A second ethics application was submitted on 8 November 2010 to the university ethics committee. Though this research proposal was not the first choice and therefore not ideal, it was felt that there was no other alternative. University ethical permission to conduct the research was given on 6 December 2010.

A pilot interview took place on 10 December 2010. Consideration was given as to whether details of the questions would be given to the participants. On this occasion they were not. The person was asked before the start of the interview whether they would have liked to have seen a copy. They responded that they would not, as it would have worried them, and that they preferred to go straight into the interview. At the end of the interview this response was checked, and they responded in the same way. This was an unexpected response. As a result of this it was decided to give each face-to-face interview participant the choice of whether they wished to receive a copy of the basic questions (Appendix 6) prior to the interview. It was also decided to send a copy of the consent form to each person to consider before the meeting, even though they would be
provided with a copy to sign at the interview. The aim was to give as much prior involvement and choice to the participant as possible.

Much consideration was given to the balance of participants, also whether the researcher should interview ex-employees linked with her own Trust. This had to be balanced against the difficulties of contacting ex/retired NHS employees. In the final outcome only one of the participants, the pilot interview, was from the researcher’s previous organisation.

The main focus around the choice of participants was that they should have substantial experience of working in, or with the NHS, and would be in a position to answer the research questions/requests for information (Appendix 6). Efforts were made to get people in different roles from different trusts across different NHS regions. A broad perspective was wanted, from as large a geographical area as possible. The final outcome was input from all the four UK countries.

The pilot interview provided some learning points and highlighted things that needed to be changed. It had been assumed that the participant would understand the term negative behaviour due to their role. This however was not the case. The term negative behaviour should have been clarified before the interview. A definition and explanation was therefore included at the top of the questionnaire document for future interviews. Some questions were not asked by the researcher due to anxiety regarding being too directive with questioning. This resulted in having a follow-up phone call to explore further issues. The recording for both parts of this interview were audio recorded and the outcome was very clear. This supported the possibility of being able to conduct phone interviews if face-to-face interviews were practically very difficult.

A questionnaire was sent to the TU FTO who did not wish to be interviewed face-to-face due to workload constraints, but who had agreed to complete an electronic questionnaire (Later cancelled due to the transfer of Universities).

In 2011, due to a number of reasons, the research studies were transferred to Manchester Business School. Approval for the research to commence was given on 9 August 2011. A different view was taken by Manchester Business School regarding the previous proposal to undertake the focus groups of trade union representatives at a workplace conference and risk managers belonging to a regional forum. On the basis that
agreement was gained from the conference committee and the regional organisers, as adults with choices of participation and of being able to be silent in the focus group, permission was given. Arrangements were made to undertake these focus groups.

The researcher was then surprisingly informed on 29 September 2011 that there had been substantial changes to the NHS research ethics committee procedures, which meant that NHS employees could be interviewed without NHS ethical permission.

Manchester Business School then gave their permission to contact staff directly employed by the NHS. This inclusion caused a major change in the direction of the research study. It was now possible after more than 16 months of attempting to gain ethical approval to interview current NHS employees.

3.6 Data Gathering

3.6.1 Research participants

The research that took place was very dependent on the specific situation of the individual e.g. geographical location, and their preference regarding the method.

The sample of participants was influenced by a number of factors and requirements:

- Key requirement for substantial experience of the NHS
- A range of staff across clinicians and managers
- A broad spectrum of roles
- Trade union and non-trade union experience
- People external to the NHS, who perhaps could view the situation more objectively
- People from a wide geographical area, multiple Strategic Health Authority regions, and the different countries of the UK
- Information from individuals and groups
- Practical issues regarding access

The interview participants were twenty-three women and twenty men (Table 3.1). Twelve had some sort of trade union role. Most of the interviews (28 people) were
conducted purely via e-mail. The mediums of face-to-face and telephone were also utilised. Every individual taking part in a semi-structured interview was asked to complete a consent form (Appendix 6, section 1). The participants were contacted through direct contact, via a third party, through national and regional organisations and on three occasions, through other participants. Three of the interviewees were also participants in the sixth ‘speed networking’ focus group. Some of the contacts were completely accidental e.g. someone happened to be part of a keep fit group, of a third party. The researcher took every opportunity to ask people to take part in the research who were completely unknown e.g. a friend of a friend, of a friend, on the other side of the country.

<table>
<thead>
<tr>
<th>Role (Not in same order as listed in the analysis in order to protect identity)</th>
<th>Method</th>
<th>Union role</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nursing Assistant</td>
<td>Face-to-face, hand written notes (refused recording)</td>
<td>TU (C)</td>
<td>Workplace conference</td>
</tr>
<tr>
<td>2. Ex Nursing Assistant</td>
<td>Face-to-face and telephone</td>
<td>TU (C)</td>
<td>Direct contact</td>
</tr>
<tr>
<td>3. Ex Physiotherapist</td>
<td>E-mail</td>
<td>TU (B)</td>
<td>Direct contact</td>
</tr>
<tr>
<td>4. Doctor/Clinical governance</td>
<td>Telephone and e-mail</td>
<td></td>
<td>Via third party</td>
</tr>
<tr>
<td>5. Senior Manager (Ex Nurse)</td>
<td>E-mail</td>
<td></td>
<td>Via third party</td>
</tr>
<tr>
<td>6. Full-time Officer</td>
<td>E-mail</td>
<td>TU (B)</td>
<td>National TU office</td>
</tr>
<tr>
<td>7. Ex Full-time Officer</td>
<td>E-mail</td>
<td>TU (B)</td>
<td>Direct contact</td>
</tr>
<tr>
<td>8. Full-time Officer</td>
<td>E-mail</td>
<td>TU (B)</td>
<td>National TU office</td>
</tr>
<tr>
<td>9. Full-time Officer</td>
<td>E-mail</td>
<td>TU (C)</td>
<td>Regional TU office</td>
</tr>
<tr>
<td>10. Full-time Officer</td>
<td>E-mail</td>
<td>TU (D)</td>
<td>National TU office</td>
</tr>
<tr>
<td>11. Full-time Officer</td>
<td>E-mail</td>
<td>TU (E)</td>
<td>National TU office</td>
</tr>
<tr>
<td>12. Full-time Officer</td>
<td>E-mail</td>
<td>TU (E)</td>
<td>National TU office</td>
</tr>
<tr>
<td>13. Full-time Officer</td>
<td>Face-to-face, hand written notes and recorded</td>
<td>TU (E)</td>
<td>Workplace conference</td>
</tr>
<tr>
<td>14. Non NHS Strategic advisory role</td>
<td>Face-to-face and e-mail</td>
<td></td>
<td>Via third party</td>
</tr>
<tr>
<td>15. Staff nurse (Physical Service)</td>
<td>E-mail</td>
<td></td>
<td>Via third party</td>
</tr>
<tr>
<td>16. Nurse (Mental health)</td>
<td>E-mail</td>
<td>TU (A)</td>
<td>Direct contact</td>
</tr>
<tr>
<td>17. Senior manager (Ex</td>
<td>Face-to-face x 2 and e-</td>
<td>Direct contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Contact Method</td>
<td>Method of Contact</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------</td>
<td>---------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>18</td>
<td>Ex Chief Executive</td>
<td>E-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>19</td>
<td>Ex Chief Executive and other roles within/linked to NHS</td>
<td>E-mail</td>
<td>Conference</td>
</tr>
<tr>
<td>20</td>
<td>Ex Chair</td>
<td>E-mail</td>
<td>Via third party</td>
</tr>
<tr>
<td>21</td>
<td>Doctor</td>
<td>Telephone</td>
<td>Via third party</td>
</tr>
<tr>
<td>22</td>
<td>Psychologist</td>
<td>E-mail and telephone</td>
<td>Direct contact</td>
</tr>
<tr>
<td>23</td>
<td>Psychologist</td>
<td>E-mail and telephone</td>
<td>Direct contact</td>
</tr>
<tr>
<td>24</td>
<td>CEO</td>
<td>e-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>25</td>
<td>CEO</td>
<td>e-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>26</td>
<td>CEO</td>
<td>e-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>27</td>
<td>CEO</td>
<td>e-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>28</td>
<td>CEO (Acting)</td>
<td>e-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>29</td>
<td>CEO</td>
<td>E-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>30</td>
<td>CEO</td>
<td>E-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>31</td>
<td>Assistant Director of Workforce Development on behalf of CEO</td>
<td>E-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>32</td>
<td>Director of Public Health</td>
<td>Telephone</td>
<td>Direct contact</td>
</tr>
<tr>
<td>33</td>
<td>Director of Public Health</td>
<td>E-mail and telephone</td>
<td>Direct contact</td>
</tr>
<tr>
<td>34</td>
<td>Doctor/Consultant</td>
<td>E-mail and telephone</td>
<td>Direct contact</td>
</tr>
<tr>
<td>35</td>
<td>Doctor/Consultant</td>
<td>E-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>36</td>
<td>Ex Social worker in Social Services</td>
<td>Face-to-face</td>
<td>Direct contact</td>
</tr>
<tr>
<td>37</td>
<td>Physiotherapist</td>
<td>E-mail</td>
<td>Direct contact</td>
</tr>
<tr>
<td>38</td>
<td>Senior Nurse Manager</td>
<td>E-mail</td>
<td>Workplace conference</td>
</tr>
<tr>
<td>39</td>
<td>Ex HR manager</td>
<td>E-mail</td>
<td>Workplace conference</td>
</tr>
<tr>
<td>40</td>
<td>Senior manager</td>
<td>E-mail</td>
<td>Workplace conference</td>
</tr>
<tr>
<td>41</td>
<td>Senior manager (Ex midwife)</td>
<td>Face-to-face</td>
<td>Workplace conference</td>
</tr>
<tr>
<td>42</td>
<td>Representative of external organisation</td>
<td>E-mail and telephone</td>
<td>National organisation</td>
</tr>
<tr>
<td>43</td>
<td>Representative of external organisation</td>
<td>E-mail</td>
<td>National organisation</td>
</tr>
</tbody>
</table>

Table 3.1 List of 43 research participants
Thirty-one of the interview participants came from thirty-one different organisations. Many of these people have worked previously in other organisations in the NHS. The trade union officers and the other more external roles (12 people) were linked to and worked with multiples of organisations, some at regional or national levels across the UK.

Seventy-seven other people/organisations were contacted in the ongoing attempt to provide a broad spectrum of participants. Often people stated that they would take part, but then did not do so. A few declined (Appendix 2).

Further to the main research (between 2013-2015) when people who were or had been NHS employees, or had some contact with the NHS were met/contacted, the researcher asked them to provide a 3 word summary’ of the culture. Most were unknown to the researcher. These contacts were made in a variety, mainly accidental ways e.g. on a train, aeroplane and a tram, in a cafe, at conferences, on holiday, in a church and a doctors surgery. A few were contacts of friends or acquaintances. These thirty people and the twenty-eight contributions represented a further twenty-nine different organisations in excess of the multiples of organisations for the main participants. Many had worked in multiples of organisations during their careers in the NHS.

3.6.2 Interviews

The interview questions were based upon the literature review and the concepts of organisational silence, normalised organisational corruption, and protection of image/ego-defences, and the theory of selective moral disengagement.

Several questions had been tested with permission at a workplace conference. This involved mainly trade union representatives from a variety of trade unions on two occasions, over the previous two years. This was extremely helpful to the researcher and resulted in the questions being amended. Following the pilot interview the interview questions were changed to include a question about the role of HR managers (Appendix 6, section 1). This was due to the focus of the participant in the pilot interview.

The first eleven participants were taken through the interview format as detailed in Appendix 6, section 1. This was amended after this to a more open interview structure, with more flexible follow-up questions (Appendix 6, section 2). This was triggered by
conducting an interview with a representative of an external organisation. The second stage of the interview used the scenario as already described in Appendix 6 (section 1). The data was such good quality that the researcher continued to use a more open structure. This was a definite learning point for the researcher. It was discovered that a list of structured questions is not necessarily required to produce extremely relevant and interesting data. The interviews then flowed more naturally and were less stilted. They were also then led more by the participant, rather than the researcher.

The consent form (Appendix 6, section 1) was also amended, to ask people to agree to not sending the interview e-mails to any third party, or to share the interview record with any third party. This was for protection of both parties and to prevent information being sent to other possible participants, which would then undermine the research (Kazmer and Xie, 2008).

There was a further change when contacting the chief executives. It was recognised that CEOs are extremely busy and that the requests for information would have to be further simplified (Appendix 6, section 3). Even then some of the CEOs gave only minimal responses. In contrast, others gave quite comprehensive information. After finding out the name of the CEOs, the initial contact was always through the personal assistants or equivalent, requesting their assistance. It was interesting that sometimes the people at the hospital switchboard did not know the name of the CEO, as there was such a change of personnel at CEO level. Only two of the CEOs were asked to share their thoughts on the scenario and only one of those did so.

To avoid any bias the researcher only contacted organisations which were completely unknown to the researcher. Trusts that had been in the press were deliberately avoided. The organisations in England, Scotland and Wales were chosen on the basis of ensuring a broad geographical area, different health regions, and to include both rural and more urban areas.

Of the possible 256 CEOs (Appendix 2) in England, Scotland and Wales, forty-five were contacted, representing a sample of 17.6%. Of the forty-five, eight responded (17.7%). As eight CEOs had responded no contact was made with CEOs in Northern Ireland as there were already a large number of participants in total.
The forty-three interviews were of varying length due to different roles and individual circumstances. For one person it was considered only suitable to go through some of the interview format and use the scenario to explore the issues. This was due to the fact that the person had refused to be recorded in a face-to-face situation and there was limited time. Every person, however, was asked for their thoughts on the culture of the NHS and requested to provide three words in summary to describe the culture. This open request at the beginning of the interview (also applicable to the focus groups) was there to encourage response, but also to give the participant an opportunity to provide positive information about the culture. The ‘3 word’ summary was used to assist in setting the overall Framework Themes.

The initial e-mail interviews using the interview format (Appendix 6, section 1) were conducted in three main stages to avoid the participant from being daunted by the prospect of the response (Bampton and Cowton, 2002). This however, was soon reduced to two stages on the feedback of one of the earliest participants. They felt it made the process more difficult, and that it was ‘easy to forget’. This is in line with the views of Bampton and Cowton (2002) and the fatigue that is experienced if given too many ‘episodes’. Once the more open interview format (Appendix 6, section 2) was used, which was also in two stages, the problem was resolved.

As well as the initial contacts by e-mail, and sometimes telephone to build a rapport, a formal research letter was sent to each participant. This letter outlined the three stages [later 2 stages] of the process (Appendix 5). The research letters were however adapted to different individuals, different roles and took account of the different situations e.g. face-to-face, telephone elements. Through the more informal communication people had chosen how they would like to respond and the letter adapted to reflect that choice.

The researcher initially used her home e-mail address on the formal letter. One of the participants however, challenged that and suggested the use of the university e-mail address so that the affiliation was clear. This was particularly helpful feedback at that part of the process as the CEOs were about to be contacted. The address was changed and it may have had an influence on the response, which was better than the researcher expected.

Immediately following the sending of the formal research letter for the e-mail interview, the participants were sent another e-mail thanking them again for their willingness to
take part, as well as including some basic points/instructions. Details around choice of embedded or attached questions, and also informing them they could withdraw at any time from the research process.

As some people were disappearing after agreeing to take part, despite efforts to retain them, that instruction was removed. They obviously didn’t need any encouragement to disappear. At first the researcher was very anxious that everything should be done absolutely correctly, and was probably over prescriptive about instructions. It also perhaps appeared slightly patronising. As the interviews progressed the researcher became a little more relaxed and less pedantic; another learning point.

The first stage of the interview was initially sent embedded in the e-mail, to enhance ease of response (Meho, 2006). The first person to respond questioned the way to respond therefore it was decided to give a choice of ‘embedded’ or ‘attachment’, whichever they preferred (Kazmer and Xie, 2008). It is the view of Kazmer and Xie (2008) that “...participants should have as much choice as is methodologically feasible” (p.273), both for the medium e.g. face-to-face, telephone or e-mail, and within the medium e.g. embedded or attachments for responses.

Depending on the amount of information being given before the formal stage of the telephone or face-to-face interview process, information was shared with the participant from a pre-written protocol/script (Berg, 2006).

3.6.3 Focus groups

At the beginning of every focus group a protocol/script was used to provide general information and guidelines of how the focus group would be conducted (Berg, 2006). None of the focus group participants were asked to complete a consent form as they had the choice to be silent, they had chosen to attend and there was no record of a name unless they gave it to request a summary of the findings of the research.

They were also asked to complete an initial written section about the culture of the NHS and a ‘3 word’ summary. The purpose of this was to encourage the individual to have their own thoughts about the topic before getting into a group situation (Berg, 2006). It also gave an opportunity to provide positive information about the culture of the NHS.
They were also asked to comment on the scenario in writing. These written responses were included in the research data gathering.

In November 2011 the first focus group (FG 1) was conducted at a workplace conference with a group of six trade union representatives from two trade unions within the NHS (Table 3.2). These people were from four NHS trusts and four regions across the UK. One person was from an acute setting and five from a mixture of community services, mental health and learning disability.

In December 2011 a second focus group (FG 2) was conducted with eight people working in the area of risk management/quality assurance in some role, in the NHS. They were from eight different organisations across one region. Three people were from an acute setting and five from a mixture of community services, mental health and learning disability.

Further follow-up questions were sent to this focus group via e-mail to one of the group asking follow-up questions. Through the same contact a request via e-mail was also made for others working in the field of risk management to contact if they would be willing to take part in the research study in the form of undertaking an e-mail interview (13 December 2011). There was no response so another e-mail was sent. The feedback was that the original emails were re-sent in January 2012, via one of the group, but again there was no response. Though the participants in the focus group had been very happy to share information in that environment, they appeared not to want to provide any more information. The reasons for that are unknown.

It was also decided to alter the scenario after this focus group. The participants of the focus group had asked some personal questions in response to the scenario. The scenario had been partly written in the first person. It was considered that the first person references should be removed for future interviews to attempt to ensure that the focus did not shift towards the researcher.

The quality of the data from the first two focus groups was extremely interesting and thought provoking so it was therefore decided to conduct further focus groups. Similar to the interviews the interviewing format for the focus groups was at this stage amended to be more open (Appendix 6, section 2)
A third focus group (FG 3) with ten trade union representatives, and one FTO from one union, but from different organisations across one region, took place in April 2012. There were follow-up questions with one person and also one e-mail response from a further representative. The reason for choice of this group was to get a perspective from a much younger age group and people from different organisations.

The fourth focus group (FG 4) in June 2012 consisted of four occupational health professionals at manager and director level from four organisations. These professionals worked with multiples of organisations. Through this focus group contact was made with a further group of four people working for an organisational support team (FG 5). This focus group of four people in July 2012 included a psychologist, psychotherapist, occupational health professional and counsellor.

The final and sixth focus group (FG 6) took place at a manager’s conference in November 2012. It was a ‘speed networking’ environment. This meant that every twenty minutes for one hour the people changed tables. Six people attended in total, all from different organisations. Five people were managers and one person a trainee manager. Sadly, there was a disaster with the first recording. A clear case of operator error! The two affected people spontaneously decided to stay on to input their information again. Three of this group of six, a senior manager, senior nurse manager, and an ex HR manager agreed afterwards to take part in a follow-up interview via e-mail. They are part of the forty-three individual interviews undertaken.

It is recognised that for FG 1 and FG 6 there would be a self-selection bias as this was within a workplace conference which gave delegates a choice of activity. The other focus groups however, though still having a choice to participate or not, took place within their existing and routine meeting arrangements e.g. regional forums.

<table>
<thead>
<tr>
<th>Focus Groups</th>
<th>Date</th>
<th>Number</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trade union representatives</td>
<td>November 2011</td>
<td>6</td>
<td>Individual written responses and group recorded at workplace conference.</td>
</tr>
<tr>
<td>2. Risk manager, quality assurance roles</td>
<td>December 2011</td>
<td>8</td>
<td>Individual written responses and group recorded. No response to follow-up questions via e-mail. Regional forum.</td>
</tr>
</tbody>
</table>
Table 3.2  Focus groups conducted between November 2011 and November 2012

The research of semi-structured interviews and focus groups were conducted between December 2010 and December 2012.

3.7 Analysis using the Framework Method

There was no formal attempt to analyse the data until October 2012. The reason for this was an early conscious decision not to ‘fix’ anything within the data. There was a concern that data would be distorted by starting to fit the later data into what had already been collected, rather than let the whole picture set the direction of analysis. However, as the data was collected, the ‘summary’ words/phrases used to describe the NHS culture were put onto a large board and considered. There was also an initial brain storm of themes that were emerging. Again, this was put on a board where it could be easily visualised, so assisting the thought processes. Interesting descriptive phrases and metaphors used in the interviews and focus groups were also listed and highlighted in italics.

The data collected either through e-mail, telephone or face-to-face interviews and the focus groups was transcribed verbatim and read and checked for accuracy a minimum of three times. Further reading took place to provide greater familiarisation with the data. Obvious expressions of emotion and stressing of meaning was included in the transcripts, as well as any long pauses.
It was decided to also make summary notes to assist in the reading of the transcripts. The wordings of these summaries were kept as close as possible to the original words, except when minor changes were made to protect identity. In hindsight other than the benefit of getting greater familiarisation with the data this material was not referenced to, or as helpful as initially expected. This is probably due to the effectiveness of the tracking process. It was a time consuming process and in hindsight perhaps a waste of valuable time.

Initially numerical indexing was used, but eventually during the process of refining and simplifying of the Framework Themes, descriptive indexing was used to identify the themes on the transcripts (Ritchie and Spencer, 1994). Due to the ongoing refinement of the Framework Themes the use of descriptors caused less disruption to the spread sheet format that was being used for the input of data.

Some of the Framework Themes were based upon the literature review e.g. ‘Raising concerns/communication’, ‘Negative behaviour’, ‘Selective moral disengagement/ego-defences’. There were also analytic Themes which came from the groupings of the ‘3 words’ used to describe the culture of the NHS and the accumulating data e.g. ‘Structure/form/groups’; ‘Hierarchical/top down/power’; ‘Change/variable’; ‘Finance/business/targets’.

Initially the Framework Themes with sub themes were:

1. Culture 1a, with the sub themes of: ‘Structure/form/different groups’; ‘Positive characteristics’; ‘Hierarchical/top down/power’; ‘Bureaucracy/policies’
   Culture 1b: ‘Finance/business/target driven’; ‘Change/variable’; ‘HR/other roles’;
   ‘General dysfunction/lack’
2. ‘Raising concerns’: ‘Raising concerns’; ‘Organisational responses/reasons’;
   ‘Other/stories’.
3. ‘Negative behaviour’: ‘Negative behaviour’; ‘Organisational responses’;
   ‘Reasons/motivations’; ‘Scenario’
4. ‘Other’: ‘Self-interest/reward’; ‘Selective moral disengagement (SMD)/Ego-defences’; ‘Relationships/protective alliances’; ‘Other’
5. ‘Actions’: ‘Leadership and management’/HR/ ‘Non-executive’; ‘Staff/TUs’;
   ‘Politicians/patients/public’
The second sub theme was ‘Positive characteristics’. That was deliberately placed second on the chart to remind the researcher that there are positive characteristics to the culture of the NHS. With the world view of the researcher, and the obvious negative slant to the research study, it was too easy to focus on the negative information. Deliberate attention was given to focusing on the positive.

As the data was considered changes and adjustments were constantly being made to ensure that the Framework Themes best reflected the data.

The data was summarised on the spreadsheets then further reduced to the Key Elements and then further refined into the Categories and Classes (Ritchie et al, 2003).

In this process it was considered that the sub themes of the Framework Themes ‘Raising concerns’ and ‘Negative behaviour’ were not helpful, were somewhat artificial and very entwined and overlapping. It was therefore decided to integrate the material on the spreadsheet back into chronological order, into one theme. The sub themes of ‘Self-interest/reward’ and ‘Relationships/protective alliances’ as they very much overlapped, were also combined, as were the sub themes on possible ‘Actions’. Most of the actions were around expectations of leadership and management of organisations. It was considered that these changes resulted in a better flow of data, didn’t result in fragmentation that served no positive purpose, and avoided any unnecessary duplication.

The sub themes under the headings of ‘culture 1a and 1b’ as described in the above list were also altered due to the vast amount of data and the complexity of it. The decision was then made to simplify the process into a larger list of Framework Themes:

1. Structure/form/groups
2. Positive characteristics
3. Hierarchical/top down/power
4. Bureaucracy/policy
5. Finance/business/targets
6. Change/variable
7. HR/other roles
8. General dysfunction/lack [Later altered to ‘General lack/dysfunction’]
9. Raising concerns/communication
10. Negative behaviour
11. Self-interest/relationships
12. Scenario
13. Selective moral disengagement/ego-defences
14. Actions

The one section that constantly caused the researcher problems throughout the process was the theme of ‘General dysfunction/lack’. This theme came out of the words used to summarise the culture. This heading caused a problem because other than the small amount of positive data, all of the data could be placed into this theme. It was almost like having a huge bin that everything could be thrown into. Much consideration was given as to whether or not to remove this theme. There was however data that didn’t fit into the other sections. Some data which obviously fitted within other sections was removed.

It was still considered there were ‘grey areas’ around this, but the decision was made to continue with this theme with its limitations. The title was changed to ‘General lack/dysfunction’, with a slightly different emphasis of general lack, inadequacies and dysfunction.

Once the data had been put onto the spreadsheets and reduced into the Key Elements and refined into the Category stages it was transferred to a table format for presentation of the data.

In the Framework Method there is a choice at how much initial summarisation takes place. It was decided to keep very close to the original transcript for that first stage, to prevent unnecessary returning to original text. The move to the Key Elements stage also stayed very close to the wording. It was only as it progressed to the Categories (Appendix 3) and grouping of Categories into Classes (Lower Level and some Higher Level Classes – Appendix 7) did the process become somewhat more conceptual and abstract. At the Category stage the choice is made regarding the level of abstraction of the data. The researcher chose to stay close to the sense of meaning in the data, with some abstraction. Every effort was made to retain what was considered critical wording to maintain meaning to be able to provide explanations.

As a secondary part of the analysis interesting descriptive words, phrases and metaphors were identified in italics. This process was not intended to be exhaustive, but to enhance the main analysis. The marking in italics was transferred to the Categories and Classes.
Elkind (1998) used metaphors to “…read the organisation of the NHS” (p.1715). “Utilising metaphor enables us to appreciate and interpret the paradoxes and ambiguities in the organisational life of the NHS” (p.1725). Learmonth (1999) studying text written by an NHS CEO employs metaphor “…to encourage thinking outside the accepted paradigms conventionally used to examine management” (p.1002).

Reading the work on the use of metaphors in the presentation of data by Tracy et al (2006) was the trigger to include this in the analysis. Their work on bullying experiences titled “Nightmares, demons and slaves: Exploring the painful metaphors of workplace bullying” seemed particularly relevant considering the topic of this research thesis. Metaphors can “…articulate and explore the emotional pain of workplace bullying and, in doing so, helps to translate its devastation and encourage change” (p.148).

The purpose of the use of metaphors in this thesis is to provide a greater richness and depth of understanding and meaning beyond the Thematic Framework analysis. If the meaning is enhanced there is also hope this will encourage a movement towards change.

During the process it was also decided that further consideration would be given to all the examples of ‘Rationalisations/justifications’ (marked in bold, R&J) and to all the references to ‘fear’ and similar words such as ‘scared’ and ‘anxiety’, which were underlined. These references and examples were then considered in greater depth.

Further consideration was also given to the specific references to the actual word culture, what people don’t want, underlying assumptions/beliefs and further observations on power and behaviour.

The order of participants in Table 3.1 is different to the order of the material displayed in the Categories tables (Appendix 3) to protect identity. It was also decided that no data would be marked with the role of the person (with the exception of the ‘3 word summaries’ and the broader terms for roles used with the main quotes in the findings chapter), so there would be further protection of identity. It also provided a situation where no prejudice could be applied to the roles, and the data would hopefully be accepted by the reader for what it was. The researcher wanted to avoid the data being tainted by preconceived judgements based upon perceptions of hierarchy or status. As shown through the research the NHS is a very hierarchical, status driven organisation, where some staff and their views appear to be more valued than others. The primary
concern was to adequately reflect the different threads and aspects of the data collected to provide possible explanations for organisational and individual behaviour.

To maintain anonymity broader terms were used with the main quotes in the findings chapter. These are: clinician; senior clinician; manager; senior manager; and external participant, relating to those who are not employed by the NHS.

3.8 Research Limitations

There is the obvious limitation, as with all qualitative research, of the sample size being small. However, as already described in section 3.4.6, it is considered that some representative, inferential and theoretical generalisations can be made (Lewis and Ritchie, 2003). It is recognised though, that there are “...strict limits on what can be generalised”, and also, “...variations in the level of certainty that can be attributed to the inference” (p.277). It is, however, also considered that the research study fulfils the important principles “...broadly summarised under four broad headings: full and appropriate use of the evidential base; display of analytic routes and interpretation; research design and conduct; validation” (p.277).

As detailed in section 3.4.5 there is recognition of the possible bias of the researcher. The researcher has attempted to make it very clear the bias she brings to the research study (Lee, 1999; Cresswell, 2009). She has also attempted to be as “…objective and neutral as possible in the collection, interpretation and presentation of qualitative data” (Snape and Spencer, 2003, p.20). The choice of the systematic Framework Method of analysis has helped to prevent ‘cherry picking’ of data in line with any bias of the researcher.

As also previously highlighted, to counteract the bias of the researcher there are more participants at a senior level than at lower levels in the NHS in this study. If similar research is conducted in the future there should be more contributions from staff at the clinical and operational levels to provide a better balance of participants. Another suggestion for any future research is to use the more open interview format from the beginning of the research study. The more structured format utilised for eleven interviews and two focus groups did, however, provide a good grounding for further exploration of the issues, so might be useful for a small number of initial interviews and/or a focus group.
3.9 Summary

Chapter 3 has restated the research objectives and detailed the ontology and epistemology. The research method, the research design and process are described as is the data gathering and process of analysis using the Framework Method. The limitations of the research study are outlined. The thesis now presents the findings from the research in Chapter 4.
Chapter 4. Research findings

4.1 Introduction

The findings from the ‘3 word summary’ responses to describe the culture in the NHS are presented. In conjunction with the literature and other data being collected these assisted in forming the final fourteen Framework Themes for the process of analysis. Appendix 8 shows the grouping of these words. Following the main research people who were met, mainly accidentally, were also asked to provide a ‘3 word summary’ and these are listed in Appendix 9.

The findings from the forty-three interviews and six focus groups are presented in descriptive format to provide an overview. Interesting descriptive words, phrases and metaphors are written in italics. The analytical Lower and Higher Level Classes for each Theme are detailed in Appendix 7. Quotes attached to the different Themes are in Appendix 10.

Material is also provided from further analysis of references to ‘fear’ and other similar words indicating fear (Appendix 11), possible rationalisations and justifications (Appendix 12), specific references to the culture (Appendix 13), what people don’t want to do (Appendix 14) and possible underlying assumptions/beliefs in the NHS (Appendix 15). Sections of verbatim interview data provide further observations on power and behaviour (Appendix 16). Feedback from the article “A model of organisational dysfunction in the NHS” (Pope and Burnes, 2013) is also included (Appendix 4).

The Categories of all the Framework Themes are detailed in Appendix 3.

The main headings are:

4.1 Introduction

4.2 ‘3 word summary’ description of culture in the NHS

4.3 Overview of data from interviews and focus groups

4.4 References to fear and similar words

4.5 Rationalisations and justifications
4.6 References to the culture in the NHS

4.7 What people don’t want to do

4.8 Underlying assumptions/beliefs in the NHS

4.9 Interview data: Observations on power and behaviour

4.10 Feedback from the article “A model of organisational dysfunction in the NHS” (Pope and Burnes, 2013)

4.11 Summary

4.2 ‘3 word summary’ description of culture in the NHS

Each participant in the interviews and focus groups was asked to respond to the same statement either in writing or verbally.

“From your personal observations and experience of work situations within the NHS:

Please describe the culture of NHS organisations.

To summarise - use up to only three words to describe the culture of NHS organisations”

There are forty interview responses detailed below in Table 4.1. The participants did not always keep their responses to three words.

<table>
<thead>
<tr>
<th>Role</th>
<th>3 word summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Doctor/Consultant</td>
<td>Dysfunctional, inefficient and damaging</td>
</tr>
<tr>
<td>2 Ex Physiotherapist</td>
<td>Cost orientated</td>
</tr>
<tr>
<td>3 TU FTO</td>
<td>Bureaucratic, unstable, politicised</td>
</tr>
<tr>
<td>4 TU FTO</td>
<td>Collective, complex, effective</td>
</tr>
<tr>
<td>5 Senior Manager – Ex Nurse</td>
<td>Lack of support</td>
</tr>
<tr>
<td>6 TU FTO</td>
<td>Pressured, regressive, chaotic</td>
</tr>
<tr>
<td>7 Ex Nursing Assistant</td>
<td>Not the caring profession, too much paperwork, everything geared to computers and paperwork</td>
</tr>
<tr>
<td>8 TU FTO</td>
<td>Patient focused, pressurised, undervalued</td>
</tr>
<tr>
<td>9 Senior Manager – Ex Nurse</td>
<td>Enclosed, no synergy (within and between organisations), insular</td>
</tr>
<tr>
<td>10 Staff Nurse – Physical</td>
<td>Hierarchical, divisive, reactive</td>
</tr>
<tr>
<td>11 Strategic Advisor</td>
<td>Indecisive, (excluding clinicians and nurses on)</td>
</tr>
<tr>
<td>Role</td>
<td>3 word summary</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Representative of external organisation</strong></td>
<td>medically related matters). Poorly educated (as managers). Lack of financial expertise</td>
</tr>
<tr>
<td><strong>Ex TU FTO</strong></td>
<td>Tribal, varied, changing</td>
</tr>
<tr>
<td><strong>Doctor</strong></td>
<td>Variable, fear, unsafe</td>
</tr>
<tr>
<td><strong>Nurse – Mental Health</strong></td>
<td>Bullying, dishonest, and lack leadership</td>
</tr>
<tr>
<td><strong>Doctor/Clinical governance</strong></td>
<td>Centralised and controlling, closed, hierarchical</td>
</tr>
<tr>
<td><strong>Representative of external organisation</strong></td>
<td>Variable, committed</td>
</tr>
<tr>
<td><strong>Ex Chair</strong></td>
<td>Top down oppressive</td>
</tr>
<tr>
<td><strong>Ex CEO</strong></td>
<td>Oppressive, authoritarian and dishonest</td>
</tr>
<tr>
<td><strong>Psychologist</strong></td>
<td>Control, performance, relationships</td>
</tr>
<tr>
<td><strong>CEO</strong></td>
<td>Caring, supportive, paternal</td>
</tr>
<tr>
<td><strong>CEO</strong></td>
<td>Blame, uninspiring leadership</td>
</tr>
<tr>
<td><strong>CEO</strong></td>
<td>Variable, professionalised, rigid</td>
</tr>
<tr>
<td><strong>CEO</strong></td>
<td>Paternalistic, controlling, multi-faceted</td>
</tr>
<tr>
<td><strong>CEO</strong></td>
<td>Defensive, confused, battered</td>
</tr>
<tr>
<td><strong>CEO</strong></td>
<td>Aspirational, insular, fragmented</td>
</tr>
<tr>
<td><strong>Ex CEO</strong></td>
<td>Top-down culture, target driven and still harassing</td>
</tr>
<tr>
<td><strong>Nursing Assistant</strong></td>
<td>Bullying, stressful and ‘out for themselves’</td>
</tr>
<tr>
<td><strong>TU FTO</strong></td>
<td>Politically reactive teams</td>
</tr>
<tr>
<td><strong>Director of Public Health</strong></td>
<td>Driven not led</td>
</tr>
<tr>
<td><strong>Senior Manager – Ex Midwife</strong></td>
<td>Oppressive, incestuous, and it’s not caring for the people who work in it</td>
</tr>
<tr>
<td><strong>Ex Social Worker Social Services</strong></td>
<td>Target driven, finance orientated, resource led</td>
</tr>
<tr>
<td><strong>Doctor/Consultant</strong></td>
<td>Defensive, bullying, blame</td>
</tr>
<tr>
<td><strong>Psychologist</strong></td>
<td>Dictatorial, uncaring, bullying</td>
</tr>
<tr>
<td><strong>Director of Public Health</strong></td>
<td>Defensive, bullying, lost</td>
</tr>
<tr>
<td><strong>CEO</strong></td>
<td>Value-based, influenced, multi-professional</td>
</tr>
<tr>
<td><strong>Assistant Director of Workforce Development (on behalf of CEO)</strong></td>
<td>Caring, hierarchical, trusting</td>
</tr>
<tr>
<td><strong>TU FTO</strong></td>
<td>Oppressive, competitive, defensive</td>
</tr>
<tr>
<td><strong>Physiotherapist</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Table 4.1 Interview ‘3 word summary’ of culture in the NHS

The responses for the focus groups are listed in Table 4.2

<table>
<thead>
<tr>
<th>Role</th>
<th>3 word summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FG 1. Trade Union Representatives</strong></td>
<td>Chaotic, understaffed, disorganised, unequal</td>
</tr>
<tr>
<td>(6 people)</td>
<td>Deaf, uncommunicative, business</td>
</tr>
<tr>
<td></td>
<td>Demoralised, deskill, defeated</td>
</tr>
</tbody>
</table>
| FG 2. Risk Managers (8 people) | • Our trust is good in implementing policy, but bad in not following it  
• Saving money above patient care  
• Patchy, unmanaged, inequality  
• Variable, tolerant, un-dynamic  
• Dysfunctional, slow, creative  
• Reactive, complacent, dissilitioned [sic]  
• Caring, worried, busy  
• Closed, bureaucratic, emotive  
• Open, proactive, supportive [said later ‘supposed to be’ open, proactive, supportive. [in FG also], “I think mine’s ‘blue sky thinking’ really”]  
• Top down driven  
• Enclosed, (a) club, dedicated |
|---|---|
| FG 3. Trade Union Representatives (10 people plus 1 TU FTO and 1 e-mail response) | • Evidence-based, Busy, Professional. Hard working  
• Target-driven, un-caring, short term thinking  
• Money centred, hierarchical  
• Uncoordinated, rushed, inefficient  
• Financially constrained, paternalistic (top down)  
• Money, not patient; forget the patient  
• Hierarchical, restrictive, nursing/consultant dominated  
• Red tape (often), professional, hierarchical, resistant to change, lacking accountability  
• Quietly accepting failure, death by conservatives, high bureaucracy levels, slow to adapt. NHS organisation.......is an oxymoron  
• Hard working, compassionate, busy  
• Pressure, cuts, time |
| FG 4. Occupational Health professionals (4 people) | • Negative, demoralising, unfocused. Ignore it and it will get better. NHS struggles with helping their own staff  
• Divisive, reorganisation, poor consolidation  
• Supportive, disjointed, caring  
• Bureaucratic, clinical (focused), negative |
| FG 5. Organisational Support Team (4 people) | • Bureaucratic, hierarchical, top down  
• Market, conflict, politics  
• Changing, pressured, hierarchical, adversarial |
| FG 6. NHS Managers at workplace conference (6 people) | • Disconnected, inclusive, stressful  
• Professional – means different things to different people, centred on evidence and proof, ‘self-interest’. Defensive, hierarchical, cautious bordering on fearful  
• Defensive, ever-changing (therefore not stable leadership), ‘taken for granted’  
• Entrenched, resolute, impulsive. Exhausted. Corporate thuggery at the highest level  
• Controlling, frantic, committed  
• Overworked, helpful, stressful |
Table 4.2 Focus group ‘3 word summary’ of culture in the NHS

The above words were first re-grouped to assess the most commonly used words:
Hierarchical (x 9); Defensive (x 6); Bullying/harassing (x 6); Top down (x 5);
Bureaucracy/bureaucratic (x 5); Variable (x 5); Control (x 5); Oppressive (x 4);
Pressure/pressured (x 4); Not/un-caring (x 4); Lack (x 4); Caring (x 4).

The words were then grouped together to assist in forming the Framework Themes for
analysis under the following headings: Positive aspects/characteristics; Hierarchical/top
down; Bureaucracy; Cost/money centred; Closed/defence/resistance; Variable/changing:
Pressure/stress; Dysfunction/disorder/lack; Different groups/Other.

A further stage was to consider the words with reference to lack, and words beginning
with ‘dis-’, and ‘un-’. Also, the use of the words ‘no’, or ‘not’.

The processes detailed above all contributed to forming the final fourteen Framework
Themes for the process of the analysis (Appendix 8). The words were also put together to
form a ‘word cloud’ (Figure 4.1).
The ‘3 word summary’ contributions from the thirty extra participants reflect the responses from the main participants. There are some positive characteristics, but again most of the responses are negative. These findings are listed in Appendix 9.

4.3 Overview of data from focus groups and interviews

This section is structured in line with the final list of Framework Themes.

1. Structure/form/groups
2. Positive characteristics
3. Hierarchical/top down/power
4. Bureaucracy/policy
5. Finance/business/targets
6. Change/variable
7. HR/other roles
8. General lack/dysfunction
9. Raising concerns/communication
10. Negative behaviour
11. Self-interest/relationships
12. Scenario
13. Selective moral disengagement/ego-defences
14. Actions

4.3.1 Framework Theme 1. Structure/form/groups

A great many references were made about the top, middle and bottom layers of the NHS, with terms such as, on the floor, shop floor, coal face, top tier, top table, of the NHS. These have also been included within the ‘Hierarchical/top down/power’ Framework Theme. There were references to tiers, and layers; the NHS is “...hundreds of layers deep” with “...too many tiers”.

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The word ‘system’ was often used and there is a management structure and chain. HR is referred to as a management tool and Occupational Health a tool of HR. There are managers/management, and there are staff.

A number of interesting descriptions and metaphors were used to provide a picture of the NHS. These include a whale, shoal of fish, a vast political machine, political pawn, a huge, big monster with hundreds of different companies, and a superstructure. It is also, a “…weird dysfunctional family”, with hickey cousins going off and doing different things. There are black sheep, and organisations under one umbrella. The NHS is a citadel, train, tanker and a ship. It is also a gang, a club and a secret society. It is insular, enclosed, strange, peculiar, weird, brittle, stretched and lean. Managers alter their behaviour as in “…concentration camps during the war”.

The debate of whether the NHS was a whale or a shoal of fish took place in one of the focus groups. It was indicated that it was both. Other wildlife is mentioned; elephants in rooms, ostriches with heads in the sand, wise monkeys who do not hear, see or speak, chameleons, goldfish, a red herring, black sheep, scapegoats, snakes in tall grass, sleeping dogs people like to leave and “…wild dogs…baying for blood”. There is also “A nasty can of worms” and “…a lot of worms”. There must also be a lot of birds as there is a pecking order. There is bullshit.

The NHS is too big, the reason for just can’t turn that ship round; one monolithic organisation and employer. No one knows what is going on in the vast machine and large systems restrain. It is a leadership challenge to pull threads together.

The NHS is described as being born, beloved, respected and a national treasure. It died at the age of 52 in 2000 with the NHS Plan. It is “…fossilising, dying on its feet, breaking apart and the private sector is sweeping like vultures to pick up the juiciest pieces left over”.

It is unimpeachable with people not being allowed to criticise it. The Department of Health has tentacles which reach down into every trust controlling, which results in the “…horrible culture”. The Citadel is the notional home of a big secret, with walls that have been broken down.
There are greatly varying cultures. *Pockets and islands* of a different culture within a large organisation. There are many varying *tribes, clans and silos*, which do not communicate and talk to one another; all fighting. There can be much conflict.

4.3.2 **Framework Theme 2. Positive characteristics**

Some people indicated that positive services are provided. Positive words such as caring, supportive, dedicated, hardworking, effective and professional were used. Staff are patient focused; focused on getting the best for the patients. Sometimes this is to the detriment of staff health and wellbeing. “People who work for the NHS generally give of their all and go above and beyond their job descriptions to give the best care possible”.

There is selflessness, and devotion to an ethical code. There can be a culture of continuous improvement, and a willingness to change. It was for one person “...one of most complicated, but fiercely effective and caring industries”, they had ever had the pleasure of working for.

The NHS meets the holistic and wide needs of all people and communities and can be effective. There are “...dedicated professional leads”, “...hard working executive teams” and “...fantastic clinical staff”. There is good ethical behaviour. Staff are proud of the service.

However, when people made positive statements, they would often also qualify them in some way. “Even managers, are to some degree caring”. There are some good and enlightened managers. The organisation is there to care, “...mostly do”. Managers are, on the whole, compassionate towards staff, want to be liked by them; are “...generally supportive”. The majority of managers try to behave fairly. There are some decent people, one or two people, in very senior positions, who have good values; “...do their best in a nightmare situation”. Staff are now “...talking about compassion”.

“...within any large NHS organisation, there will often be *individual pockets, or islands* if you like, of where, there is actually at a speciality level or ward level quite a different culture where you may have a number of staff who work very well together, or seem to have been able to *insulate* themselves and they will often talk to you in terms of well, this trust is awful, but actually in this particular bit, we work together quite well” (Senior clinician: telephone interview).
One person described “...institutional dishonesty” in the NHS. They had seen bullying, impoliteness, cowardliness, pride, arrogance, outright dishonesty, corruption, yet the NHS was “...full of some of the most able, caring, innovative people in the country!”

A few participants viewed HR managers positively, but most did not.

The service provided varies. There are very bad hospitals, and some extremely good hospitals. Many people are treated successfully, but many are not. The vast majority people get good care. The staff are working hard and can be over worked. Reference is made to providing the best service within the financial restraints.

Regarding leadership and management at senior director level the metaphor of a nursery rhyme was used to illustrate the opinions of a trade union official. “There was a little girl and she had a little curl right in the middle of her forehead. When she was good she was very, very good but when she was bad she was horrid”.

One person gave their ‘3 words’ for the culture of the NHS as “Open, proactive and supportive”. Later they shared in the focus group that this is what it was supposed to be, and they were “...blue sky thinking”. Another person in another focus group said they wanted to believe that the underlying culture was caring and supportive. There are a lot of things that “...eat away at concern”.

4.3.3 Framework Theme 3. Hierarchical/top down/power

The word hierarchical was used many times. There were references to tiers, and layers; the NHS is “...hundreds of layers deep” with “...too many tiers”. The phrases such as the top, the top level, top tier, top down, at the top, top layer, top table, are also often used. The people at the top are also described as the “...hierarchy of elites”. Managers are the “...cock of the walk”, with people on “...fabulous salaries at the top”. The NHS is “...arrogant and elitist at the top”. The phrase of gone up the ladder was used as was HR thinking they were “God’s gift, like sat on a pedestal”. The NHS is paternalistic and senior managers; “...as Gods and very powerful”. There is empire building within directorates, to build directorates up, individual reputation up. People look upwards within the hierarchy rather than outwards to population they serve and status influences how much people are listened to.
Phrases such as the bottom, at the bottom, bottom up, on the ground, ground floor, shop floor, on the floor, coal face, beneath them, lower staff, low down the pecking order, ordinary folk, underlings and lowly occupations, people at the bottom rowing and running are often used. “...there is (sic) two lots of people in the NHS. There is the well paid and the poor paid and there is a hell of a gap in the middle. And that is a lot of it...But there is that gap”.

The NHS is an organisation with a bottom, middle, and a top. Several participants indicated that the people at the bottom are not valued as they should be. “Some [managers] 10 a penny like us”; expendable. “You will always find that the higher grade person will come off better. It’s like the little people don’t count sometimes...I don’t like that”. People are “Not appreciative of clinical/lower banded staff”.

The NHS is described as an “…ultra socialist entirety”. “It is almost a soviet style of central control to keep the budget etc in check and with that comes the culture of a soviet style of political control”. There is a “…tendency... towards totalitarianism”. The central domination, is a major problem, and worsening. There is “…central kowtowing” to the Department of Health.

One person’s image of the NHS was of “Hitler in his bunker”. This image because it was optimising secrecy, colluding and non-consultation, fitting with the sentiment that people on the ground floor don’t have any say. Another person said, “It’s like...there is some power wielding person like a Hitler figure going to do something really nasty to them. Under great threat. Something really, really nasty. Why don’t people say no?” A further person asked “Why does nobody ever push back up and say I am sorry, but this is not good. We take, take, take but we never push back up, up?” Two people indicated there were ‘enforcers’ in the NHS.

People consider that the culture of the NHS is set, led and caused by those at the top and the top table. There is a culture of fear and blame, insecurity and cover up. There is avoidance of responsibility and a lack of accountability. Certain senior levels and groups have a lot of power while others feel powerless and lack autonomy. In contrast HR, CEOs and politicians were sometimes described as being powerless.

There is a desire for power, status, privilege and position and “...power matters”. There is the power of patronage and nepotism. There is legitimate power/influence, but in
contrast there is also “...informal power” where staff may carry out an act of sabotage to show managers they do not have as much power as they think. “...staff can stop things from happening every single day”.

There is reference to people singing a corporate tune. “Senior managers have a habit in appointing puppets as they are not challenging and do as I say culture, sadly this is the case for many NHS organisations”. Few organisations have leaders and visionaries. There are inadequate selection processes and managers are appointed who have “... 'yes' written on their foreheads”. There is an expectation that people will conform. There is the dynamic of the “...survival of the un-fittest”.

The NHS is “...not caring for the people”, it is “...uncaring”. It does not act adequately in protection or improvement of patient care. Political decisions can have negative impact on trusts and delivery of patient care. There is however a

“...very powerful narrative in society about NHS staff being caring, selfless and dedicated, the bad apple exceptions proving the rule. This was embodied in the Olympics opening ceremony no less, suggesting this narrative is part of our national identity” (Manager: e-mail interview).

4.3.4 Framework Theme 4. Bureaucracy/policy

There is “…bureaucracy and red tape” and the NHS is “…overly bureaucratic”. Some people recognised however, that due to the size the NHS has to be bureaucratic, and bureaucracy can have good intentions. Bureaucracy can provide a framework that is fair and consistent.

In contrast the bureaucracy can be seen as restrictive where everybody, even chief executives can be “...trammelled by the rules”. “Even a chief executive of a health service hospital has very little freedom to do as they wish, or individual clinicians for that matter”. Staff are “…tied up in bureaucracy”. “Trying to get a response based on a sensible moral argument is difficult there appears to be little leeway outside of the rules”.

There is a focus on the formal aspects of policy rather than informal, on policy and not individuals, and this can be perceived as unfair and punitive. HR “…resort to disciplinary procedures and politically correct action as soon as there is any dispute”. People can
“...feel powerless against an insensitive bureaucracy/system” and “...policies are overwhelmingly full of rules and specific guidance rather than allowing discretionary action”. Bureaucracy paralyses; “...you have to go through so many committees to get things sorted”. “Too often policies are used as a way of closing down a complaint or problem prematurely due to ‘lack of evidence’”.

In contrast, if it suits, policy can be ignored or interpreted in very different ways. People can get rid of regulations/guidance when inconvenient, and PIDA is “...too easy to evade”

There is a “Failure to enforce codes of practice” and there are “...no sanctions”.

There is light handed regulation and it is considered to be ineffective. There is a lack of planning and autonomy as well as inadequate appraisal and performance management. There is a need for simplicity.

The NHS is very good at “...ticking the right boxes”. “So there is a pressure, to tick, to tick those boxes”. The Care Quality Commission is inadequate with “...bureaucratic tick boxing”; it does not recognise organisational pathology.

Everything is geared to computers and paperwork. “Paperwork taking us away from providing a good service”; not patient centred. Paperwork “...bogging people down, can’t do hands down clinical work”; too busy writing. When people try to raise concerns about the level of paperwork, people don’t want to hear. Failure to fill in paperwork is becoming a disciplinary offence.

The purchaser provider split just introduced “...trolley loads of unnecessary bureaucracy”. It is a “...bureaucratic machine” and there is a lack of humanity, care and compassion. The NHS is “Run by policies, rule rather than common sense which could rely on moral judgements and empathy”.

The quote attributed to Petronius AD 66, regarding a “...controlling, bureaucratic organisation...” is used to describe the NHS.

4.3.5 Framework Theme 5. Finance/business/targets

Despite no question being asked about finance and targets the topics were often mentioned.
The NHS is lean, stretched and brittle, “And there is a real danger, a danger that things could actually start collapsing”. It is under huge pressure, lacking capacity and target driven. “Getting resources is like getting blood out of a stone”. The whole NHS, “...utter chaos on the move, all the time, nobody wants to admit that”. There are “...dangers of over trading”.

“Promising they can do things that they can’t do. Trying to do too much, and the big word in the quality world is capability. Work within your capability. In the NHS it’s ‘come all ye’, so capability is not a word that is used” (External participant: telephone and e-mail interview).

“It seems that with the financial constraints that are being imposed it is impossible to offer a true service. Many departments are running with a skeleton service with very high levels of patients unseen each day” (Clinician: focus group)

The government is cutting resources/services. There are “...constant hoops to jump through” and “...high pressure to meet government targets”. There is a fear of failing and a pressure to cheat. Regarding waiting times; “...politicians want to be able to brag”.

Saving money is put before patient care. Management have a “...complete obsession with cost”. There is an “Inappropriate focus on input, process and output targets rather than outcomes and quality”, and a “Bullying intolerance of failure to meet irrelevant targets, regardless of the consequences”. The “Financial management and institution viability” has “...overriding primacy” and the only thing valued/rewarded is the delivery of targets. There are “…pervasive financial incentives”.

The more driven business model imposed is alien to the culture and value system of people in the NHS; results in conflict. Most clinicians/staff do not subscribe to internal market, business model. Have own professional code of ethics and service model; a huge clash of values. The focus on cutting budgets is a “...dangerous madness”. It is “Not just efficiency any more, it’s madness. Unsafe madness. It’s a dangerous madness”. The evidence is that the NHS “…values ‘delivery’ over some of the more human characteristics of care and compassion”. There is a lack of humanity. Savings are the focus; patients are put at risk and employees are expendable. People “…feel like cogs in a machine”, just told what to do. “...the culture is very much target driven, patient care and the morale, wellbeing and training or the workforce no longer matters”. It is “Very,
very difficult, if not impossible, to get trusts to invest in wellbeing of staff, if financial cost”. “From experience with management the focus tends to be on cost savings as opposed to supporting staff and helping them provide the best care”.

Things are not joined up. Cuts in one place produce increased costs, work elsewhere. There is waste and inefficiency. Some boards have shown restraint regarding pay, others have not.

Some SHAs don’t care how make financial balance, meet targets, just want to know are met; “don’t want ‘bad news’”. There is also downgrading of risk at executive level for political, appearance and financial reasons. “Trusts fear being publically noticed”. Bad news published outside could “impact on funding streams”.

There is a lot of talk about improving quality and patient care yet all decisions are financially motivated. “Frequent lip service paid to improving patient services & staff working conditions”; decisions don’t reflect this. “Head on conflict with the line of control coming down from centre”.

There are conflicts of interests, bribes, fraud and financial irregularities. There is a lack of clarity where money goes; “...serious dishonesty”. People who raise concerns, are made to resign. A bad manager can go onto subsequent trusts. There are no proper financial checks, and a lack of governance/control. The prevailing culture is of no accountability. There is “Institutionalised dishonesty...yes absolutely, yes, um, this is when people fiddle waiting lists times, targets or the finances”.

There are situations where CEOs/senior managers can be “…offered to another organisation as a free good, in terms of the salary being paid”.

“The managers refuse to accept any blame for the wrongdoings of the health service. Indeed they expect to get large payments when they are sacked for failings...witness the Stafford case where so many people died. The managers do not get "struck off" like clinical staff. Usually they reappear at another hospital on a higher salary” (Senior clinician: telephone interview)

Sometimes [negative] behaviour serves the organisational need; people can make things happen. Behaviour ignored so long as continue to 'perform', bring in on budget, making
difficult cuts in services. “The thing that usually prompts action is high turnover and/or sickness, because this has financial implications and so hurts the organisation”.

4.3.6 Framework Theme 6. Change/variable

The NHS is “...nothing like it was”; “...bears no resemblance”. The culture “...hasn’t always been like this”. One participant described the NHS as having changed from a “…benign dictatorship” to a “…malign organisation controlled by professional managers”. Another said “…we have had a publicly funded NHS since 1948, but I think this horrible centralising controlling culture is more recent. To me I do put it down to the rise of general management in the NHS. I think Griffiths did us all a terrible disservice”.

Many participants referred to constant changes or restructures. The NHS is viewed by many as under constant imposed organisational and structural change. There is little, or no time for consolidation, leading to paranoia and paralysis. The NHS is constantly changing, but in many ways not changing, and very slow to change. “Trying to make changes in the NHS is like trying to run through treacle”.

The quote ascribed to Petronius is used to describe what is happening in the NHS.

“Controlling, bureaucratic organisation which is constantly changing/reorganising “creating the illusion of progress whilst producing confusion, inefficiency and demoralisation Petronius AD 66”” (Manager: focus group).

The role of HR has changed from Personnel Manager, to HR, to Business Partners. It is not "...staff support"; it is another management tool. The role varies in different organisations.

The focus is constantly changing, and priorities constantly shifting and changing, which can have a negative impact and lead to a lack of planning and to situations where nothing seems to be finished.

“There seems to have been a significant cultural shift in the organisation I worked for, in being non-punitive, to being very punitive, and the culture of "learning from mistakes" seems to have been lost. Openness in the organisation has been discouraged” (Senior manager: e-mail interview).
There is variation of cultures, situations and services.

“It is a mixed workplace culture. In some places it is supportive, learning orientated and focussed on evidence based progression and sharing knowledge. In other places it is dark, blame orientated with leaders not taking responsibility for poor decisions and blaming others” (Senior manager: e-mail interview).

4.3.7 Framework Theme 7. HR/other roles

There were mixed views of the HR role and “...different pictures around the room”. Some people who were managers described a positive supportive role, which they thought was more the Personnel Manager role. This was as someone there to be neutral and also to have a supportive role to staff.

There is ‘NHS think’

“It’s quite interesting if you get some HR people from non-NHS coming into your HR department, it is very different. You suddenly get a different vibe and a different advice and you think Oh hello! Whereas I think, sometimes the HR departments, have got ‘NHS think’ and you suddenly get somebody else in and you realise, that isn’t how it is done outside” (Manager: focus group).

Several described the change in role from Personnel Manager to Human Resources and then to Business Partner. This change was not viewed positively. The new titles indicate a lack of neutrality. Some people were very clear that the HR/Business Partner role is there to support the organisation; a management tool. “…101% in league with managers, and biased as hell”. Maybe perceived as “…organisations hatchet men”. They were seen as on the opposite side from staff. It was considered sad that when there are genuine whistle-blower raising concerns about standards of care, HR was “…always on the opposite side of the line” to the individual/individuals. Some people were unsure about what they did do.

HR personnel were viewed as people who are distant, detached and separate from staff. People described, with some amusement, the change of HR having locks on their doors.
HR/Business Partners were not seen as effective and as not instructing the “...proper way of doing things”. They were perceived as being aware of problems, but not taking action. People question whether many HR departments know what bullying is, or have any idea how to investigate it. They encourage, and “...facilitate bullying on many occasions”. There can be “...bullying at the top level, but HR is in the middle of it”. One person thought HR were corrupted and “...embroiled in organisational failure”.

“HR directors they’re...they’re corporate, and...they’re ‘singing a corporate tune’, and...they are detached as those bad detached NHS managers of all sorts really”. One focus group agreed that an SHA HR Director with vision for staff wellbeing was considered to be an exception.

It was also recognised that HR can be under enormous pressure, and sometimes understaffed with the cut in staffing in recent years. They also have to deal with very difficult people.

One person described HR as powerless when senior managers breach policy. Another suggests that HR and cronies had more power and control than the Chief Executive. “I'm the HR... think they are God’s gift, like sat on a pedestal”. They can be seen as pressuring, bulldozing and bullying staff; HR rules. People are not supposed to argue with them; if do, “...are the nasty guy”.

There can be some good non-executives, however some quite negative views were expressed.

“I do think that most non-executives are also, are pretty much a waste of space. Cause they ought to be there representing, in part, the voice of patients on boards, and they don’t. I mean again, they just become, part, oh, there are a few good ones, but if they raise too many questions or something, they usually get pressure put on them, that their views are putting the service into disrepute, or they are being difficult, or whatever. Um, and I think they can be as much a part of the problem as of the solution, because they usually ‘go native’ very quickly and might as well be the executive team. They don’t keep their independence, they don’t keep their questioning minds...I do think that most non execs are just completely passive and useless” (Senior clinician: telephone interview).
There are also career non-executives who have financial and career interests and use the role as a *stepping stone*.

Some concerns were expressed about the trade union role and the need to be stronger and more independent. Local representatives may have a *cosy relationship* with managers. Trade unions are involved in the negotiation of confidentiality/gagging clauses, and this is seen as a problem. With HR they can make deals and sometimes this is not viewed as being helpful. Unlike HR, Risk Managers thought they stayed with the problems. They are “...*bearers of ‘bad news’*”.

4.3.8 Framework Theme 8. General lack/dysfunction

The NHS is under huge pressure; working beyond capacity. Organisations are *buffeted* by government priorities, director politics, SHA level, higher up, or internally; “...*almost cripple ourselves* within the wider NHS”. The NHS is “...pressurised, regressive and chaotic”. It is rushed, frantic and overstretched.

There is a lack of coordination, *joined up thinking*, connection, intelligent planning, and communication. The NHS can be inefficient and ineffective. There is much description of lack in many areas, but particularly regarding training provision for all staff. There is a lack of staff and a lack of skills, ability, experience and knowledge. There is a lack of learning. Many comments were made about the lack of training for managers. The quality of management is often described as being poor. One person described management as “...*grossly poor*”. Management requires a “...major overhaul”.

There is a lack of good quality leadership. There are not many inspirational leaders, not sure any in the view of one person. There is a lack of vision and purpose as well as a “...*lack of moral fibre*”, values, courage, honesty, and there is “...ethical fading”. Morality and ethics “...*can go out of the window*” and “The managers are in denial with regard to their own role in creating bad practice in the workplace”. The NHS is slow, entrenched and un-dynamic. There is something “...*very plodding*”, despite change. There is a sense that things don’t change, a “...sort of *frippery going on around edges*”. The core work, problems, still persist. It is very entrenched; and very difficult to *turn that ship/tanker*. A person described a state of “...learnt helplessness” which they thought helped to explain the disaster at Mid Staffordshire hospital.

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Patients and staff suffer while managers try to meet targets. “In the NHS there are many ways in which excellence is discouraged and mediocrity encouraged”. There are perverse incentives and dynamics which negatively impact on patient care and staff welfare. Disagreement with management is viewed as a disciplinary matter by HR. The dynamic of “...survival of the un-fittest” is described where the wrong behaviours are rewarded. The NHS is a “...self perpetuating dysfunctional system”.

Many staff do not feel supported and there is a lack of morale. Staff are struggling and can feel exhausted and battered. There is a lack of care for both patients and staff. There are problems with the appraisal process and the recruitment process is flawed. “Personalities of senior managers are part of the problem. Hubristic tendencies. These people should be screened out at interview stage. Regretfully, I think they are actually screened in”.

There is not a focus upon positive values such as care and compassion, and support of staff. Regulation is described as “...light handed”. There is a basic lack of standards regarding behaviour.

One person described general disorder with work not being done properly and a lowering of standards compared to what happened in the past. The person was deeply concerned with what they saw and completely frustrated because little could be done. They described the situation as “...awful” and staff were described as “...bitches”. Another person described everyone as “...having their own agenda”.

At the bottom there are patients dying and unhappy staff.

**4.3.9 Framework Theme 9. Raising concerns/communication**

A person detailed the lack of ordinary communication. A workplace where no one smiles, says good morning or hello. Everyone was “...fighting their own battles”. That was in their view “...horrendous” and they felt distressed by the culture. Certain groups such as older women and ethnic minorities were in their view excluded and ignored. Senior managers are seen as remote and separate. An executive team was perceived as being “...in a silo”. There is a lack of connection between the different groups in the NHS.
“In reality in our organisation I am not sure how many people would even recognise the chief exec. You see her walking down the corridor, and you go to say hello, her head is down. And you know we seem to have a bunch of people who don’t have those sort of, when times get tough they will prepare the cascade, they’ll do the communication, but it’s all stuff that, it’s just words really. There is no humanity behind it, you know. There is no, we walk around the hospital on a daily basis, we pick up on something that hasn’t been cleaned. They don’t go in and speak to patients, you know to hear the patient view, because they rely on patient groups coming to them” (Manager: focus group).

Many issues, topics, concerns are difficult to raise. Anything that is a criticism, anything contrary to prevailing policy or agenda and anything that puts the person or the organisation in “…a bad light” is difficult to raise. Managers “…quickly learn that questioning things is not popular”. A person’s status affects how much they are listened to.

Complaints can end up in electronic waste paper baskets and risks are “…de- escalated”. A person sending in risk/incident forms was told “…don’t send any more of these in, you’re making me look bad”. “There is a reluctance to share bad news too far up the management chain and especially when it goes beyond the Trust/PCT to the SHA or DoH”. People don’t want truth and reality. “Overall there has been a very unhealthy tendency to dismiss the views of clinicians”.

Concerns can be raised e.g. PFI, but “…still railroaded through”. Gagging clauses and compromise agreements are referred to and the view given they should be stopped. The NHS does not have a “…learning culture” and doesn’t learn from its mistakes. The “…effect of management is to silence critics”. Clinical excellence awards can “…buy silence”. People can be bullied and “…go quiet”. The “…top-down bullying culture…suppresses constructive dissent”.

People are “…deaf”, resisting any negative information. They can close their eyes and ears. They don’t want to know and staff are facing brick walls. There is retribution for raising concerns and staff are frightened to do so. People can get flak, be shot or slapped down. Those who question and challenge are seen as negative, as a troublemaker, an enemy and not in the team. They keep their heads down and don’t want to put themselves in the firing line. A lot of people don’t speak up or put their head above the
parapet. This was described by one person as a “...sea of silence”, where very few people cared. There was a deep sense of being failed by the “...silent majority”. There is a “...silent negative force”, “...the silent aggression” of people “...who should have had more courage and should speak out”. “The golden rule is keep stum, don’t let it out”. Have to “...keep the lid on it”. People are not allowed to “...give the game away”, or “...expose dirty linen”.

Some participants had experienced extremely unpleasant and painful experiences at the hands of their employer. Some of the responses to the person are very extreme where anything is done to suppress information and to find justifications to get rid of the person; “...scraping for crumbs”. Raising concerns can become an employment issue as people seek for reasons to get rid of a person who has raised a concern. The words such as witch hunts, and “...set the trap”, are used. Of “...trying to dig dirt” and being “...savaged by a mob of wild dogs, who are still baying for blood around me” referring to the behaviour of senior managers. The end justifies the means and there is a lack of moral values and care and concern for individuals. Some described extreme detriment to their jobs and personal welfare. There was a perception of great injustice. The experiences of health professionals when they raise concerns is described by one person as “Kafkaesque”.

“From the individuals that we have worked with, their experience of trying to raise concerns often leaves them isolated, threatened, distressed and professionally compromised, with a significant impact on their health and well-being. Certainly the description given by some healthcare professionals of what has happened to them is Kafkaesque” (External participant: e-mail interview)

The problem of the resistance to raising concerns impacts on the service to the patients. Maintaining the finance and budget, and self-interest is more important than patient and staff welfare. How things look is also more important. Nothing matters except the goal.

A small amount of information is given regarding positive responses to raising concerns. The picture however appears to be overwhelmingly negative. A phrase used by one person was “...horrible culture”.

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The word ‘bullying’ is commonly used by participants. One person said “I think we have a lot of bullying and harassment”. Another participant gave an example of a chief executive who described himself as a “…circus ringmaster”, of a bullying management style which is seen as acceptable. The NHS is “…still harassing”. NHS organisations “…tend to be very centralised, controlling, um, hierarchical, ah, pretty closed, meaning intolerant of criticism. Not open and transparent, although they claim they are. And frequently, um bullying, not always, but frequently… so really I think that is the prevailing culture. I think in failing organisations for various reasons that culture may be more evident, or maybe more extreme. But unfortunately I think there are probably very few organisations in the NHS where it isn’t widespread and endemic” (Senior clinician: telephone interview)

There is a “…like it or lump it culture”. A “…do as I say culture” in many NHS organisations. A “…command and control style” from the top. The culture is “…enforced by Whitehall”. There is a “…deeply engrained malaise”, a culture of bullying and dishonesty. “The prevailing culture is bullying, command and control leading to fear, insecurity and cover up”.

The NHS is described as having changed from a “…benign dictatorship” to a “…malign organisation controlled by professional managers”. Another person thought that “…management in the health service” had a “…malign influence”. There are witch hunts. “The system will eliminate” people. People who raise concerns about patient safety and other concerns can experience negative behaviour. People can be reluctant to raise concerns about negative behaviour.

There is a culture of disrespect. There is disrespect and conflict between different teams and the many different professional groups. Bullying and harassing behaviours can go on for years, and nothing is done. At senior level people are seen to perform well in other ways and are valued despite their behaviour. Certain groups such as managers, doctors and senior clinicians are seen to be treated differently to other staff. The apex and senior management of the organisation “…protect each other”.

Performance processes can be perceived as bullying. These processes can be very damaging to people. Managers can be repeat offenders regarding negative behaviour,
but are not removed from post. One senior manager was attempting to address problems of negative behaviour, but found it very difficult, and felt under much pressure.

“I’ve been there 9 months and I currently, have commissioned four investigations into staff, because there was, again that word, entrenched. Entrenched, what I think are bullying and harassment behaviours happening in the service that have been going on for years and years, but nobody has ever done anything about”
(Senior manager: focus group)

Generally behavioural problems can be swept under the carpet and people like to leave sleeping dogs lie. Reports are given the “...three wise monkeys treatment”. On the whole HR is perceived as being ineffective and not supportive. Trade unions are sometimes seen to be part of the problem, of not addressing behavioural problems in the workplace.

There is a lack of management and people skills, and competencies. There is a lack of training and support for managing negative behaviour situations. Policy can be applied rigidly with a focus on the formal stages and used to avoid dealing with problems. Policy can be ignored or be inadequate. There is a lack of use of informal interventions.

The wrong behaviours can be rewarded in the NHS and there is a tendency for the wrong people to get promoted. One participant described the NHS, as a “...self perpetuating dysfunctional system”.

4.3.11 Framework Theme 11. Self-interest/relationships

People are trying to “...create names for themselves” and “...build empires”. There is a pressure to fit in and become part of the group. Pressure to toe the party line, play the game, join the club and sing from the same hymn sheet. There are interrelating networks, providing mutual support and benefit. The apex and senior management of the organisation “...protect each other”.

“...one person was sort of, um, protecting the other person. If you, um, uh, if you, um, uh, support me I will support you, sort of thing. If you give me a pat on the back, I will give you a pat on the back. So there was a lot of that going on”
(Senior clinician: telephone and e-mail interview).
There is the “...self serving complicity of the “elite circle” and the “...elite closed circle of career driven managers”. There is personal interest in serving political objectives. There are career non-executives who have financial and career interests and use the role as a stepping stone. People, “... have got their own agendas which takes us back to right where we started, which was about whatever, whatever level you are, far too many have their own agendas”. Manipulative behaviour, working the system for own benefit is not uncommon.

The words cronyism, nepotism, cliquey, incestuous and coterie are words used to describe behaviour in the NHS. Favouritism and unfair distribution of resources starts conflict. There is a dependency on grooming from above to achieve and gain promotion.

“...she came in, in a sort of cocktail dress, in heels, and this jacket and sort of all this...and the next thing we knew she had been um, um, promoted”. “... one minute she came in a cardigan and the next day she came in, in a cocktail dress” (Senior clinician: telephone and e-mail interview).

People can be “...prepared to shed the previous life because, because there is a vested interest for her and she has got nothing else”. People can be chameleons to gain advantage.

“I think those people are the most dangerous, those people are the ones who are most chameleon like, because they just take on the next thing that is required, and they’re almost, um, they are not bad people I’m sure, they are kind to their families and so on, but they are almost, at work, almost value free, and that is quite hard” (Senior clinician: telephone and e-mail interview).

The self-interest goes far beyond the individuals and the organisations. It spreads to self-interest of politicians, newspapers and universities resulting in conflicts of interests. The regulators are also identified as being complicit. There is possible “...misuse of entrusted power” for personal and political gain at senior levels. Self-interest distorts priorities.

Recruitment is such that managers are appointed who have “...'yes' written on their forehead” and who are puppets. There is a need to have good relationships with managers, to “...kiss their arses”. “Managers are there to line their pockets and get away with it!...corruption is what comes to mind”. Some people are very good at “...’managing up’ so they give a good impression to those above them whilst being very unpleasant to
those who work for them”. People “...kiss up kick down”. The NHS was considered by
one person as “...rotten from top to bottom”.

Managers control clinicians via jobs, funding, clinical excellence awards, and patronage. Rewards buy silence and obedience; money speaks.

As well as the formal culture, there is the unofficial culture. Behavioural problems don’t get resolved because informal relationships affect responses. “…they know where the bodies are buried”, and “…deals are done”.

There are people in the NHS who are not there to serve the interests of the patients or their organisation. Self-interest and ambition is their overriding priority. If people “…want to prosper, they just join the corporate line. They “…quickly learn that their careers will, shall we say, be enhanced by ‘being corporate’, that their careers will suffer if they are not ‘corporate’”. There is a loss of values and principles. People lie to protect their positions.

“...it troubles me that NHS managers that if they ever had principles I think they lose them. They sacrifice them on, you know, the altar of maintaining or developing their careers” (Senior clinician: telephone interview).

The need to protect the individual image and the distortion of priorities means patient care can be negatively impacted.

4.3.12 Framework Theme 12. Scenario

A few people did not recognise, or had experienced, the behaviours described in the scenario, believing the scenario was artificial and not plausible. Some were quite shocked at the behaviours described. Many however had seen similar behaviours. The behaviour was considered to be typical of the way the NHS conducts itself in response to the highlighting of problems and concerns and in general conduct of the senior managers towards other staff.

“This isn’t, this isn’t an unusual scenario, it is played out on a daily basis. I, I, witness it on a daily basis.” The culture was described as dysfunctional, sick, unhealthy, and there being a culture of a “…deep cover up of bad news”.
There was avoidance and suppression of *bad news* and managers appear to be extremely sensitive to the image of both themselves and the organisation they worked for.

Managers did not like their “…*dirty linen being aired*”. There is the *Elephant in the room, and ostriches with their heads in the sand*. The presentation of evidence *puts the spotlight on them*. There is a focus on providing positive information and “…*maximum gloss*”. There were many mentions of people being fearful for their reputation and being seen not to know what to do. People felt threatened.

It is a case of “…*shooting the messenger*” and “*Sticking fingers in my ears, humming loudly*; it’s not happening”.

The managers in the scenario were said to be all *singing from the same hymn sheet*. There is great difficulty in acting outside the accepted cultural norms within the NHS.

 “…providing they all maintain ranks, then they can get away with it. And if one of them breaks ranks and says actually we need to know about this, um, then they may get ‘outside of the club’” (Manager: focus group).

To do so brings detriment to individuals who can be isolated and victimised, with financial and career implications. The aspects of power, arrogance and self-interest feature in the explanations of what happened. Referring to directors/senior managers

 “…I would also say, as well, that they may know that this is about inappropriate behaviour. But they actually don’t care because I certainly am aware of director’s comments to a member of staff that they were ‘untouchable’”… “It then, that goes back to our other conversations around personal agendas and power bases”.

 “…very similar behaviour patterns can be apparent when patients challenge poor care. Fear, protectionism, trench mentality, ignorance, a form of collective stupidity, self-preservation. Poor quality of management - a long standing issue within the NHS - and lack of good quality leadership”.

R “But they are supposed to be caring about patients”

[laughter] “But they wouldn’t”.

 “Yeh”

 “Yeh”
“Yeh, but they clearly don’t, they have got their own agendas, which takes us back to right where we started, which was about whatever, whatever level you are, far too many have their own agendas” (Managers – focus group).

People are also controlling what is thought about.

“Yes, they come across as feeling threatened, but also they are trying to control the definition of um, what can be talked about, aren’t they? They are sort of, and they are hoping that if nothing gets talked about, nothing can be thought about”

“And then nothing needs to be done” (Clinicians/Senior clinicians: focus group).

4.3.13 Framework Theme 13. Selective moral disengagement/ego-defences

There is avoidance, rejection and burial of bad news and a desire for good news and the “...rosy picture”. “It is very tempting to join the club and be part of the ‘good news factory’”. People don’t want to face up to problems and reality. “They don’t care about anything else as long as not reported”. There is manipulation and corruption of data to deliver good news; dishonesty and wilful blindness. ”...’corrupt’...to denote the deception and manipulation of the truth in relation to the denial of reality when things go wrong”. There is a need to be seen “...whiter than white”.

The good news factory ”...has two manifestations - great when things go well, nasty, aggressive, dishonest, vindictive, and much more when they go wrong”. Bad news is “...swept under the carpet” and people “...turn a blind eye”. Concerns are brushed aside. People do not want to wash, expose or air their dirty linen in public. They shoot the messenger. Reports can get the “...three wise Monkeys treatment”. People “...hear nothing, they see nothing and they say nothing”. There is “...disattending of the highest order...from all levels”. When there are problems in organisations “...then they begin to go into a paranoid defensive state”.

R “Are there any particular topics that are more sensitive than others?”

“Well, anything to do with, I think if you look at elements around anything that the CQC covers I would say... so anything that might look bad in the press about your
reputation. It could be what people eat, how they are cared for, how where they are, you know”

“The performance targets”

“Yeh”

“Anything that if it hit the Daily mail would make, would sort of crucify your organisation, that’s what people get very sensitive about”

“Because you don’t ever come back from bad press”

“No, no, absolutely”

“Because the STEIS system, the reporting serious incidents system, it’s not really about because it’s serious, it’s about”

“It’s about telling the Department of Health that something might hit the press, that’s the only reason STEIS was designed for”

“That’s what it’s about”

“Yeh”

“I got that from the Department of Health”

R “Really?”

“Yes, it’s being made aware of anything that might hit the press”

“So it’s all wrapped up with about being about patient safety and being open”

“Yeh”

“When there is nothing actually in place”

“No”

“To make that learning happen across the other organisations”

(Managers: focus group)
It’s the “Iced cake syndrome, lovely on the outside, mouldy on the inside”. Part of a culture led by the government, to “…present a pretty picture fed up to the voters. Underneath it’s a bit of a shambles”. “The golden rule is keep stum’, don’t let it out”; the “Emperor’s new clothes”. People can live in “…La La Land”. People begin to believe own rhetoric/propaganda.

The NHS is described as being ‘…beloved’, a “…national treasure” and there is a powerful narrative in society of staff being caring and dedicated.

Regarding Mid Staffordshire, people “…kid themselves”, “…almost go into denial”. It’s like there is “…some power wielding person like a Hitler figure going to do something really nasty to them. Under great threat. Something really, really nasty”. There is a culture of secrecy, fear, defensiveness, denial, blame and punishment. “…secrecy…is a default of the NHS”.

“…there is a specific sackable offense for managers which is damaging the NHS brand. It is written into the manager’s code of practice, and various other things, and I have been threatened with that DIRECTLY, you know to my face and in writing….” (Senior clinician: telephone and e-mail interview).

The NHS is not a learning organisation. There is rhetoric, empty words, spin, “…veneer that gets painted”, a “…constant fabrication”, maximum gloss, charade and whitewash. Evidence is “…airbrushed out of history”. “But what you are doing a lot of the time is feeding the beast with what it wants to hear. Not raising concerns and flagging up problems”.

“There are many examples of research, including evaluations, being done of NHS activity etc, that do not come out how people want, and are often quietly dropped”.

References were made to Orwell’s book ‘Nineteen Eighty Four’. A focus group discussed the effect of acronyms which stopped thought. An interview participant described the differences in realities between the top and the bottom of their NHS organisation.

“…no-one has got any bread to eat, and it’s all absolutely ghastly and they are drinking horrible, you know, cheap, you know, spirits, and God knows what, to keep, to keep their hopes up, and there is an announcement saying, you know, it’s
fantastic news, the grain yields are up by a million percent this year”
(Senior clinician: telephone and e-mail interview).

People can adapt their behaviour for reasons of self-interest and survival as in “...concentration camps during the war”. Managers can be “...chameleons” and dangerous, lacking in personal positive values. Some people put on a mask. There can be “...ethical fading” and a moral vacuum.

One person described the NHS as a train

“The train is just a metaphor. In normal mode the NHS runs along quite smoothly as it covers up all of the chaos; it gets to a complex set of points, slows down swings and sways (the Mid Staffs disaster), but spins and lies it way past it, then goes smoothly on” (External participant: telephone and e-mail interview)

A situation was shared with one participant and a focus group for their comments. An HR Director had given a glowing account of HR practices in their trust. When asked by the researcher what the figure was for bullying and harassment they appeared not to know. Finally, they said that it was “so low” they didn’t have to think about it. The actual figure was in fact 15%. The focus group responded that not having to think was critical. It was a “...giveaway phrase” because “...it is painful for people to think about things”, and “...some of these people live in kind of bubbles”. They also considered that peer groups would collude in not thinking because “...people will only tell them what they think they want to hear”.

The nature of bureaucracy is that people are rewarded for taking good news to their boss.

4.3.14 Framework Theme 14. Actions

A range of interventions are advocated by the participants to address the problems of negative behaviour and to improve the overall culture. Radical change is called for; a major overhaul. “Would have to be something gigantic...to break the culture”.

The following are but a few of the actions suggested. There is a need to de-politicise the NHS “…so that the Government, via the DH, doesn’t always has to have a good news story and can admit, and publish, that some hospitals do not do well”.
There needs to be a facing up to problems and the truth. The cultural problems need to be exposed to the “...light of day”. Expectations, and codes of behaviour need to be clearer. There needs to be discussions about culture. Staff need to be respected and valued in reality, and not feel constantly under threat. Negative behaviour needs early intervention. There is a need for more informal interventions and a greater discretion when it comes to policy to enable people to respond with “…common sense which could rely on moral judgements and empathy”.

Managers should be educated on whistleblowing. There should be “A ban on gagging clauses”, “…a duty of candour”, a cap on the amount able to be spent by trusts for tribunals to “…level the playing field” and chief executive and directives held accountable for their behaviour, “…if employee abuse proved”. Investigations should be undertaken by external agencies with no dependency on the NHS. A “Whistleblowing line may be helpful, but it is a sign of system failure that we need it”.

Clinicians need to be given greater autonomy, control and power. The NHS needs to learn from failures. It needs a person of Mandela character to lead and to “…break the mould”; someone with vision. There is a “…need to break the culture of denial”. There is need to “Get rid of the well poisoners”; to “…cut hard, and cut deep”.

The appraisal process needs to be improved as does the recruitment process with better interviewing techniques and processes. “…hubristic tendencies” need to be screened out at interview.

“I think to eradicate this endemic culture in the NHS is a fantasy! It will never happen until another generation! Capitalism does not help the cause either! We need to be more clever about interviews and forget this crap about the best on the day strategy! If you got the gift of the gab and dazzle the panel with bullshit! You’ll definitely get the job! That’s why the NHS has problems now! I think the way forward is emotional intelligence interviews!” (Clinician: e-mail interview)

There is a need to face the truth so that change can take place and to focus constructively on both the negative and the positive aspects of organisations. The changes have to come from the top. The rhetoric needs to become reality.
“...the culture needs to change from the top doesn’t it? And the message needs to come from the top that bullying is not acceptable. It’s ok to have it on paper, saying zero tolerance. It’s tokenism at the moment” (Clinician: focus group).

Chief Executives and senior managers are seen to have a key role in “…cleaning up organisations”. No bullshit, they should just get on and do it; stop talking and get on and do it.

4.4 References to fear and similar words

It was decided to consider in more depth all the many references to fear and similar words implying the presence of fear. Several participants viewed the NHS as having a culture of fear. The following words were identified:

1) Fear, fearful, frightened, frightening, fright
2) Scared, scary
3) Anxious, anxiety, anxieties
4) Worried, worry
5) Petrified
6) Nervous
7) Threatened, threat
8) Panic
9) Cowed
10) Nightmare

The Lower and Higher Level Classes for the references to fear are listed in Appendix 11, as are the categories relating to ‘fear’.

The Higher Level Classes are:

1) Fear of higher authority
2) Fear of threat and punishment
3) Fear of blame and shame
4) Fear of impact on individual and organisational reputation; bad name/image
5) Fear distorts thinking and behaviour
6) Fear produces negative behaviour/outcomes
7) Fear of the truth
8) Fear relating to change
9) Fear for personal security and benefit (job/role/position/promotion)
10) Awareness of lack produces fear
11) Fear of standing up and being counted; speaking
12) Fear of problems
13) Fear of journalists/the press/getting monstered/...a journo doing a ‘beat up’"

4.5 Rationalisations and justifications

A direct question about rationalisations or justifications (R&J) was not initially asked. This changed after one of the participants described the response to them as a director, trying to raise concerns and complexities at a board meeting, about the delivery of patient care. Phrases were used such as “...we haven’t got a choice”, “...we have to do it”, “...there is no option”, “...we must do it this way” and “...there is no alternative”. After this interview, when appropriate, some of the participants were asked whether they were aware of any rationalisations or justifications used to support actions that were detrimental to staff or patients. Other participants also mentioned rationalisations in the process of their interview/focus group without being asked.

The Lower and Higher Level Classes in Appendix 12 include the explicit responses to the specific question (marked as R&J) and phrases considered by the researcher to be possible R&Js. A few possible euphemisms and redefinitions are also identified e.g. “Release staff”, not redundancy; “...talent spotting” when choosing people outside of agreed, acceptable and due process; “...incompetence”, “...conflict situations” and “...challenging behaviours” instead of bullying; and there were “...difficulties in communication” and “...genuine distress”, but these were not due to bullying. Senior managers use words similar to the “...old fashioned phrases” of “...working smarter” and “...sweating the assets”.

The Higher Level Classes are:
1. Adoption of R&J mind set; becomes overarching culture
2. No choice/alternative (helplessness)
3. Claim of obedience to a higher authority
4. Shifting/displacement of responsibility
5. Inability to take action (passive role)
6. Policy and process used to avoid action
7. Money/economic imperative
8. Individual and group rationalisation
9. Data/reports used to provide justifications
10. Redefinition/reframing of language and behaviour/reality
11. R&Js for action and inaction
12. The negative becomes positive
13. Justify actions; deflected onto system/organisation as reason
14. Progression of bad practice/normalisation
15. Multiple rationalisations
16. Make choices/decisions
17. R&Js based upon possible perceived risk
18. Protecting the organisation

The Categories for R&Js are identified in Appendix 3.

4.6 References to the culture in the NHS

Further to the gathering of the ‘3 word summary’ descriptions of culture a search was conducted on all the specific references in the Categories (Appendix 3) to the word ‘culture’ in the NHS (Appendix 13). One person described culture as a “...set of values and beliefs” which are “...very, very powerful”. Some people described a positive culture; many did not. Some saw both positive and negative and recognised that the cultures were “...enormously variable”. Many people referred to the fact that the culture needed to change, and change radically in a major way. A major overhaul was required. There needed to be a positive culture. Some expressed the opinion that the culture could change. Another said that to eradicate the endemic culture in the NHS was “…a fantasy” and that it would take a generation. One person however, was of the view that the
culture could actually change quickly if the right people were in place. The statements represent data from all of the Framework Themes.

Linked to the word of ‘culture’ words that indicate a widespread, engrained and potentially powerful problem with a great impact, were further considered:

1) Several people referred to a “...prevailing culture”, general culture, also of a culture that filters down from the top. The culture was sick and unhealthy.
2) Fear pervades the NHS
3) A “common denominator” was defensiveness
4) “…in common” was that the manager was seen as “…always right”:
5) A “…deeply engrained malaise”, culture of bullying and dishonesty
6) An “…endemic top-down bullying culture” in DH suppresses constructive dissent
7) “Overarching mind-set” and culture of rationalisations and justifications
8) “Cronyism is rife”
9) A bullying culture can permeate

4.7 What people don’t want to do

A search was conducted in the Categories (Appendix 3) for the words ‘don’t want’ which provide some explanation relating to dysfunctional behaviour in the NHS. It is considered that people don’t want to know, hear, listen, admit, acknowledge, accept, believe, create fear, learn, think, speak, make changes, or act. People do not want reality, truth, evidence, things in black and white, bad news, bad press, mud sticking, muddying of the waters, to be tarred, or reflected in a bad light/looking bad. They don’t want anything negative reported up the line. They would much rather prefer to put their heads in the sand, and not believe anything is happening. Rather than bring it out into the open, they would rather bury it. They don’t want to give the game away, or let anything leak out. They don’t want to be responsible or seen as lacking.

People who see things of concern are frightened and don’t want to put their head above the parapet and say shoot me. They don’t want to stand up and be counted.

All the references imply people are making choices and consequently doing what they want and taking, or not taking, actions. The full list is in Appendix 14.
4.8 Underlying assumptions/beliefs in the NHS

Rationalisations and assumptions overlap. Several possible explicit and implicit assumptions were highlighted in the course of the research. The related explanations and quotes are detailed in Appendix 15.

1) Managers are always right/tell the truth/know best
2) Staff are liars
3) Non managers/staff are dishonest and managers are honest
4) Non managers don’t know what is best
5) Non managers are always wrong
6) A manager serves the purpose/best interests of the organisation
7) If a manager makes a mistake it is “...OK or plausible”, therefore justified
8) Pressure is good and produces hard work and commitment
9) The NHS is there for the patients
10) All NHS staff are dedicated
11) Cultures take a long time to change
12) Public assumption; NHS there “…solely to make them better”
13) Increasing number of safety incidents reports is a good thing
14) Nothing can be done

4.9 Interview data: Observations on power and behaviour

Seven sections of verbatim interview data have been included in Appendix 16, as they reflect a number of the themes. They also provide interesting perspectives and observations on power and behaviour within the NHS.

1) There are different forms of power in the workplace; legitimate/influence and power and informal power and sabotage.
2) The main priority of the senior managers can be cutting the budget. There is an “…unsafe madness”, a “…dangerous madness”.
3) Relationships can affect practice and responses to negative behaviour in the NHS.
4) A number of reasons for the “…poor culture” are given. A “…good news factory” is operating in many trusts.
5) There is alteration and adaptation of behaviour, a loss of values within the NHS, and dependency “...on being groomed by the ones above them”. There are different views of the organisation at the bottom compared to those at the top; Orwell’s 1984 situation. People protect themselves from cognitive dissonance.

6) The “...nature of bureaucracy” and hierarchy is being “...rewarded for taking good news to your boss”.

7) If managers want to prosper they have to “...join the corporate line”. “...they sometimes begin to believe their own rhetoric” and the propaganda.

4.10 Feedback from the article “A model of organisational dysfunction in the NHS”

Contact was made with thirty-two individuals. Thirty-one were sent the article “A model of organisational dysfunction in the NHS” and one person made contact after seeing the article to ask a question. Fourteen of these people were participants, eighteen were not. Fifteen gave some level of response related to the article and seventeen did not. Only one specific request for review was made in any of these contacts as the researcher did not want to put pressure on people. This was to the person who had of their own accord responded to the article. The feedback is provided in Appendix 4 and provides further insights into behaviour in the NHS.

Seven external organisations with an interest in the NHS were also sent a copy. Six did not respond. Only one acknowledged the e-mail. Seven politicians were also sent a copy. Six did not respond and only one acknowledged the e-mail.

4.11 Summary

Chapter 4 provides the findings from the ‘3 word summary’ responses to describe the culture of the NHS. The findings from the forty-three interviews and six focus groups are presented under the fourteen Framework Theme headings. The Lower and Higher Level Classes for each Theme are detailed in Appendix 7.

There is further analysis of the references to ‘fear’ and other similar words, possible rationalisations and justifications, specific references to the culture, what people don’t want to do, and possible assumptions/beliefs. Sections of verbatim interview data
provide further observations on power and behaviour. Feedback from the article “A model of organisational dysfunction in the NHS” (Pope and Burnes, 2013) is also included.

The thesis now moves to the discussion stage in Chapter 5. Comparisons are made between the proposed model of organisational dysfunction (Pope and Burnes, 2013) and the research findings. An extended and developed model is suggested.
Chapter 5. Analysis and discussion

5.1 Introduction

In this analysis and discussion chapter the research purpose, and objectives are restated, as are the gaps in the research literature. Comparisons are made between the proposed model of organisational dysfunction (Pope and Burnes, 2013) and the research findings. An extended and developed model is suggested, as are causal drivers. Further possible explanations and models are offered to increase understanding of the dysfunctional behaviour exhibited in the NHS. These include an adapted model of selective moral disengagement as relating to the NHS. Perverse manager characteristics which are valued and rewarded are also proposed.

The overall purpose of the doctorate research is to understand the reasons and motivations for the behaviours in the specific scenario described in Chapter 1. It is also to consider more generally the organisational responses to negative behaviour between and towards staff, and to understand more fully the broader cultural context and the possible causal drivers of such behaviour.

The research objectives are:

1) To assess the organisational responses to negative behaviours between staff in the NHS

2) To assess and analyse the motivations/reasons for the organisational responses

3) To increase understanding of why some NHS organisations do not take action to address the problems of negative behaviour between staff

4) To contribute to changes of policy and practice within the NHS

The main headings are:

5.1 Introduction
5.2 Compare and contrast the proposed model of organisational dysfunction and the research findings

5.3 Making choices for action/non-action

5.4 Perverse manager characteristics valued and rewarded

5.5 Summary

5.2 Compare and contrast the proposed model of organisational dysfunction and the research findings

As outlined in Chapter 1 there are a number of gaps in the research literature. Firstly, the reasons for the culture in the NHS, and the ongoing problems of negative behaviour towards staff over many years. Secondly, the reasons and motivations for the often inadequate organisational responses to negative behaviour. Thirdly, none of the literature explores the role of selective moral disengagement in the perpetuation of the dysfunctional culture of the NHS. Fourthly, only a limited amount of relevant literature was found relating to corruption in the NHS. Fifthly, no literature, other than Pope and Burnes (2013), draws together the well-known and recognised concepts of organisational silence, normalised organisational corruption and protection of image in a model to explain organisational dysfunction. This research study has gone some way to addressing those gaps in the literature.

The scenario, when the directors walked out of the room at the start of a presentation of MSc research on negative behaviour between staff, was the original catalyst to undertake doctorate studies. There was a desire to understand the behaviour and the reasons for the apparent resistance to taking action at the local, regional and national levels of the NHS. The doctorate has been a journey of exploration, trying to find explanations for this scenario and other similar circumstances.

As described in Pope and Burnes (2013), over time some NHS colleagues were asked to give their opinion on the possible reasons for this experience. One said ‘fear’, another, “they didn’t want to know” and they were “scared”. Other responses included “protecting their image” and “you were showing them a mirror”. All of these link with the writing on organisational narcissism, which includes the emphasis on denial. Other
people suggested it was about exerting control, power and senior managers showing their authority (Clegg et al, 2006; Blaug, 2014).

The actual event when the directors/senior managers walked out of the room was probably about silence breaking (Zerubavel, 2006). They knew, but they had chosen to ignore, and they didn’t want to know. They had chosen not to see and to know (Heffernan, 2011).

Most of the participants and focus groups were asked to comment upon the scenario. Their responses in the findings support the above opinions. The Higher Level Classes for the scenario are the metaphorical terms of: The Elephant in the room; Ostriches with heads in the sand; No airing of dirty linen; Shooting of the messengers and: Sticking fingers in my ears, humming loudly- it’s not happening. All of these Classes relate to the protection of image and denial of reality, and wilful blindness (Brown, 1997; Zerubavel, 2006; Heffernan, 2011) and leadership blindness (Vincent, 2014). There is an active rejection and suppression of negative information and “bad news”.

As the Findings chapter shows the situation was also about the expression of power and authority, power bases and personal agendas. There is also the dynamics of group behaviour and of having to fit in with ‘the club’ and “…singing from the same hymn sheet”. Individual and group rationalisations are identified.

“…in relation to this story. I said they would have had a rationalisation, they would have constructed amongst themselves a rationalisation for the way they were behaving, which will be convincing to them as a group”

Participants considered that people also do not care, and are not interested. Some senior personnel see themselves as “untouchable”. There is an inability to learn. One person referred to the scenario as “… a form collective stupidity” where there is “…fear, protectionism, trench mentality, ignorance, self preservation”.

In the proposed model of organisational dysfunction (Pope and Burnes, 2013) the three concepts of organisational silence, normalised corruption and protection of image are considered to reflect three aspects and perspectives of the NHS culture. The mechanisms of selective moral disengagement enable the persistence of this dysfunctional culture. The model provides some possible reasons for lack of action and response to problems of negative behaviour towards staff from other employees (Figure 5.1).
It was suggested that the protection of the organisational image and also the image and self-esteem of the individuals involved (Brown, 1997), was probably the dominant influence. It was concluded that “…organisational behaviour in the NHS can be dysfunctional, not always rational, and perverse” (Pope and Burnes, 2013, p.691), which reflects a ‘darker side’ to the NHS (Vaughan, 1999).

It was proposed that

“…the NHS exhibits too high a level of collective ego defences and protection of its image and self-esteem, which distorts its ability to address problems and to learn. Organisations and the individuals within them can hide and retreat from reality and exhibit denial; there is a strong resistance to voice and to ‘knowing’. The persistence and tolerance of negative behaviour is a corruption and is not healthy...”
or desirable. Negative behaviour is one of the ‘elephants in the room’ for the NHS.” (Pope and Burnes, 2013, p.691).

Based upon the literature review and direct observation within NHS organisations, some possible characteristics of an organisation retreating/hiding from reality, exhibiting denial, were also proposed (Figure 5.2).

<table>
<thead>
<tr>
<th>Centralised decision making/authoritarian leadership</th>
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<tbody>
<tr>
<td>Suggestions for improvements not received well/active resistance to upward feedback</td>
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<tr>
<td>Managers choosing to remain uninformed</td>
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<tr>
<td>Important issues/problems are avoided/deflected</td>
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<tr>
<td>Organisations refuse to acknowledge/deny problems</td>
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<tr>
<td>Not admitting responsibility for errors</td>
</tr>
<tr>
<td>Pretence that things are OK when they are not/lack of honest self assessment</td>
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<tr>
<td>People who raise concerns are marginalised/intimidated</td>
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<tr>
<td>Organisation acutely sensitive to outside interest by the press or other interested parties/staff talking to the press.</td>
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<tr>
<td>Staff access to Non-Executives strongly controlled/restricted</td>
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<tr>
<td>Patient complaints are deflected</td>
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<tr>
<td>The presence of fear</td>
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</tbody>
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**Regarding negative behaviour:**

Denial that negative behaviour exists in the organisation

Extreme reluctance to class/label any behaviour as ‘bullying’

Staff/managers who intimidate people can be protected/promoted

Figure 5.2 Possible characteristics of a dysfunctional organisation which is retreating/hiding from reality (Pope and Burnes, 2013, p.691).

All of these characteristics except for “Staff access to Non-Executives strongly controlled/restricted” have been reflected in the research findings. Some people did, however, express their concern regarding the non-executive role.

In the literature review of this thesis it is also suggested that further to these characteristics identified, that in an organisation which reflects the proposed model there would be:

- Resistance to voicing concerns on a range of topics
- Widespread negative behaviour with high levels of toleration and normalisation; a bullying culture
• Reluctance to address problems of negative behaviour
• Reluctance to address problems/concerns generally
• A sensitivity to, and rejection of any information that would put individuals and organisations in a ‘negative light’
• Widespread denial of problems
• Evidence of reframing/redefinition of bullying
• Evidence of rationalisations and justifications providing excuses for actions/non-action

Evidence of these characteristics has also been found within the responses. The findings in Chapter 4 support the original proposed model, but also extends and develops it (Table 5.1). The model is now discussed under the specific concept headings and selective moral disengagement. There is much overlap between the three concepts. They are completely interlinked, entwining and reinforcing each other.

• Organisational silence

The findings reflect many of the factors and characteristics of the comprehensive model of organisation silence (Morrison and Milliken, 2000, p.709). The findings do indeed describe a “...centralisation of decision making” (p.709) with its “top down driven”, “authoritarian”, “command and control”, “hierarchical” structure and system. Four of the main participants and two of the extra participants used the word “oppressive” to describe the culture.

Using the words of Morrison and Milliken (2000, p. 709) there is also the “Managers’ fear of feedback”, resulting in the managerial practices of: A “Tendency to reject or respond negatively to dissent or negative feedback” and; “Lack of informal solicitation of negative feedback”.

The findings as relating to the NHS indicate however, a far more negative situation in the workplace. Some additions to strengthen the ‘silence model’ are therefore suggested (Table 5.1) as it appears somewhat benign compared to the experiences of some staff within the NHS. Two participants used the word “malign”. One was to describe the NHS itself as an organisation and the effect of management. The other described the
influence of NHS management. The “...endemic top-down bullying culture...suppresses constructive dissent”.

There should be a reference in the ‘silence model’ to the presence of fear, as one of the factors affecting employee interaction and also as an effect/outcome of organisational silence. The participants made many references to fear. The presence of fear appears to be a major factor in the NHS, regarding being a driver of behaviour, and the impact on choices made and priorities.

In the Morrison and Milliken model there are also the implicit managerial beliefs that; “...employees are self interested”; “...management knows best, and “...unity is good and dissent is bad” (p.709). As detailed in the previous findings chapter this research study identified assumptions/beliefs that the “Manager is always right”, they “...always tell the truth”, “...know best” and “...staff are liars”. The implicit conclusions from these statements are that managers are honest and staff dishonest. These are particularly corrosive and clearly erroneous assumptions to have in a workplace. There are also other possible assumptions in the findings such as: A manager serves the purpose/best interests of the organisation; If a manager makes a mistake it is “...OK or plausible”, therefore justified; Pressure is good and produces hard work and commitment and; "...nothing can be done". These assumptions could all have an extremely detrimental impact.

The impact of organisational silence according to Morrison and Milliken includes a “Lack of critical analysis of ideas and alternatives”, a “Lack of negative internal feedback” which results in “Poor error detection and correction”. Employees have feelings of “...not being valued resulting in “Low commitment”, and “Low trust” leading to “Low internal motivation”, “Low satisfaction”, “Withdrawal” and “Turnover”. They also perceive there is a “...lack of control” with the outcomes of “Stress” and “Sabotage/deviance” (p.718). The findings show that all of these aspects can apply to the NHS. In addition, a lack of autonomy was often mentioned by the participants. There is also the hiding/cover up of negative information, as well as “spin” and “lies”.

Raising a concern can have an extremely detrimental impact (McDonald and Ahern, 2000). Jobs are lost, careers are destroyed and lives and health damaged (Heffernan, 2011; Pink, 2013; Drew, 2014). A few of the participants had suffered much detriment through raising concerns in the workplace. They shared some appalling experiences.
One of the participants considered that high profile whistleblowers are simply the ‘tip of the iceberg’. These are the ones who refuse to be gagged and continue to speak out. Beneath are those who are formally ‘gagged’. Then there are the people who try to speak out, are intimidated and bullied and go quiet, or leave their work situations because of the difficulties. The ‘messenger is shot’, and many problems are covered up and hidden. At the bottom are those who see what is happening and stay silent. They are the “silent majority” and the “sea of silence”.

It is interesting to note the omission of suppression and silencing of voice in the list of techniques/attributes of institutional power (Clegg et al, 2006). Suppression of voice is surely fundamental to exerting total institutional power.

The term ‘whistleblower’ is not used in the Core Model (Table 5.1) as it is considered limiting in its application. The researcher prefers the broader term of ‘raising concerns’ which is happening within the NHS at all levels. Pink (2013) prefers the term of ‘truth teller’. ‘Silence breaking’ is used by Zerubavel (2006) to denote revealing of “…open “secrets” of which we are aware yet unwilling to publically acknowledge” (p.65). This is in contrast to whistleblowing with the revealing of “…ordinary secrets” where people are not aware. Silence breakers help to “…uncover “elephants” rather than “skeletons” a whistleblower might bring to light” (p.65). ‘Background’ information is publicised rather than ‘backstage’ information. Glazer and Glazer (1989) use the term ‘ethical resistance’ in the context of whistleblowing.

The findings identify the perceived lack of autonomy and powerlessness of many in the NHS. Certain groups and people are described as powerful and “..power matters”. Morrison and Rothman (2009), consider that power is such a strong driver of social behaviour that “…the power imbalance inherent in organizational roles is perhaps the most important factor that makes employee silence such a common experience” (p.112). They propose that silence “…results from the combined effects” of a position of high power and someones position of low power (p.113).

When the research started the researcher was unsure whether negative behaviour was more sensitive and difficult to raise than other problems. It may have more sensitivity than some problems, but it is clear that any problem or major concern or anything that is contrary to the latest directive is difficult to raise and will often have negative repercussions. Anything negative or any “bad news” which puts anyone or the
organisation in a “bad light” is also difficult. Negative behaviour is but one of the ‘Elephants in the room’ in the NHS. The NHS does not appear to like ‘truth telling’ or ‘ethical resistance’ in any form. Further research would have to be conducted to assess levels of sensitivity. One participant described the NHS as being “deaf”. The generalised evidence suggests the NHS is systemically and institutionally deaf, with its fingers stuck in its ears, humming loudly.

• Normalised organisational corruption

The original model identified negative behaviour as normalised organisational corruption as described by Ashforth and Anand (2003). This aspect of the model has been developed considerably as many aspects of corruption in the NHS are identified.

The findings chapter identifies the toleration of negative behaviour and intimidation of people who raise concerns, as well as the poor and inadequate management of negative behaviour. The word ‘bullying’ is commonly used by participants and bullying is viewed as “…rife” and “…endemic”. There appears to be a systemic culture of disrespect, as well as a culture of elitism, fear, bullying, blame and a lack of accountability. Participants particularly identify a lack of respect for those at the lower, and more clinical end of the NHS, but also lack of respect between the different groups. In a troubled organisation staff are not always treated with respect or as individuals, or made to feel that they matter (Fevre et al, 2012). “One clinical indicator for corruption by power is the systematic devaluation of subordinates capacities” (Blaug, 2014, p.113).

In a very large scale study in the NHS Dixon-Woods et al (2014) found that “Lack of support, appreciation and respect and not being consulted and listened to were seen as endemic problems by staff in some organisations. In contrast, some senior managers - particularly those engaged in comfort seeking – tended to see frontline staff behaviour and culture as the cause of the problem” (Dixon-Woods et al 2014, p.7).

The findings of this thesis indicate that the management of bullying could be viewed as “..a serious and corrupt activity’ as described by Hutchinson et al (2009, p. 213). All of their five aspects of “…bullying as organizational corruption” (p.217) are reflected in this
research study. Relationships are also key to maintaining the dysfunctional behaviour. Their statement that "The worse you behave, the more you seem, to be rewarded" is supported (p.213). The findings identified that certain people and groups can be protected, particularly at the top of organisations.

Little is specifically mentioned in the literature reviewed about the human resource function in the NHS relating to responses to negative behaviour. It is almost as though HR personnel are not there, when in fact they have a considerable impact in situations regarding negative behaviour and raising concerns. One of the participants said that sadly, when there are genuine whistle-blowers raising concerns about standards of care, HR was "...always on the opposite side of the line" to the individual/individuals. The findings suggest that most responses from HR are in fact inadequate, reflecting the work of Harrington (2010) and Harrington et al (2012). The HR professionals appeared to support and protect managers and the organisation. There was evidence of reframing of behaviour. HR personnel did indeed appear to tend to favour management "...with considerable negative implications for employees, and currently, the employee voice appears denied" (2012, p.405).

In the “Freedom to speak up” review (Francis, 2015) HR are clearly implicated as patient safety concerns can all too often be shifted into being employment and disciplinary situations. It appears in the words of one participant for this thesis that HR can indeed be “...embroiled in organisational failure”.

In the view of some of the participants there has been a proliferation of managers in the NHS (Goddard, 2008; Riddington Young et al, 2008; Traynor et al, 2014). It is the view of Goddard (2008) that when the original administrators who “...saw themselves as facilitators” became managers, they embraced the government driven changes. “Presumably this is because power corrupts” (p.204).

In the King’s Fund report (2014) the views of leadership in the NHS have improved since 2013, but “...a majority still believe the quality of leadership is poor or very poor” (p.10). Woods et al (2014) found “...substantial variation in the quality of management” (p.7). The interesting description “...sleek suited” is used of leaders of big teaching hospitals (McLelllan, 2013, p.3). Many of the participants in this thesis study viewed management behaviour and practice as poor. There are examples of mismanagement and abuse as
described by Hodson (2001). The culture could be viewed as toxic (Ballatt and Campling, 2011).

As in the European Commission study (2013) the findings identify the dimension of a misuse of (high) level positions to fulfill self-interests and personal advantage. For some, perhaps many at senior levels, self-interest and advancement is their primary aim. The findings identify that relationships are a major factor in the advancement of self-interest and reward. Words such as “incestuous”, “nepotism”, “cronyism” and “favouritism” are used by participants.

Participants identify there is a huge pressure to deliver; a culture of bullying performance management which can have unintended dysfunctional consequences (Mannion and Braithwaite, 2012; Newdick and Danbury, 2013). The “Institutionalised dishonesty” where staff “...fiddle waiting list times, targets or the finances” is described. Chief executives are being given as a “...free good” to other organisations paid for by the NHS. There is also the practice of “...bad managers” going on to lead and work in other trusts. It appears that people at the top of the NHS are protected. The words “...ethical fading” are used to describe what is happening in the NHS. Some people see organisations as a “...moral vacuum”.

The House of Commons Public Accounts Committee (3 July, 2013) challenged the practice of large severance payments for failing chief executives and their subsequent jobs in other organisations paid for by the NHS, including charities. The Health Service Journal discovered that the HR Director from NHS England was given a two year secondment to a university paid for by the NHS (Lintern, 2014).

The work of Pinto et al (2008) considers whether an organisation has corrupt individuals within it or whether it is a corrupt organisation, or both. Due to the widespread, persistent and top down nature of the problems in the NHS and the destructive impact of them, it is suggested that the NHS is both an organisation where a significant number of its individuals act in a corrupt manner, and a corrupt organisation. Not only are individuals being seen as corrupt, but organisations themselves “...are increasingly being construed as corrupt entities” (Ashforth et al, 2008, p.670).
The NHS health system does appear to have “...deviated from the core goal of delivering health”. It appears to be ‘ailing’ and ‘rotten’ to a significant degree (Ibrahim and Majoor, 2002, p.20).

A participant describes their view of the primary purpose of the NHS

“The citadel is a metaphor for the NHS - picking up on AJ Cronin’s title. Its primary purpose is to protect itself even though the public believe it is there solely to make them better.”

Commenting on Mid Staffordshire this person also considered that some of the staff thought the organisation was “...for them”.

With the ongoing problems of negative behaviour and the numerous failures in the NHS there does appear to be “...a general failure to orient to the common good, a crisis of moral judgement and an aggrandised and hubristic distortion of individual thinking” (Blaug, 2014, p.2). There is a “...a failure of virtue that has impoverished...thought and judgement” (p.2) and “...a disorder of meaning (p.7).

The NHS is described in the findings as a “machine” and a “system”, where there is great complexity and great pressure to deliver with limited resources. There is constant change and there can also be disorder and chaos. The NHS is an extremely vast hierarchical and bureaucratic institution; an “...insensitive bureaucracy/system”. Ballatt and Campling (2011) refer to the focus moving away from the patient with the purchaser-provider split, the widened gulf between the “…clinical and business expertise” and the creation of “…crushing bureaucracy” (p.187). The NHS appears to be a coercive bureaucracy rather than facilitative, as described by Hodson et al (2006). They suggest that “…the interplay of relational powerlessness and organisational chaos gives rise to bullying” and chaos creates openings for the abuse of power (p.382).

Participants describe some characteristics in the NHS which could be viewed as Kafkaesque. These are according to Hodson et al, (2013) inherent in a bureaucracy. The Kafkaesque experiences described by Riddington et al (2008) occurred in the 1990s. These are similar to behaviour described in the findings and the experiences of whistleblowers identified in the literature review (Heffernan, 2011; Pink, 2013; Drew, 2014). One participant allegedly had their computer hacked.
The findings indicate there is a power imbalance in the NHS. Some people have a lot of power and many are powerless. Under certain conditions “...wielding institutional power changes the power holders in ways that is conducive to dehumanization” (Bandura, 1999, p.200). People in positions of authority have “...coercive power over others with few safeguards to constrain their behaviour” (p.200). Having power can result in the devaluing of those we control. Many of the techniques of total institutional power as described by Clegg et al (2006) are reflected in the findings to some degree.

The findings also identify that staff in the NHS are under authority and have their individual goals to achieve. Obedience and conformity is expected from the centralised “command and control” structure. When people are under authority within a bureaucracy there can be appalling examples of a lack of humanity and destructive behaviour and “...responsibility is essentially ‘unpinnable’ (Bauman, 1989). A lack of accountability is identified in the findings particularly at more senior levels (Goddard, 2008). Power is held by managers, but responsibility and blame has been shifted down and devolved.

The term “...learned helplessness” was used by a participant to describe the responses of staff in the Mid Staffordshire situation where patients were neglected. Some participants asked questions such as “Why does nobody ever push back up and say I am sorry, but this is not good?” and “Why don’t people say no?” This reflects the writing of Blaug (2014) regarding corruption by power and the impact on subordinates. The “...common symptoms are dependence, apathy and blind obedience” (p.4). Learned helplessness is one of the costs of “...hierarchic relations of power” (Blaug, 2014, p.105).

Another participant observed that if instead of saying “...we have got no choice in this”, and “...we have to do it”, “...if all you chief execs said this is counterproductive, and not actually in the interests of the patients. And if you all stuck to your guns”. They couldn’t understand why no one resisted.

The generalised evidence suggests the NHS is systemically and institutionally bullying, and is a troubled organisation. Corrupt and unethical behaviour has been identified as have totalitarian and Kafkaesque characteristics. The NHS could also be described as a coercive bureaucracy and under certain definitions a corrupt entity. The NHS appears to be an organisation with a heart of darkness (Clegg et al, 2006); a “...self perpetuating dysfunctional system”, where there is the perverse dynamic of “...survival of the
unfittest”. In the context of corruption by hierarchical power, it is also suggested there may be widespread “...learned helplessness” (Blaug, 2014).

• Protection of image

The data very much supports the aspect of the proposed model regarding protection of image, applying to both individuals and the collective organisational image. It appears to be a very powerful driving force and focus, which seems to override all other considerations, including the needs of the patients or the staff. It does appear that the protection of the organisational image and the image and self-esteem of the individual is the dominant influence.

The findings show that people individually and collectively can retreat and hide from reality. They can be detached from, and unable to cope with reality. Individuals refuse to face reality and fail to address problems indicating an inability to learn. There is evidence of the three wise monkeys, ostriches with their heads in the sand, and of turning a blind eye; a wilful blindness. There is an avoidance of ‘bad news’, secrecy and concealment, and a culture of fear and denial. Reality is redefined and reframed. The NHS is described as a “good news factory”, or as one person preferred, a “…stopping bad news factory”.

Orwell’s book ‘Nineteen Eighteen Four’ is given as an example of how supposed reality is declared at the top of an organisation which is very different to the reality perceived at the bottom. Behaviour is distorted and there is a distorted morality. Good can become bad and bad can become good. Harmful practices have to be vindicated and “…they have to make out that what’s harmful is, in fact, good” (Bandura interview in Heffernan, 2011, p.259).

Participants identified the alteration of behaviour that can take place. The cardigan can be discarded for the cocktail dress, heels and jacket. People can “…just take on the next thing that is required”. Values and principles can be discarded and lost.

“...it troubles me that NHS managers that if they ever had principles I think they lose them. They sacrifice them on, you know, the altar of maintaining or developing their careers.”
The participants indicate that the protection of the image is everything and no one is allowed to expose any “...dirty linen”. The Emperor’s New Clothes story is given as an explanation of what is happening in the NHS and there is a creation of a positive reality. There is much rhetoric, rather than reality. There is “spin”, “maximum gloss”, “veneer”, “fabrication”, “false front”, “whitewash”, “lies”, “a charade”, and a “rosy picture”.

Power holders have a tendency towards having a very positive view of themselves (Morrison and Rothman, 2009). The different perceptions of reality are also seen in the King’s Fund report (2014) on leadership and culture in the NHS.

The findings indicate such widespread ego-defensive behaviour, and resistance to ‘knowing’ which “...is at the core of the ‘pull towards perversion’” (Ballatt and Campling, 2011, p.141), that the NHS could also be described as a perverse organisation. Perversity underpins the more obvious conscious corruption. “Corruption builds on an underlying social fabric of perversity” (Long, 2008, p.3).

“A fundamental aspect of perversion is the process of turning a blind eye and, with this, the development of perverse certainty, the denial of a reality that continues to be encountered and the consequent self deception that seduces accomplices and breeds corruption” (Ballatt and Campling, 2011, p.140).

Perversion is also about “...seeking individual gain and pleasure at the expense of the common good, often to the extent of not recognising the existence of others or their rights” (p.139). The result of this perversion in the NHS appears to be a distorted and ‘upside down’ morality, and a loss of correct and morally acceptable priorities.

The findings identify the organisational forces of wilful blindness (Heffernan, 2011). “...obedience, conformity, bystander effects, distance and division of labour – combine to obscure the moral, human face of work”. “...then money is the final incentive to keep looking away” (p.257). “To paraphrase Burke, all that evil needs to flourish is for good people to see nothing – and get paid for it” (p.258).

Pink (2013) described how in 1990 he learned that regarding a health authority meeting “...it was the publicity rather than the quality of care that exercised members’ minds.” (p.99); sadly, the research data confirms this mind-set. It appears this attitude and overriding concern with image appears to have changed little in the intervening years in
the NHS. The situation has probably got worse with the increased pressure in the NHS and the constant changes.

“Self-interest is always a strong driving force of behaviour, as is the tendency to justify its pursuit” (Gabor, 1994, p.336). It may be that self-interest is the driving force behind the dysfunctional behaviours in the NHS. The apparent focus on protecting the reputation/image of the organisation may simply be part of the rationalisation process to justify self-interest and the protection of peoples own self-image and self-esteem. These factors may also, however, be linked with our sense of identity and how we meet our needs for self-esteem through being part of a particular organisation.

People are extremely sensitive to their organisations external image and promoting a positive image becomes very important when individual self-esteem is so closely linked to that of the organisation’s identity and sense of legitimacy. Information that threatens an organisation’s collective self-esteem is “…ignored, rejected, reinterpreted, hidden or lost’ (Brown and Starkey, 2000, p.103). They contend that organisations fail to learn due to the ego-defences that maintain collective self-esteem.

“Primitive defences are all based on the process of denial...Denial is a step on from repression and involves active distortion of the truth and consequent distortion of relationships. Denial frequently involves omnipotence, grandiosity and triumphalism...There is evidence that this was happening in the Mid-Staffordshire Trust” (Ballatt and Campling, 2011, p.75-76).

The aspect of identity with the organisation (Schwartz, 1987a; Brown and Starkey, 2000; Blaug, 2014) has not been specifically raised by the participants, though the findings strongly imply this. It can perhaps be speculated that the identity of clinicians may be linked more to the care of patients. The managerial levels are perhaps more likely to meet their needs for identity and self-esteem as being part of the organisation and see themselves more as the organisation. To assess the role of individual identity and the impact on behaviour in the NHS further in-depth research would have to be conducted on this topic.

The NHS appears to have a strong tendency to ‘comfort-seeking’ rather than ‘problemsensing’ (Dixon-Woods et al, 2014). As detailed in the findings such is the apparent level of ego-defensive behaviour with the resistance to ‘bad news’ and desire for ‘good news’,
with the resulting dishonesty, it is suggested the NHS is perhaps literally incapable of assessing itself honestly, or truly learning. If organisations are incapable of recognising their failures and learning, they are incapable of improving.

When organisations

“...become clogged by corruption. Stuck hierarchies, inflated leaders and disengaged subordinates serve to shut down the knowledge-processing engine and render the organisation ineffective...The corrupting organisation starts to turn inward; it fails to interact with its environment. As a consequence, it stops learning” (Blaug, p.112).

This inability to learn has huge implications for the assessment of patient complaints and any internal investigations. This could also have impact on the regulators which have ex-NHS staff as assessors. This is linked into the relationships the regulator may have with the NHS.

The generalised evidence suggests the NHS is systemically and institutionally deaf (with its fingers stuck in its ears, humming loudly), bullying, defensive and dishonest, exhibiting a resistance to ‘knowing’, denial and “wilful blindness”; a dysfunctional, perverse and troubled organisation. Corrupt and unethical behaviour has been identified as have totalitarian and Kafkaesque characteristics. The NHS could also be described as a coercive bureaucracy and under certain definitions, a corrupt entity. The NHS appears to be an organisation with a heart of darkness; a “...self perpetuating dysfunctional system” where there is the perverse dynamic of “...survival of the unfittest”. There may be widespread “...learned helplessness”. Overall, the needs of the NHS and the protection of image appear more important than the welfare of staff or patients. It does seem to be a “...good news factory”, rejecting and hiding any “bad news”.

Table 5.1 details the characteristics exhibited by the NHS under the concept headings and reflects a developed Core Model of organisational dysfunction. There is some overlap within the concepts.

<table>
<thead>
<tr>
<th>Organisational silence</th>
<th>Normalised organisational corruption</th>
<th>Protection of image</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistance to, active suppression of voice</td>
<td>Collective tolerance to negative behaviour; normalisation</td>
<td>Organisational narcissistic /ego-defensive behaviour</td>
</tr>
<tr>
<td>Don't want to listen; “They're deaf”</td>
<td>Systemic culture of disrespect</td>
<td>Resistance to ‘knowing’, Denial, pretence, wilful</td>
</tr>
</tbody>
</table>
| Hiding of negative information; cover up Lies and spin Assumptions/beliefs e.g. managers are “...always right”/“...always tell the truth”/“...know best” ”...staff are liars”/managers are honest/staff are dishonest Silence “...driven by fear” Silence produces fear Failure to voice; “sea of silence”, “silent majority” Don’t “...put their heads above the parapet” Imbalance of power Intimidation/victimisation of person raising concerns/’truth telling’/’silence breaking’/“...uncover elephants’”/’ethical resistance’ Shoot the messenger Witch hunts, “...set the trap”, “...trying to dig dirt”, “...savaged by a mob of wild dogs...baying for blood” “The system will eliminate” people Kafkaesque experiences Loss of jobs and careers Detriment to health and wellbeing Inability to learn/improve | “...arrogant and elitist at the top” Bullying from the top Culture of fear and blame Lack of accountability Intimidation of people who raise concerns Dishonesty/lying “Institutionalised dishonesty”; “...fiddle waiting list times, targets or the finances” Pressure to cheat Manipulation of data Suppression of information important for improving staff/patient welfare Desire for power, status and position Self-interest/ambition put before patient/staff welfare “Money speaks”/money, awards, honours, buying silence Protection of managers Reward for failure/dysfunctional behaviour “Survival of the unfittest” “Self perpetuating dysfunctional system” CEOs as a “...free good” to other organisations Misuse of public funds/fraud Recycling of “...bad managers” Self-serving relationships Powerful and protective alliances; “You pat my back” Incestuous, nepotism, cronyism, cliques, favouritism “The end justifies the means” Lack of moral/ethical values; moral vacuum Distorted morality and perversity (Good becomes bad and bad becomes good) Focus on organisational needs “Learned helplessness” “Slippery slope” | blindlessness Turning a ‘blind eye’ “Truth suppression” Perversity “Good news factory” Avoidance of ‘bad news’ No washing, exposing, or airing of dirty linen in public Problems “...swept under the carpet”/’concerns brushed aside Secrecy Concealment Culture of fear and denial Rhetoric not reality; “spin”, “maximum gloss”, “veneer”, “fabrication”, “lies”, “whitewash”, “rosy picture”, “charade”, “false front” Need to be seen “...whiter than white” Live in “...La La Land” “Iced cake syndrome” Protecting image is more important than patient/staff welfare “If I stick my fingers in my ears and hum loudly, then it’s not happening” Reports can “...get the three wise monkeys treatment” Ostriches with their heads in the sand (“Ostrich effect”) The Elephant in the Room The Emperors Clothes Inability to learn/improve Painful to think/don’t want to think

| Selective moral disengagement; Rationalisations and justifications; Denial; Redefinition/reframing of reality; Acronyms and mantras (cultural language) |

Table 5.1 A developed Core Model with the specific characteristics of the NHS
The possible causal drivers/factors are depicted in Figure 5.3. This figure highlights the factors that could contribute to the developed Core Model. The factors outlined are thought to have a key impact on the situation, particularly the apparent underlying idealisation of the NHS within society and the strong desire for good news emanating from the political top of the NHS.
Societal relationship with NHS; idealisation, “unimpeachable”, a “national treasure”, “sacred cow”/Assumption; people care, staff are dedicated

Adversarial political system/“Candid media”

Fear/Self-interest; desire for reward, “create names”

Political desire for delivery and ‘Good news’/NHS as “political pawn”; politicians want “to be able to brag”; present “pretty picture fed up to the voters”

DH/SHAs/through NHS–Desire for ‘good news’, avoidance of/’bury bad news’

“Vast political machine”; “Whale”/ “shoal of fish”; “Weird dysfunctional family”; Tribes and clans; “too many tiers”; “hundreds of layers deep”

Self-interest; promotion; Ambition; Desire for status, power, self-esteem

Arrogant elitism; Hubris; “As Gods...powerful”; “Untouchable”; “God’s gift like sat on a pedestal”

Hierarchical; Top down driven; Command and control; Power at the top; Power and powerlessness - imbalance; Legitimate and informal power; Tendency towards totalitarianism

Insular; Enclosed; Closed

Change cardigan to cocktail dress, heels and jacket; “Sleek suited leaders”

Core model

Culture of fear; “a Hitler figure going to do something really nasty...under great threat”

“an insensitive bureaucracy/system”; Inadequate policy and procedure; misuse/non-use of policy

Chameleons, “just take on the next thing” required; ‘Yes’ written on their foreheads; Appoint puppets

Constant change, reorganisation; Shifting priorities; Instability; No change, inertia/paralysis;

Disorder; Complexity; Pressure; Working beyond capability; NHS is ‘brittle’

Loss of primary purpose/focus; Needs of organisation and individual more important than needs of patients/staff

Lack of resources, knowledge skills, training, experience

Inadequate HR, Non-executive roles; Poor leadership/management

Relationships (formal and unofficial); benefit through powerful alliances

Weakness of Trade Unions

Relentless cost cutting; “Money not patient”; “A dangerous madness”; targets and perverse incentives

Lack of responsibility, accountability; Displace blame; Shift blame down

Lack of value/respect for staff; “the little people don’t count”; “Still don’t talk to them, walk past”

Weakness of Trade Unions

Leadership distant, separate, remote, detached; “Chief exec...go to say hello...her head is down”

Inadequate recruitment, appraisal processes

Lack of support for staff

Proliferation of managers (managerialism)

Engrained assumptions impacting behaviour

Lack of autonomy

Figure 5.3 Possible causal drivers/factors impacting on the developed Core Model
Figure 5.4 reflects the overall conclusions and perhaps better reflects the way that the concepts are entwined, each reinforcing the other resulting in a dysfunctional, perverse and troubled organisation; a “good news factory”.

![Diagram of the NHS: A dysfunctional, perverse and troubled organisation; a “good news factory”]

- Selective moral disengagement

Based upon the literature review and the development of the Core Model (Table 5.1), additions are also suggested for the combined models of the mechanisms of selective moral disengagement as relating to the NHS (Figure 5.5, additions in bold). There are implications for other organisations.
5.3 Making choices for action/non-action

Human beings have the inhibitive power to withhold from inhumane actions and the power to proactively behave positively, humanely and morally (Bandura e.g. 1990b, 1991, 1996, 1999, 2002, 2004b). We have the power to make that choice.
The following models attempt to reflect some of the processes that are taking place in the NHS. There are many things that people didn’t want (Appendix 14). People make choices supported by the rationalisations/justifications and redefinitions/re-framing of reality that make those choices more comfortable.

Figure 5.6 Making choices for action/non-action supported by rationalisations/justifications, and redefinition/reframing of reality

The findings identified some of the rationalisations and justifications people may be using in the NHS. One of the participants thought they were

“...probably not a good person to ask as it is a mindset I have difficulty understanding. If you get on by never making a mistake or more to the point no mistake ever being pinned on you and work in that sort of blame culture perhaps it is an inevitable consequence. Worse perhaps many of those who get into positions of power have got there through adopting that mindset and that becomes the over-arching culture?”
Linked to Figure 5.6 the next model (Figure 5.7) is one that shows how fear, not wanting to know, hear etc., and self-interest and other factors can be driving those choices. The model also reflects how the mind-set of rationalisations/justifications becomes the overarching culture as more people are rewarded for that mind-set and promoted within the NHS.

Figure 5.7 Choices driven by fear and other factors supported by a rationalisation/justification mind-set and redefinition/reframing of reality

5.4 Perverse manager characteristics valued and rewarded

Characteristics have been drawn together from the research to provide a perverse profile of a manager who is valued, rewarded and promoted in the NHS. It may be the case that
it is very difficult to achieve any high position in the NHS unless people do adopt a rationalising mind-set and able to compromise their values. It certainly appears very difficult for a person to raise concerns and highlight poor care. It seems that people who care and raise concerns are not welcome in organisations and can be victimised. This is obviously an extremely disturbing picture and situation.

A retired clinical team leader (not a participant) was asked as part of testing the manager profile “What are the characteristics needed to prosper in the NHS?” The first response was that “It depends on what you do”. “It would be different for a clinician”. If it was through “…the management line” it would be:

- “Toe the party line
- Have the gift of the gab
- Tell people what they want to hear
- Knowing when to challenge and when to back off. If clinical, wouldn’t back off so early
- Be good at interviewing and good in meetings. Able to think on your feet
- Knowing and able to use the current terminology
- Good at applying directives, or being seen to be applying directives”

These characteristics would be required to “go up the tree”. When shown the list from the research they commented that people would not always reflect all those characteristics, but they could think of one person who did. This person had worked in the strategic health authority.

The possible characteristics of a manager who prospers based upon the research data – “Survival of the unfittest” are:

- “…‘Yes’ written on their foreheads”/”…a ‘yes’ person”
- “…kiss their arses”,
- Kiss up, kick down/”…very good at ‘managing up’”/”…give a good impression to those above them whilst being very unpleasant to those who work for them”.
- Join the club/play the game
- Toe the party line/sing the corporate tune/singing from the same hymn sheet
- Able to sell themselves; the best and the greatest
- “…the gift of the gab and dazzle the panel with bullshit”
- Able to tell people what they want to hear
- Cover up and hide negative information
- Produce *spin* and able to lie
- Produce *good news, maximum gloss* and *paint veneer*
- Mind-set of rationalisation and justification
- Loss of principles/values; “...almost value free”, “...if they ever had principles”
- Get rid of the cardigan and put on the cocktail dress, heels and jacket
- *Chameleon;* “...just take on the next thing that is required”/“...can just move on to the next thing”
- Able to *turn the blind eye/put fingers in their ears and hum loudly*
- Choose not to see, listen, hear and act
- Keep stum, don’t let it out
- Don’t *air, expose or wash the dirty linen*
- Lacking in care and compassion
- Able to compartmentalise their life
- “…prepared to shed the previous life” because there is “…a vested interest” for them
- Able to *walk by on the other side*
- Unthinking obedience
- Self-interest, career and promotion comes first

One of the focus groups responded that not having to think was critical. It was a “…giveaway phrase” because “…it is painful for people to think about things”, and “…some of these people live in kind of bubbles”. They also considered that peer groups would collude in not thinking because “…people will only tell them what they think they want to hear”.

It may be what Alford (2001) describes as

“Thoughtlessness” which “…is a medium of doubling, described...as a way of living in which one works terribly hard not to know what one is doing. The result is dissociation, a feeling that nothing is quite real...Thoughtlessness might more accurately be called fear of thought” (p.117).
“While Arendt calls bureaucracy the rule of Nobody, it might be more accurate to call it the rule of the living dead, those who no longer exist as actors because they can no longer bear to think about what they are doing. More than a few whistleblowers talked about their bosses and co-workers as dead, or zombies. “Sometimes they don’t seem human”, said one whistleblower of his co-workers. “I think people must kill a part of themselves to remain part of the system”” (p.119).

He goes on to describe thoughtlessness as

“...a way of not having to choose between loyalty to others and loyalty to oneself. In this regard, thoughtlessness is a lie, the pretense that one is living in a world in which it does not really matter what one does, for one is not doing anything real” (p.121).

5.5 Summary

In Chapter 5 the research purpose and objectives are restated as are the gaps identified in the research literature. Comparisons are made between the proposed model of organisational dysfunction (Pope and Burnes, 2013), and the research findings. An extended and developed model is suggested as are key causal drivers. The extended model is then represented in a different format to perhaps better reflect the way that the concepts are entwined, each reinforcing the other resulting in a dysfunctional, perverse, and troubled organisation; a “good news factory”. Further possible explanations and models are offered to increase understanding of the dysfunctional behaviour exhibited in the NHS. There is an adapted model of selective moral disengagement as relating to the NHS. A further model is proposed which shows the many things people don’t want, leading to choices for action/non-action supported by rationalisations/justifications and redefinition/reframing of reality. This is linked to another model identifying the path moving from fear and other factors, which produce rationalisations/justifications, and the choices made, resulting in an organisation becoming perverse and corrupt. There is also the progression from the individual and collective mind-set/reward for mind-set, of rationalisations/justifications to becoming the overarching culture. Perverse manager characteristics which are valued and rewarded are also proposed.
The next and final chapter examines the extent the original overall purpose and research objectives have been achieved and some conclusions are drawn. The implications are discussed, and some recommendations made, as are suggestions for further research.
Chapter 6. Conclusions and implications

6.1 Introduction

In this chapter there is an examination of the extent the original overall purpose and research objectives have been achieved. Some conclusions are drawn. Representational, inferential and theoretical generalisations are proposed. The implications for both organisational practice and academic theory and knowledge are discussed. Some recommendations for policy change are made, as are suggestions for further research.

The main headings are:

6.1 Introduction
6.2 Conclusions
6.3 Generalisations
6.4 Implications
6.5 Further research

6.2 Conclusions

The overall purpose of the doctorate research was to understand the reasons and motivations for the behaviours in the specific scenario described in Chapter 1. It was also to consider more generally the organisational responses to negative behaviour between and towards staff, and to understand more fully the broader cultural context and the possible causal drivers of such behaviour.

The research objectives were:

1) To assess the organisational responses to negative behaviours between staff in the NHS

Forty-three interviews and six focus groups were undertaken in this research study. The first objective has been achieved and demonstrated in depth in the findings chapter. The ‘3 word summary’ responses from both the main and the twenty-eight extra participants,
as well as data from the interviews and focus groups detailed in the findings provide a
greater understanding of NHS culture and of organisational responses to negative
behaviour between and towards staff. Information on the organisational responses is
also presented in the Categories (Appendix 3), and the analytical Lower and Higher Level
Classes (Appendix 7).

Though a small amount of good practice was identified, the majority of participants
indicated an inadequate response to the issue of negative behaviour. A strong resistance
to acknowledging problems was identified to this, and also other problems. The overall
culture was one of resistance to the voicing of any problem or concern which might
reflect badly upon individuals and the organisation and anything contrary to directives
coming down from the centre. The findings indicate that the NHS is a very deaf and
defensive organisation, often exhibiting denial. There are many ‘Elephants in the room’ in
the NHS and problems are often ‘swept under the carpet’ and given the “...three wise
monkeys treatment”.

Certain groups such as Doctors/consultants and managers appear to be protected. Self-
interest and relationships are key factors in this protection. There are powerful
protective alliances which provide benefit to individuals. Wrong doing can be rewarded
and good behaviour/practice punished.

2) To assess and analyse the motivations/reasons for the organisational responses

The second objective has been accomplished through the analytical processing of the
data using the Framework Method of qualitative analysis. The broader cultural context
and the possible causal drivers of such behaviour are evidenced in the findings, the
analysis and discussion chapter, and in the proposed models (Table 5.1, Figure 5.3, 5.4,
5.5, 5.6 and 5.7). Details regarding reasons and motivations are also provided in
Appendix 7 which lists the analytical Lower and Higher Level Classes for each Framework
Theme.

Further material is provided in the appendices considering the references to fear in the
NHS (Appendix 11), rationalisations/justifications used in the workplace (Appendix 12),
specific references to culture (Appendix 13), what people don’t want (Appendix 14),
underlying assumptions/beliefs (Appendix 15) and further observations on power and behaviour (Appendix 16).

As part of the research process for this doctorate the scenario situation and other similar situations were explored. The twelfth Framework Theme in the findings chapter and the corresponding Lower and Higher Level Classes provide details of the responses of the participants to the scenario and gives further understanding regarding the motivations and the reasons for the scenario. The major driver in the culture of the NHS appears to be the protection of individual and organisational image and the protection of self-esteem. This seems to be a very powerful influence which overrides other drivers in the NHS. Everything else appears to be secondary.

3) To increase understanding of why some NHS organisations do not take action to address the problems of negative behaviour between staff

Greater understanding has been gained through conducting the research study, analysing and presenting the findings in this thesis. The findings, analysis and discussion chapter, the proposed models (Table 5.1, Figure 5.3, 5.4, 5.5, 5.6 and 5.7) all provide greater understanding of why organisations do not take action to address the problems of negative behaviour between staff. The analytical Lower and Higher Level Classes for each Framework Theme (Appendix 7), the references to fear in the NHS (Appendix 11), rationalisations/justifications used in the workplace (Appendix 12), specific references to culture (Appendix 13), what people don’t want (Appendix 14), underlying assumptions/beliefs (Appendix 15) and further observations on power and behaviour (Appendix 16) also provide increased understanding of what is a complex cultural situation. It would be perhaps more accurate if the wording in this objective was ‘many’ and not ‘some’ organisations, as the problems seem to be very widespread.

Understanding has hopefully also been increased through the publication of the conceptual article “A model of organisational dysfunction in the NHS (Pope and Burnes, 2013). The findings in this research study extend and develop the proposed model (Table 5.1, Figure 5.3 and 5.4).
4) To contribute to changes of policy and practice within the NHS

The fourth objective has perhaps partially been achieved through the publication of the article “A model of organisational dysfunction in the NHS” (Pope and Burnes, 2013).

The researcher has also contributed to the Robert Francis review on raising concerns in the NHS entitled “Freedom to speak up: An independent review into creating an open and honest reporting culture in the NHS” (https://freedomtospeakup.org.uk/). The researcher sent the article to the review panel and was then requested to further contribute at two of the seminars held across the country. There is an intention to publish the findings of this research study as soon as possible. These actions may in some way contribute to changes of policy and practice within the NHS.

The above objectives have been achieved and some conclusions can now be drawn. This thesis predominately highlights the negative aspects of the NHS culture and most of the contributions from the participants are negative. Many expressed their concern at what they saw and wanted change. It is however recognised that there are teams, departments, and parts of organisations that work very well and deliver high quality care. Some organisations in the NHS are better than others. By focusing upon the negative it is hoped it will encourage the required changes that will better safeguard the wellbeing of both staff and patients. It is not in anyone’s long term interest to have a dysfunctional, perverse and troubled health service in the UK.

There is a lack of humanity within the hierarchical, “top down driven” NHS. The NHS is an enclosed “system”, a “machine” and an “insensitive bureaucracy” where there is great complexity and great pressure to deliver with limited resources. There is constant change and there can also be disorder, chaos and paralysis. There can be a lack of care, concern and compassion for both patients and staff. A culture of disrespect is described and many staff do not feel valued. Negative behaviour appears to have become tolerated and normalised and responses to such behaviour are often inadequate. There is a strong resistance to voicing concerns and any information which puts individuals or the organisation into a ‘negative light’. People who raise concerns can be victimised. The “...top-down bullying culture...suppresses constructive dissent”.

There appears to be a culture of elitism, fear, blame, bullying and a lack of accountability; a culture where power, self-interest and status matters. Good practice/behaviour can be
punished, and bad rewarded, as can failure; a distorted and irrational upside-down morality. The NHS is described as a “...self perpetuating dysfunctional system” where there is the perverse dynamic of the “...survival of the unfittest”. The NHS may well reflect the general British culture and “Structures of impunity” as described by Whyte (2015).

It may be that the NHS has become a structure solely there to meet its own needs and to provide self-esteem for the people who work in it and those who control it politically. It may simply be a structure where people are “...creating names for themselves”. The productive work becoming “...less important than the maintenance of narcissistic fantasy” (Schwartz, 1987b, p.52). “Totalitarianism represents a turning away from reality” (p.52).

There are examples of good practice and culture, but the needs of the NHS, as an organisation, and the protection of image appear more important than the welfare of the staff or patients. It seems that the NHS has deviated from its “...core goal” (Ibrahim and Majoor, 2002, p.20). There also appears to be “...a general failure to orient to the common good, a crisis of moral judgement and an aggrandised and hubristic distortion of individual thinking” (Blaug, 2014, p.2).

There seem to be “islands” and “pockets” with a positive culture, however, the generalised evidence suggests the NHS is systemically and institutionally deaf (with its fingers stuck in its ears, humming loudly), bullying, defensive and dishonest, exhibiting a resistance to ‘knowing’, denial and “wilful blindness”; a dysfunctional, perverse and troubled organisation. Corrupt and unethical behaviour has been identified as have totalitarian and Kafkaesque characteristics. The NHS could also be described as a coercive bureaucracy and under certain definitions, a corrupt entity. The NHS appears to be an organisation with a heart of darkness; a “...self perpetuating dysfunctional system” where there is the perverse dynamic of “...survival of the unfittest”. There may be widespread “...learned helplessness”. Overall, the needs of the NHS and the protection of image appear more important than the welfare of staff or patients. It does seem to be a “...good news factory”; rejecting and hiding any “bad news”. The NHS appears to have “...lost its way” and its focus/purpose as an institution. Negative behaviour is one of many ‘Elephants in the room’ in the NHS.
6.3 Generalisations

There is a wide geographical spread of participants, and a wide range of roles with a breadth of experience. Participants represent a large number of NHS organisations from across the UK. The researcher considers that some representational, inferential and theoretical generalisations can be made (Lewis and Ritchie, 2003).

Looking beyond representational generalisations within the NHS as already described, it is considered that some inferential and theoretical generalisations can also be made.

It is proposed that other similar large, autocratic, hierarchical and bureaucratic healthcare organisations could exhibit the characteristics of the developed Core Model and the specific characteristics. There are close similarities to the research described by Hutchinson et al (2009) in an Australian health system, when they describe the management of bullying as a corrupt activity. Though the UK NHS is very politically driven and the desire for a positive image is very strong, there could be other reputational drivers other than the political which could perhaps produce similar behaviours and outcomes.

It is also considered that other UK public sector organisations would probably reflect to varying degrees the characteristics of the developed Core Model as they are in the same political context. People may not however have the same idealised views of those institutions.

Other large organisations outside of healthcare with similar hierarchical, top down driven characteristics could also exhibit similar behaviours e.g. large private corporations, Universities and Churches. It is proposed that the simpler more conceptual model of organisational dysfunction as described in (Pope and Burnes, 2013) could be applied to these situations and provides some explanation for persistent dysfunctionality and tendency to retreat from reality.

Smaller organisations are probably less likely to be prone to such behaviour simply because there is less of a gap between the top of the hierarchy and the bottom. It would be much harder to hide from reality. However, there could still be a tendency towards the behaviours in any organisation, of any size, where there are reasons for being resistant to hearing and addressing ‘bad news’.
6.4 Implications

6.4.1 Implications for practice/the organisation

There are implications for a range of people such as senior leaders/managers including HR professionals, regulatory bodies, trade unions, as well as those at a political level and interested parties external to the NHS. There are also implications for every person employed within the NHS. Every person has a responsibility to not be part of the “sea of silence” and “learned helplessness”. The care of the patient and the welfare of the staff has to be at the core of everything that is done. There needs to be a facing up to reality and a “…cleaning up” of the NHS. All employees in the NHS must choose to see, listen, hear, know, acknowledge, think, challenge, speak and act for the benefit of the patient and other staff. The ‘undiscussable’ needs to become ‘discussable’ (Zerubavel, 2006). The NHS must re-orientate its focus and choose to care and exhibit ‘intelligent kindness’ (Ballatt and Campling, 2011). There needs to be a culture of respect (Leape et al, 2012, Part 1 and 2), where every role is valued.

There needs to be recognition within the NHS that the degree of dysfunctional behaviours described in this thesis and the responses to such behaviour are not normal or acceptable. The behaviours can be extremely destructive and dangerous. This is particularly seen in situations such as the Mid Staffordshire trust. Both patients and staff can be extremely damaged. Everything possible should be done to address these problems to protect the welfare of both patients and staff. There is a need to very consciously and determinedly move counter culturally, so there is a healthy level of individual and collective ego-defences and narcissism. The NHS needs to embrace the identity of being a listening, learning and honest organisation.

The impact of the political control of the NHS needs to be seriously considered. The evidence suggests that politicians should not be responsible for both providing and monitoring the NHS, as there is a conflict of interest and a driver towards defensive behaviour. The problems of the imbalance of power and the dominant relationships/alliances within organisations need to be addressed. The researcher suggests that HR should be external to organisations rather than being under the direct control of the CEO and the Board, to ensure greater independence. They will probably
need to be retrained due to the long term learning of poor employment practice. A few participants in a focus group suggested the complete removal of HR.

It is also suggested that consideration be given to the appropriateness of the current non-executive role and whether it helps or hinders sensitivity to organisational problems. Does the role promote or discourage good behaviour and practice? Does the role enable and reinforce bad behaviour and practice, and increase organisational defensiveness? The focus has to be on the patient, not delivering ‘good news’ to higher levels of hierarchy. Clear, rather than diffuse, lines of responsibility and accountability are required.

There also needs to be a fundamental and major shift in the relationship between those who provide clinical services and those who administer the bureaucracy and the organisation. Clinical autonomy needs to be restored. There should be a move away from the hierarchical “command and control” management structure with a corresponding move towards consensus management which was earlier criticised in the 1980s (Newdick and Danbury, 2013). A move away from the language of ‘leadership’ and ‘management’ and a shift towards the language of administration, facilitation, support and partnership would be helpful. Administrators should be there, as in the past, as facilitators and people who support the clinicians to achieve quality services, not as dictators and controllers. Strong ongoing independent external pressure will be required to ensure change.

Perhaps the NHS should take advice from John Timpson, who is chairman of the large shoe repair chain Timpson Ltd (Timpson, 2010)? He is committed to the concept of “Upside down management”.

“Our style of Upside Down Management has made me aware of the modern techniques and forms of ‘best practice’ that get in the way of good business. Management science has gone too far. Too many people are promoted because they obey the rules, and many managers are afraid to use their initiative. It’s time we blew the whistle on all this top-down management; we need fewer directives and less red tape. Managers should cancel meetings and visit the real world to find out what’s going on. Instead of relying on consultants, they should listen to the people who actually do the job” (p.x).
Currently, the researcher has little optimism regarding the possibilities of bringing about change; such is the engrained nature of the problems over many years and the overall political control. The NHS may just continue to crash from one disaster to another. Tragically, it may be that the NHS will require further disasters to shock it into more serious focused action. “A common form of shock is media exposure. Significant negative exposure creates a socially undesirable image, often galvanising change” (Ashforth and Anand, 2003, p.38). It requires a significant organisational effort to remove normalised corruption.

The NHS does seem to be very “deaf” and extremely resistant to cultural change. As described by Morrison and Milliken (2000) multiple layers of personnel may have to be removed. Long (2008) is of the opinion that “Perversion begets perversion” and “Abusive cycles are hard to break” (p.34). Newdick and Danbury (2013) write that “Financial austerity, institutional instability and political anxiety do not provide firm foundations for optimism” (p.6). Davies and Mannion (2013) are also not optimistic as they recognise the complexity of the factors impacting on the culture of the NHS.

One of the extra participants said the NHS “Needs a complete wipe-out. Take everybody out and put them back in again. Retrain the managers. Need to have people in the caring system who care. Taking the bureaucracy out of the care system. It is plagued by bureaucracy...Whole of system is flawed. Lost in politics”.

One participant said it “Would have to be something gigantic...to break the culture”. Another said “I think to eradicate this endemic culture in the NHS is a fantasy! It will never happen until another generation!” In contrast, relating to the BRI inquiry and what they saw as “Kennedy’s fundamental errors” a further person had a very different view. “That cultures take a long time to change - they don't; true leaders can change them overnight. Evidence of it every day”.

6.4.2 Implications for theory/academic knowledge

The extended and developed Core Model, and other models increase understanding of actions, behaviours and relationships in the NHS. As described above there are also implications for organisations beyond the NHS.
Firstly, the model of organisational silence (Morrison and Milliken, 2000) needs to be developed and strengthened as identified in the discussion. Secondly, behaviour in organisations now needs to be assessed against a broader model of concepts rather than simply e.g. ‘organisational silence’ or ‘normalised organisational corruption’. The research shows that the three concepts in the model are very much entwined, overlapping, and reinforcing the other, supported by the mechanisms of selective moral disengagement, rationalisations and justifications (Figure 5.4).

There is a need for testing of the extended and developed Core Model and the other proposed models within the NHS. Testing also needs to take place within other organisations external to the NHS, to assess the possible broader relevance.

### 6.5 Further research

1) The developed Core Model of organisational dysfunction needs to be further tested within the NHS to ascertain the accuracy of the model and the conclusions that have been drawn. The broader application of the model also needs to be tested in organisations external to the NHS.

2) The possible causal drivers/factors in the NHS need to be tested as does the developed model of selective moral disengagement.

3) The model showing the many things people don’t want, leading to choices for action/non-action supported by rationalisations/justifications and redefinition/reframing of reality and the other linked model need to be tested.

4) Further research is required on the role of HR, poor HR/employment practices and the impact in the NHS.

5) More in-depth research needs to be conducted around the topic of rationalisations and justifications employed within the NHS, as well as the deeply held assumptions and beliefs that exist. The impact of these ways of thinking needs to be better assessed. Increased understanding and knowledge would hopefully contribute to more effective interventions to bring about positive change and improvement. Three particular areas need to be covered.
• Rationalisations/justifications employed when poor HR/employment practices are utilised.
• Rationalisations/justifications employed regarding the passing of CEOs as ‘...free good’, other roles as secondments paid for by the NHS, and other similar irregularities
• Rationalisations/justifications employed in victimisation of people who raise concerns

6) The underlying societal idealisation may have a huge impact on the ability of the NHS to learn and improve, due to the reluctance to criticise and challenge. There should be research on the attitudes of the public/staff towards the NHS and how these might impact the inability of the NHS to improve.

7) Research on the concept of individual identity being linked to the organisational identity and the impact on behaviour in the NHS
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Appendices

Appendix 1. The Clinical Indicators for corruption by power (Blaug, 2014, p.104)

1. **Self Inflation**: growing self-confidence and the gradual privileging of own perspective; progression from more usual methods of maintaining self esteem to an (unusual) narcissistic aggrandisement; automated reification of one’s own superiority as natural; widespread confirmation and affirmational bias; increasingly subjective conception of public good and subordination of the public good to one’s own psychological needs; strong identification with the organisation and substitution of organisational knowledge processing by own cognition; evidence of battery cognition and increased proclivity for crimes of obedience; heightened attraction to hierarchic management philosophy and its attendant justifications and schemas; arrogance and disinhibition; defensive hardening degenerating eventually into the inability to learn.

2. **Devaluation of Subordinates**: automated reification of subordinate incapacities as natural; increased adoption, automation and reification of negative schemas regarding subordinates; stereotyping of subordinates as a free-riding and coherent out-group that has abnegated decision-making responsibility – and thus as requiring disciplinary control and paternalistic guidance; dehumanisation of, and loss of empathy for, subordinates; increased narcissistic injury to subordinates (conscious and unconscious); increased proclivity for crimes of obedience; contempt; arbitrary cruelty.

3. **Separation**: emergence of a cognitive divide between the leader and subordinate, reflecting their respective directions of cognitive substitution.

   For the leader ‘taking over’ organisational knowledge processing; a growing inability to take other perspectives on board; selection of advisors who support the leader’s views; widespread confirmation bias and adoption of automated and static schemas resulting in shrinking sources of knowledge; progressive isolation and cognitive immunisation.

   For subordinates ‘ceding’ their cognition; increased awareness of, and orientation to, the leader’s needs; automated reification and internalisation of own incapacities; collusion; self-debilitation; resentment and resistance; increased proclivity for battery cognition and crimes of obedience.

   For both leader and subordinate; increased automated reification of the hierarchic organisational form and its supporting ideological schemas; communication breakdown.

4. **Invisibility**: obtains when the above three behavioural changes take place outside the conscious awareness of affected individuals, and do so through a process of reification bias and automation. Though corruption by power entails an interaction between individual and group, the social influence on individual thinking remains invisible. Corruption is thus a perceptual distortion. It is a disorder of cognition and epistemology, and is parasitic on the invisibility of the processes by which meaning is constructed.
### Appendix 2. List of 77 research contact outcomes – Non response/declined

<table>
<thead>
<tr>
<th>Role</th>
<th>Outcome of contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Full-time Officer (A)</strong></td>
<td>Contact through regional office. After verbal agreement no response to initial e-mail contact in December 2010.</td>
</tr>
<tr>
<td><strong>2. Ex Chief Executive</strong></td>
<td>Direct contact. No response to initial contacts x 2 in January 2011.</td>
</tr>
<tr>
<td><strong>3. Ex HR Manager</strong></td>
<td>Letter sent 13 August 2011 via a third party. No response.</td>
</tr>
<tr>
<td><strong>4. Theatre Nurse</strong></td>
<td>Contact through third party. Verbal face to face agreement to take part. No response after first stage sent on 21 August 2011.</td>
</tr>
<tr>
<td><strong>5. Patient Liaison Volunteer</strong></td>
<td>Contact through third party. Chose not to participate in September 2011.</td>
</tr>
<tr>
<td><strong>6. Community Nurse team leader</strong></td>
<td>Contact through third party. Chose not to participate in December 2011.</td>
</tr>
<tr>
<td><strong>7. Staff Nurse</strong></td>
<td>Contact through third party. Initial e-mail sent 6 November 2011. Initial agreement, but then no response.</td>
</tr>
<tr>
<td><strong>8. Full-time Officer (A)</strong></td>
<td>Contact through national and then regional office. Initial e-mail sent 6 November 2011. Second e-mail sent 21 November to named person. Response 23 November 2012. Agreed to take part. First stage sent 24 November. No response. Further request sent 9 Jan 2012, no response. Another FTO contacted and they passed it to original FTO. FTO agreed to have phone conversation and also to complete interview. Did not telephone as had agreed. No further contact made.</td>
</tr>
<tr>
<td><strong>11. Ex Chief Executive</strong></td>
<td>Contact via third party. Initial e-mail sent 10 Dec 2011 requesting interview. No reply. E-mail resent 17 December 2012. Responded and agreed to take part and research letter sent 19 January 2012. E-mail resent 10 February 2012. No response. Consent form and first stage sent 21 February 2012. No response.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>14. Campaigner on NHS issues</strong></td>
<td>Contact via third party. Initial e-mail and research letter sent 15 May 2012. No response.</td>
</tr>
<tr>
<td><strong>15. Ex NHS Chair/Chief Executive</strong></td>
<td>Direct contact. Initial e-mail and research letter sent 15 May 2012. Agreed to take part in e-mail interview 15 May. Consent form and first stage sent 15 May 2012. Reminder sent 8 June 2012. No response.</td>
</tr>
<tr>
<td><strong>16. Ex Chair</strong></td>
<td>Direct contact. E-mail and research letter sent 18 June 2012. No response.</td>
</tr>
<tr>
<td><strong>17. Community Psychiatric Nurse</strong></td>
<td>Direct contact. Face to face contact 29 November 2012. Declined to take part.</td>
</tr>
<tr>
<td><strong>18. Doctor/Clinical Advisor to CQC</strong></td>
<td>Direct contact. Initial e-mail sent on 31 October following face to face contact at conference. Agreed to take part but said was going on holiday, and would contact when back. First stage by e-mail sent. No response.</td>
</tr>
<tr>
<td><strong>19. Psychiatrist</strong></td>
<td>Direct contact. Initial telephone call to organisation with request to contact. Agreed verbally and on e-mail to contribute. Emails with questions sent August 2012. No response. Further e-mail sent 17 October 2012. No response.</td>
</tr>
<tr>
<td><strong>20. Ex NHS physiotherapist</strong></td>
<td>Direct contact. Person had left the NHS because of the way negative behaviour had not been addressed by an organisation. They did not want to take part in the study as they felt it would be too traumatic reliving the experiences.</td>
</tr>
<tr>
<td><strong>21. Ex Full-time officer</strong></td>
<td>Contact made at workplace conference. Person made a comment in general conversation about whistle blowing and there being a worse response when it is against the organisation, rather than a specific individual. Wrote via the trade union asking further questions. No response.</td>
</tr>
<tr>
<td><strong>CEOs England</strong></td>
<td>Direct contact. E-mail. Total contacted = 30 Based on website data reviewed on 23 May 2012: 3 Ambulance Trusts contacted out of 11 - no response 6 Mental Health trusts contacted out of 58 - 5 did not respond, 21 Acute Trusts contacted out of 167 - 16 did not respond.</td>
</tr>
<tr>
<td><strong>CEOs Scotland</strong></td>
<td>Direct contact. E-mail. 10 Boards contacted out of 14. No response.</td>
</tr>
<tr>
<td>CEOs Wales</td>
<td>Direct contact. E-mail. 5 Boards contacted out of 6. 3 no response.</td>
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<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>CEOs Northern Ireland</td>
<td>Decided not to survey as had enough responses from CEO’s (8).</td>
</tr>
<tr>
<td>External organisations/patient groups with interest in the NHS – 11 out of 13 did not participate</td>
<td>Contacts made through national offices</td>
</tr>
<tr>
<td>2. Initial e-mail 21 February 2012. No response. Phone call - Message left with assistant. No response. E-mail resent 24 April 2012 and research letter. Response stating they would contact. Further response indicating someone will communicate. No response.</td>
<td></td>
</tr>
<tr>
<td>3. Initial e-mail 21 February 2012. No response. Phone call. E-mail resent. No response. E-mail resent 24 April 2012 and research letter. No response.</td>
<td></td>
</tr>
<tr>
<td>4. Initial e-mail 21 February 2012. Further e-mail sent. No response. Further e-mail sent 1 May 2012. No response.</td>
<td></td>
</tr>
<tr>
<td>5. Initial e-mail 21 February 2012. No response. Phone call. Referred to Director. No response. E-mail resent 24 April 2012 and research letter. Responded and agreed to take apart. First stage sent 29 April 2012. No response.</td>
<td></td>
</tr>
<tr>
<td>8. Initial e-mail and research letter sent 1 May 2012. Response 3 May 2012 and agreed to take part. Consent and first stage sent 4 May 2012. Follow-up e-mail sent 8 June 2012. No response.</td>
<td></td>
</tr>
<tr>
<td>9. Initial e-mail and research letter sent 1 May 2012. Automatic response. 15 May 2012 responded. Did not consider they had the knowledge and experience to contribute.</td>
<td></td>
</tr>
<tr>
<td>10. E-mail and research letter sent 11 May 2012. Response 15 May 2012. First stage sent for information 15 May 2012. No response. Discussion October 2 2012. Further phone call. Stated they did not consider they had the knowledge and</td>
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<tr>
<td><strong>11.</strong></td>
<td>Phone call 15 August 2012. Staff member agreed to take part and to send information to another staff member who was linked to a whistle blowing helpline. E-mail, research letter and first stage sent 15 August 2012. No response. E-mail and information resent 31 October 2012. No response.</td>
</tr>
</tbody>
</table>

experience to contribute.
Appendix 3. Data Categories from focus groups and interviews

Framework Theme 1. Structure/form/groups

[Added from ‘Hierarchical/top down/power’] Introducing powerful management structure in NHS, has allowed tentacles of DOH to reach down into every organisation and control it. Where horrible culture comes from. Deadly combination. Adversarial political system. Whoever in opposition casting about for criticism to hurl at whoever’s in power and whoever’s in power does not want to hear from front line staff about problems.

[Added from ‘HR/other roles’]

HR as management tool. Occupational Health as tool of HR.

[Added from ‘Self-interest/reward/relationships/protective alliances’]

NHS is one employer

<table>
<thead>
<tr>
<th>FG</th>
<th>Categories for Framework Theme 1. Structure/form/groups (Focus groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Key positions; some trusts male, some female, some male.</td>
</tr>
<tr>
<td></td>
<td>Predominately staff all levels female.</td>
</tr>
<tr>
<td></td>
<td>Spreading of same behaviour/ideas through whole system; endemic</td>
</tr>
<tr>
<td></td>
<td>Managers faces different, all doing same things; scary.</td>
</tr>
<tr>
<td></td>
<td>Thought out plan or instruction from on high?</td>
</tr>
<tr>
<td></td>
<td>Collusion?</td>
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<tr>
<td></td>
<td>Get in room together?</td>
</tr>
<tr>
<td></td>
<td>Hoover up ideas.</td>
</tr>
<tr>
<td></td>
<td>Got away with it</td>
</tr>
<tr>
<td>2</td>
<td>Closed, enclosed, emotive, (a club).</td>
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<tr>
<td></td>
<td>Isolation (Club, gang, secret society, same language).</td>
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<tr>
<td></td>
<td>Weird way of working.</td>
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<tr>
<td></td>
<td>Don’t talk to one another.</td>
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<td></td>
<td>Set teams, all fighting each other.</td>
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<tr>
<td></td>
<td>Cut off from outside world which doesn’t understand.</td>
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<td></td>
<td>Constantly changing priorities.</td>
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<td></td>
<td>Told what to do but real world do what want.</td>
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<tr>
<td></td>
<td>Part of huge monster</td>
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<tr>
<td></td>
<td>Big monster; hundreds of different companies.</td>
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<tr>
<td></td>
<td>Organisations under one umbrella.</td>
</tr>
<tr>
<td></td>
<td>Same organisation [NHS] everything different</td>
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</tbody>
</table>
|    | Like family, loads of cousins going off doing different things, ‘Hickey cousins’.
|    | Some disown each other.                                              |
|    | Always black sheep in family.                                        |
|    | Weird dysfunctional family.                                           |
|    | NHS is political pawn.                                               |
|    | Teams fighting each other.                                           |
|    | Competition.                                                         |
| 3  | Restriction                                                          |
| 4  | Size it is, needs to be bureaucratic.                                |
|    | Disjointed.                                                          |
|    | Whale versus shoal of fish.                                          |
|    | Sub, micro cultures mini organisation.                               |
|    | Challenge to pull threads together.                                   |
Tension between 'one big organisation' and different policy/behaviour.
Disjointed impacts feeling and engagement with organisation.
Institutionalised culture, large organisation reason for *just can’t turn that ship round*.
Strange.
*Lots of fish versus large whale.*
Large systems restrain.
*Big whale, not independent.*
Some trusts, departments, *effective fish*

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<th>6</th>
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</table>

Different groups representing own interest.
Factions, silos defending own position.
Culture is group specific e.g. discipline, professional group, went to school with somebody.
Impacts upon culture.
When in crisis, coalesces in good and bad.

<table>
<thead>
<tr>
<th>Int</th>
<th>Categories for Framework Theme 1. Structure/form/groups (Interviews)</th>
</tr>
</thead>
</table>
| 1   | Too many tiers.  
Don’t communicate with different groups.  
Don’t connect.  
Not a whole.  
People treated differently.  
Two lots of people, high paid and poor paid; *hell of a gap in the middle.*  
A gap; distance. |
| 2   | Large organisation |
| 3   | No single culture.  
Organisations, cultures vary.  
Different cultures large units.  
Experiences differ.  
High degree tribalism; *pits* one group against another.  
Medical model hierarchy of elites; hampers team working.  
Leaving aside senior management, medical staff one group, rest another group.  
Both tribes, contain conflicting *clans*.  
Difficulty resolving problems.  
A for C partnership fostered; not beyond A for C.  
Bigger roles for private, voluntary sectors have own cultural climate.  
Tribal.  
Lack of collaborative working. |
| 4   | Silo working.  
Divisions; lack of sharing information. |
| 5   | |
| 6   | |
| 7   | |
| 8   | Highly complex.  
Diverse.  
Collective.  
Complexity.  
Complicated.  
Meeting holistic, wide needs all people, communities. |
| 9   | |
| 10  | |
| 11  | |
| 12  | Enclosed.  
Not open *whistle blowing culture.*  
*‘Closing of ranks’.* |
Staff in NHS, thinks does it best. 
Not always open to learning from external sources. 
Tesco’s famous, employee recommend improvements not translated to much action on floor of NHS. 
People ‘on the floor’ lots of good suggestions to improve, but doesn’t happen. 
Different organisations within one trust. 
Physical dimension; THQ separate building. 
Perception directors don’t understand issues facing those on ‘coal face’. 
Current climate, focus on financial side, constant change. 
Communication always big issue. 
No synergy within and between organisations. 
Insular.

13

14

15 Unimpeachable institution
Inward looking.
Machines.
[Why?] No humanity; no human factor in operation.
[Why insular?] [staff] live, breathed NHS nothing else; very closed culture.
Managers, 1980s, quickly part of enclosed culture.
Links to command control style from the top.
Culture NHS ‘Looking up not out’.
Hide critical reports; sneered at them; dismissal.
Proves how NHS operates.
Whole era, behind [other situations] understanding safety and quality.
So diverse, so exploded.
No one knows what going on in ‘vast machine’.
Complexity is mega.
[Unimpeachable?] NHS ‘respected’, ‘beloved’.
Reputation had, and not wanting to complain; not criticised.
Medical professions came out of ‘gentlemen’, Florence nightingale, whole ‘angel thing’, as NHS born.
Cannot criticise the NHS.
Unimpeachable is very dangerous.
Citadel, notional home of big secret; metaphor for NHS.
Society not noticed increased complexity.
One monolithic organisation.
Political responsibility.
Man in Richmond House dictates; therefore it’s a nightmare.
Could change it easily, if wished.
Little organisations can just do things; values very close to, short gap between values and front line.
Vast organisation, hundreds of layers deep.
If slice, chop organisations into [smaller units/teams] still have problem when aggregate them
Massive organisation.
Funded/worked on own might be better, but getting bigger.
Doctors and nurses treat patients not managers

16

17 More focus on hospitals, specialist services rather than total NHS.
Encouraged to stretch beyond areas of competence.
Services fragmented.
Complex systems.
No independent NHS Board.
Not “whole NHS”.
Cultures, context, vary across UK.
Absence of internal market induces different behaviour.
English NHS is "conflicted".

18

19 Lots of NHS’s.
### Bastard culture.
Peculiar situation.
*Hybrid thing of a social mission*, with, peculiar attempts mimicking private sector.
Parody on the original.

#### 20
Vast organisation of many cultures.  
All affected by culture *at the top*.  
Years of political control distort conduct  
Nothing remotely size of NHS

#### 21
Leadership challenge, size and diversity.  
All types health care across large geographical area.  
Massive organisation.  
Not one thing; different sub cultures.

#### 22
NHS organisation vary; but common themes.  
Strong professional identity.  
Loyalty to occupational group rather than organisation.  
Strong informal networks parallel to official, formal structure; may be more powerful.  
Professionalised.  
Conflict between professions: different approach or ethos.  
Simple conflict of strong personalities; different visions of service model.

#### 23
Different cultures in different organisations.  
Behaviours driven by most senior individuals; organisations history; current level of performance.  
Multiple cultures in organisations.  
Divisions between managerial, and clinical elements; starkest.  
Sub components, driven by different drivers.

#### 24

#### 25

#### 26

#### 27

#### 28
Professionally dominated.  
Low sense of common purpose collectively.  
Individual level high aspirations, but low belief in *the “system”*.  
Aspirational.  
Insular.  
Fragmented.

#### 29
Titles don’t necessarily reflect what do.  
Lack of clarity around roles.  
Titles more sophisticated, but further away from what do.  
Managers managing finance and administration, consultants managing medical practices.  
Consultants constrained by finance and admin.  
No idea how fits.  
Confusion.  
Lots of tiers; finance and administrators.  
Finance people, lots more tiers; ‘non jobs’, everywhere.  
[Why all these tiers?] Aims to take away cost from government; started with old Maggie Thatcher.  
Move to privatisation.  
Quangos, administrators, finance, managing budgets instead of health professionals.  
Gone, all a bit crazy.

#### 30

#### 31

#### 32
*Dear old NHS*, is *fossilising*, *dying on its feet*, breaking apart.  
Private sector *sweeping like vultures to pick up juiciest pieces left over*.  
Very gloomy.  
No longer national health service, series of competing health care businesses.  
Shouldn’t call itself NHS anymore.  
*NHS died at age of 52* in 2000 (*NHS Plan*).  
Different countries in different directions.

#### 33
[Added] Going up ladders

#### 34
Mixed workplace culture.  
Some supportive, learning orientated, focussed on evidence based progression, sharing knowledge.
## Framework Theme 2. Positive characteristics

### [Added from categories of ‘Finance/business/targets’]

Most staff dedicated, give patients best service available in restraints of finance.

Funding by taxation, resource allocated according to need very admirable. Not worried about payment

### [Added from ‘Change/variable’]

Still dedicated and creative. Still bounce back. In end all down to patient safety. We, our families use health service, families, families, use health service. Because caring people, don’t want to see anybody hurt.

Continue to reinvent ourselves to maintain patient safety. Resilience. Adaptability.

### Categories for Framework Theme 2. Positive characteristics (Focus groups)

| 1 | Pockets of increase training/up skilling, not consistent. Good team & manager. Respect inside teams but not from outside. |
Only few examples good practice – Current manager, informal relationships, can say what going on, carries out action.
Previous [manager] - Simple things, going out of way to do things, awareness of staff, positive way to treat them.
Managers [now] don’t take same responsibility.
Question why still there?
Better devil you know.
Love the patients.

2 Tolerant; Creative; Caring;
[Open, Proactive, Supportive ‘supposed to be’, ‘blue sky thinking’]
Dedicated.
Organisation there to care, mostly do.
Clinicians always banging on about, patients more important than meetings.
Caring profession.
Even managers some degree of caring.
Caring dedicated crew, but more than 2 tier organisation.
CE - Not good enough for family not good enough.
Can raise; immediate manager, good relations.
Supportive HR.
Big push on respect behaviours, good response.

3 Evidence-based, Professional.
Hard working; Professional.
Hard working, compassionate.
Willing to help towards goal best care possible.
Quality managers vary - Managers good when work ground level with you.
Some higher bands don’t understand, some fantastic because clinicians.
Quality of team work varies.
Quality Senior/director management varies, nursery rhyme ‘There was a little girl and she had a little curl right in the middle of her forehead. When she was good she was very, very good but when she was bad she was horrid’
Some very talented.
Talent shines through organisation.
Good ones engage extensively, through walking the job.
Others detached, arrogant, paternalistic, failure to engage all levels, know best, drive through personal agenda through operation of trust.
When not good staff fed up, disenchanted.
When good, really on top of job, problems get ironed out

4 Supportive, caring; Clinical (focused).
Clinical not business focus.
Want to believe underlying culture caring/supportive.
Lots of things eat away at concern.
People are carers, want to care;
[L&M], culture start at top.
Need leaders who will lead.
SHA HR Director with vision for staff wellbeing; an exception

5

6 Working hard/over worked.
Desire to get job done for patient.
Varying beliefs whether wish to get to bottom of complaint.
Staff proud of service.
Committed, because wanted to be positive, also believe NHS full committed staff.
Sometimes staff not well supported

<table>
<thead>
<tr>
<th>Int</th>
<th>Categories for Framework Theme 2. Positive characteristics (Interviews)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Some areas excellent.</td>
</tr>
</tbody>
</table>
Most staff dedicated, work to give best service available in restraints of finance. Good HR department with good trust policies very supportive to staff in negative behaviour situations. Where strong staff side, management find it more difficult not to honour staff side agreements. Even then budgets/peoples jobs frequently mentioned in negotiations.

Occasionally find somebody does not mind being told about problems, happy with alternative ideas.

One of most complicated, but fiercely effective, caring industries, pleasure working for. Meets holistic and wide needs all people and communities. Effective Generally give their all, go above and beyond job descriptions to give best care possible.

Culture overwhelmingly concerned with patients and their wellbeing. Focus on getting best for patients, sometimes to detriment of staff health and wellbeing. Focus on patient as individual. Culture of continuous improvement and willingness to change. Patient focused.

Many treated successfully, sadly, many are not. Vast majority people get good care. People there, got on and done things. I’m sure there are good hospitals.

Not all organisations, parts of NHS are bad. Are very bad hospitals, some extremely good hospitals. When good comparable to best US hospitals. Some very bad hospitals. Whole of NHS many good points, structure, funding by taxation, resource allocated according to need very admirable. People not worried about payment.

Are good and enlightened managers. Also strong culture, good interpersonal process, good will, achieving work by developing good relationships with staff. Strong culture of professionalism, evidence based practice amongst clinical staff. Corporate functions also try work in line with evidence based practice where possible. Good social support, peer relationships very much part NHS culture. Staff need relationships to survive difficult work, work very well many areas. Relationships. Some excellent managers in NHS but could do much more to foster, develop managers. Crucial to performance of services and wellbeing of staff. Dedicated professional leads. Hard working executive team. Fantastic clinical staff. Lack of translation up and down. Some decent people, one or two people, very senior positions, good values; do their best in nightmare situation.

Strong public sector ethos. Positive and negative connotations (positive: selflessness, devotion to ethical code)

Some positive, constructive behaviours in cross organisational and multi-disciplinary working. Mutual respect, all members reflecting each valid contribution to make.
<table>
<thead>
<tr>
<th>Page</th>
<th>Text</th>
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<tbody>
<tr>
<td>24</td>
<td>Caring. Supportive.</td>
</tr>
<tr>
<td>25</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Patients/relatives have excellent services. Changes to primary care. Appointments to see particular G.P [Back to what it used to be!] May reduce DNA rate.</td>
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<tr>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Aspirational Individual level high aspirations</td>
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<td>29</td>
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<td>30</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Staff now talking about compassion.</td>
</tr>
<tr>
<td>32</td>
<td>Some of most able, caring, innovative people in the country! [Re responses to neg beh] Also good ethical behaviour. Non-executive board members useful source mediation or support. People are strength of NHS. Lot of good people still around.</td>
</tr>
<tr>
<td>33</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Some places supportive, learning orientated, focussed on evidence based progression, sharing knowledge.</td>
</tr>
<tr>
<td>35</td>
<td>Managers are, on the whole, compassionate towards staff, want to be liked by them.</td>
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<tr>
<td>36</td>
<td></td>
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<tr>
<td>37</td>
<td>Committed.</td>
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<td>39</td>
<td></td>
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<tr>
<td>40</td>
<td>Majority of managers try to behave fairly.</td>
</tr>
<tr>
<td>41</td>
<td>[Organisation] sees itself learning organisation; open.</td>
</tr>
<tr>
<td>42</td>
<td>Within any large NHS organisation, individual pockets, islands, different culture. Staff work very well together. Able to insulate themselves. Often talk this trust is awful, but this bit, work together well.</td>
</tr>
<tr>
<td>43</td>
<td>High pressure work environment, fosters culture hard work, commitment (? R&amp;J). Caring. Trusting.</td>
</tr>
</tbody>
</table>

**Framework Theme 3. Hierarchical/top down/power**

[Added from ‘Raising concerns’]

Bullying management style. CE, circus ring master, school of management acceptable. *Middle layer* of very, very, grateful managers; no one questions. Staff so defeated. Complaint; *come down on* member of staff.
[Added from ‘Finance - Fraud/corruption/conflict of interest’]. No proper financial checks, lack of governance/control. Prevailing culture of no accountability.

[Added from ‘Change/variable’] Passing the buck.

<table>
<thead>
<tr>
<th>FG</th>
<th>Categories for Framework Theme 3. Hierarchical/Top down/power (Focus groups)</th>
</tr>
</thead>
</table>
| 1  | **Downward pressure.**  
Responsibility not taken.  
Some [Managers] 10 a penny like us, expendable.  
Belief are gods; should bow down.  
It’s their way or the highway.  
Instruction from on high.  
Don’t know whether from the top, thought out plan or together in room.  
Comes out same.  
[Staff] In cycle can’t get out of cause got no power.  
If no power frustration builds up.  
If not treated properly things explode within workplace  
No power to do anything, anywhere else. |
| 2  | **Top down driven**  
Reactive.  
2 tier, 3 tier organisation.  
People at the bottom rowing and running, always there because dedicated.  
Policies come through government; NHS just reacts, not necessarily right reasons.  
Led by CE, top tier.  
Depends who are, whether works.  
If worked shouldn’t matter.  
New CE, all change.  
Stop, start, never finish anything.  
At mercy of constant higher and outside shifting demands.  
Frightened in light of changes.  
Driven from the top, not driven from the bottom.  
Eyes really opened, no greater plan and people at the top don’t understand.  
No evidence for action.  
Talking but just empty meaningless words.  
Creating names for themselves throughout NHS.  
Rhetoric versus reality.  
Opened my eyes, witnessed organisational behaviours, absolutely mayhem.  
Ambitious people.  
NHS is political pawn.  
Place to make your name, agenda is their own.  
Achieve, move on, the top people only stay few years.  
Disappear before goes funny.  
Can’t have bad name.  
Do same other places.  
Empire building within own directorates, to build directorates up, individual reputation up.  
“For God’s sake have got far too many leaders, what we need is some good managers”.  
Where it comes from, creating power base, with people wanting to be leaders.  
Just need good established, solid, functional managers to drive things forward, keep things going.  
Three tiers.  
Top two tiers think ‘blue sky’.  
Implementers as well.  
Not implementers, ‘blue sky thinkers’, and top level.  
Could change title to fit.  
Coming out with same things.  
Media, yes, taken on board.  
Awfully sorry, putting new policies, procedures in place  
Rhetoric versus reality. |
People accept rhetoric, don’t question. Just a response, a spin response. Changes at the bottom at local level. Say involve people, not involved as should be. Rhetoric versus reality. Design should be from bottom up, not from the top down. Top two tiers are implementers. Role split in two, affect patients, when wrong. Implement will of government. Just get signal down and have to implement. That level, that pay. Standing on my box? Why nobody push back up say not good. We take, take, take but never push back up. Good management say how do we achieve it as opposed to imposing change. Good organisations dialogue all way through, opposed to being done to. Key words, have to do, never change. Public money linked with government. Waste of money, always will. Need leaders willing to challenge. Don’t understand NHS unless worked in it. Top level saying do this, don’t understand intricacies, how slow to move things. Need more negotiation. More senior, move up structure, move further away from insight, from reality. Butterfly effect down becomes massive, huge, vast piece of work. How influence up there? People on the ground don’t understand needs of other patient groups than own. Higher up go can’t understand what’s happening on the ground. Organisation in hierarchy. Worst team, but if getting results why change? Making a point, about credibility, control and power. Cultural at the top. Being led by culture at the top. Walking out on them acceptable at lower level; suspect not? Implement without you. Culture comes from the top. How filtered down and behaviours senior leadership allowed to do. Senior managers not allowed to point score against each other. Hasn’t filtered all the way down yet. Higher up go, word patient not mentioned. Cannot see how impacts. Distance from patient. Not realising everything affects patient care. Culture to kick researchers. Don’t have power, authority to impact, influence trust. SHA, CQC do, can penalise, withdraw funding.

'fear' of upper management.
Clinical staff detached from bigger picture.
Lost hierarchy
Don’t have middle person to fight for us, with management.
From up on high, got to deliver this, certain way, up to you.
Deflection of practical problems/responsibility.
Nobody in middle fighting.
Higher up, more away from role, not got a clue about patients
It’s all to do with money, not services.
Detached.
Not got a handle on how difficult to implement at lower level.
Big decisions easy if distance yourself from effects at working level.
Things passed down end up with staff struggling on wards.
Unrealistic decision making.
Not managed correctly.
Not willing to listen, implement.
Disregard concerns.
'Told you so' later.
Particularly directorate, very detached from real life, caring for patients.
Plans good on paper.
Just haven’t got a clue.
Making decisions, reorganising.
[Managers] detached, arrogant, paternalistic.
‘Know best’.
Failure to engage at all levels.
HR directors ‘they’re corporate’, ‘singing a corporate tune’, detached as bad detached NHS managers.
HR Director determined to push policies through, reduce staff or cost; corporate attitude, detached from real people doing their jobs.

4 Controlling, bureaucratic organisation constantly changing/reorganising “creating the illusion of progress whilst producing confusion, inefficiency and demoralisation”, Petronius AD 66.
Reorganisations continually imposed.
Little/no time for consolidation.
Not timely
Divisive.
Often paralyse parts of organisation.
Very controlling, with budgets.
Lack of manager autonomy.
Cultural change has to start at the top.
NHS needs leaders who will lead, take organisation in right direction.
Need to get sign off at triple level.
Need confidence in individuals below them to do job.
Ship description, captain walking around because confidence in deputy running ship.
Managers should have autonomy.
Ludicrous, frustrates management team.
Executive team don’t get opportunity to ‘walk around the ship’.
No autonomy second question.
Fearful of making mistakes.
Need someone to authorise.
HR will rubber stamp this process.
Not allowed to be proactive.
Culture set by the 'top table'.
Where leadership needs to come from, what is/isn’t acceptable.
Senior managers should be managing.
Things don’t go on in isolation, lots people will have known.
If nobody picked it up, managed it.
Poor management, nothing more, nothing less.
Very centrally driven, politically orientated.
Professional politicians, only out to make gains for themselves.
Very grim.
Can’t see how *going to turn the corner*
*All point scoring* between parliamentary representatives not what need to do.
Not making difficult decisions.
*Back tracking* all the time.
Don’t instil confidence able to deal with crisis.
Management style to *railroad things through*.

5
Hierarchical, banding/ role very important;
Hierarchical.
Directive.
Hierarchical.
Top down.
Underlying causes, like power.
How power expressed managers and staff, between staff.
Hierarchical, ‘top down’ same as hierarchical.
 Doesn’t always learn by its mistakes.
Same themes, iterative, repeats itself.
Conflict, power, dynamics of inclusion/exclusion, communication, perceived power are themes.
Some people perceived to have more power than others.
Tendency towards totalitarianism in large *centralised organisational structures*, way of getting things done.
*Totalitarianism is system, only small group control* definition what truth is, what thought about.
Otherwise excluded.
*Have to play particular game otherwise in danger of, in worst extremities being shot e.g. under the Stalin era*.
Totalitarianism *rises up* in modern organisational life.
Power to define, what thought, talked about, people can do.
Threats of exclusion and worse, sacking.
*Split* between clinical side, management side.
Before more led by clinical side.
*Now emphasis corporate approach and management style*.
*Hold the power, more corporate thinking*.
Management style more power than clinical side.
Managerialist thing lot to answer.
Insecure managers, often over controlling.
To detriment, inexperienced managers seriously underrate staff power.
Can’t have followership without leadership, leadership without followership.
Interdependence.
Might think manager *hold the cards*, legitimate influence, power.
Informal ways stop things from happening.
Managers distressed, often, *overly authoritative management style blowing up in their face*.
Don’t want to follow.
Sabotage.
Everything disrupted.
*Saying* not in control as think.
*Domination and arts of resistance*.
If *movement towards totalitarian state style of management*.
More insecurity, un-skilfulness than good idea, most of time.

6
*Hanging onto power*.
Have to respond *back up chain of command*.
Bizarre behaviour/actions.
Leadership defensive.
Controlling, goes well with resolute.
So controlled.
Feel can’t influence.
Just happening to them.
Health board, *a command and a control*, not involved workforce.
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<tr>
<th>Int</th>
<th>Categories for Framework Theme 3. Hierarchical/top down/power (Interviews)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Too many tiers. Always higher grade person come off better. The little people don’t count sometimes; don’t like that. 2 lots of people. Well paid and poor paid. Hell of a gap in the middle. [Why doesn’t NHS care about staff?] People at the top never worked with patients. If gone up the ladder; forgotten. Distant, separation; thinking affected. Bullying when 2 or 3 managers, HR around table. Bullying at top level; HR in the middle of it. I’m the HR. God’s gift, like sat on a pedestal. HR more evident than CE. [Who really controls?] Probably HR [L] and the cronies.</td>
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<tr>
<td>2</td>
<td>Hierarchy of elites. Work of TU rep/HR can be undermined by more senior level. CEOs frequently remote. Minions do good job; no authority to make decisions.</td>
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<tr>
<td>4</td>
<td>Developed from originally benign dictatorship run by clinicians, into malign organisation controlled by professional managers. Disciples follow whims of managers religiously. Managers wish to control clinical staff. Removal of clinical freedom; to control expenditure, but detriment of patients. [Managers] wish to be in control. Attitude of managers; get rid of staff who disagree. All about control. Fight between managerial dictatorship and professionalism. Clinical staff should be put back in control. Management very far removed from patients, do not want to be closer. Hype on management courses on manipulating staff; how to delegate lower staff. Lower staff, you and me, despite more appropriate qualifications. Disagreement with management viewed disciplinary matter by HR. Effect of management is to silence critics, also local councils and EEC.</td>
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<tr>
<td>5</td>
<td>Politically sensitive. Politicised. [Why neg beh?] Personality clash, power/control, insecurity and insensitivity.</td>
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<tr>
<td>6</td>
<td>Bullying. No-one is accountable. Managers not accountable.</td>
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<tr>
<td>7</td>
<td>[L&amp;M] Frustrated; not allowed to work autonomously.</td>
</tr>
<tr>
<td>8</td>
<td>Hardened approach to industrial relations, case management. Disciplinary action used as controlling mechanism by management, e.g. sickness absence. Less inclined to negotiate, facilitate win-win outcome. More draconian measures. Management feeling little room to manoeuvre. [Why neg beh?] Power and control, especially where people having to compete.</td>
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<tr>
<td>9</td>
<td>Hierarchal (sic), divisive, although much talk given to idea of 'teamwork'. Rhetoric not reality. Reactive rather than proactive.</td>
</tr>
</tbody>
</table>
Hierarchical.  
Divisive.  
Reactive.  
Leaving; fed up with politics.

| 12 | Some cultures very hierarchical, some inclusive.  
Common; if manager is wrong, very difficult to challenge.  
Culture; manager is always right.  
[Why?] Individual leaves organisation, not manager.  
Often what manager trying to do, serves purpose of organisation.  
Managers considered right.  
Difficult to challenge manager’s action and get positive outcome.  
Managers, seen as having best interests of organisation *at heart*, individual has to prove “beyond reasonable doubt” manager flawed in thinking, assumptions.  
Assumptions made; bias.  
Employee at disadvantage.  
Need to be very strong to challenge this.  
In past, move on, *today’s climate* isn’t always possible.  
Continually changing executive teams easy to make *scapegoats of those low down the pecking order*. |

| 13 | Pride in quality of work can occasionally become arrogant and patronising; “we know best” attitude.  
Powerless against insensitive bureaucracy/system.  
Unhappy in work; feel ignored, criticised or powerless.  
Unable to get what want, little control over work.  
Powerlessness.  
Power plays a role; doctors difficult to manage.  
Pressures on managers; coerce staff rather than inspire. |

| 14 | ‘Way run – “top down”’.  
Culture reflects dominance of *Command and Control* Culture exhibited by DOH and Ministers.  
“Systems Thinking in the Public Sector” John Seddon.  
How managers with little expertise, can successfully operate in this environment, is a mystery.  
Effective action inhibited by C&C culture. |

| 15 | Tony Blair, NHS used as political machine.  
Command & control style.  
Managers rude, arrogant & secretive.  
Managerialism.  
Bullying is endemic in NHS.  
Like it or lump it culture.  
All organisations reflect command and control style emanating from Whitehall.  
Enforcement, at least 15 years.  
Top down culture.  
Every unit of NHS a microcosm.  
Afraid not to do Whitehall’s, DOHs bidding.  
Fear; translates into bullying.  
Default is secrecy and blame.  
Not blame free.  
Unpleasant.  
Millions treated in midst, many successfully, sadly, many not.  
Command and control.  
*Command and control style from the top*.  
Culture ‘Looking up not out’.  
Management all parent behaviour, some child behaviour.  
A game; who is going to face up?  
Someone starts to *face up to it*, not in position of ultimate power, *system* will eliminate them.  
Nobody to go to senior level, say, ‘is utter and absolute mess’.  
If top person recruited to *keep the lid on*, in deep trouble, unless *person of sufficient weight*.  
[managers] ‘cock of the walk’.  
Imposition.  
Enforcers, needed  
Series of enforcers in Whitehall; most still in position.  
Deficit 2005 *Tidied up* very quickly; by bullying, forcing them to meet financial targets. |
You will do this; did what Downing street wanted.
Brutal reality of top down culture
Nasty culture definitely enforced from Whitehall.
['tramelled by the rules'] Even CE hospital very little freedom, or individual clinicians.
Assumption most execs very willing participants in this game, plenty of clinicians too.
"Yes" on the forehead is good'.
Root cause society hands over responsibility to politicians, who delegate to public, civil servants, who do politicians bidding.
Because are politicians, rule is don't embarrass prime minister, don't embarrass SoS for health.
Underlies behaviour any hospital; Kiss up, kick down.
Control, top down like it or lump it approach.
Difficult to escape that; overriding behaviour.
Reason for behaviours, people bought off.
NHS management not impressive.
Whole society bullying, but deferential.
Society has existential problem.
[Added from structure/form/groups - One monolithic organisation.
Political responsibility.
Man in Richmond House dictates; therefore it's a nightmare.

16  Inherent spineless managers.
Do not act adequately in protection or improvement of patient care.
Senior manager's habit of appointing puppets, not challenging.
'Do as I say culture'; many NHS organisations.
Few organisations have leaders and visionaries.
Leadership and management two different, separate issues!
A failure, why in such a mess; blame Margaret Thatcher brought in managers in NHS; no clinical background.
Lots of bullying, staff scared to speak out in fright of retribution.
A shame.
Leaders not usually managers, managers not usually good leaders!
[Key blocks] time, leadership, arrogance, power.
Inadequate selection processes.
Appointed managers 'yes' written on forehead.
Disciplinary process bias way resolving staffing issues!
Too much weight given on punishment, don't take balance view!
When make mistakes i.e. HR or Management it's ok or plausible!
Others make mistake rest assured will be targeted!
Bullying pure and simple!
It's about power, sadly!
Individual staff easy target (united stand, divided fall).

17  Top down rather than bottom up.
Top down target culture.
Mixed messages; conflict between top down targets and local commissioning.
Simplification of complex systems for political purposes.
Bullying management culture.
Insatiable political demands for good news, burial of bad news.
Political interference in operational management.
Top heavy DOH structure.
SHAs bullying to enforce what comes from politically driven centre.
Senior SHA staff limited operational experience.
CEOs, other managers bully and suppress staff.
Inadequate managers adopt bullying, autocratic/repressive management style.
Lack of high calibre senior managers.
Concerns about job security.
Confusion around accountability of exec and non-executive Boards.
Lack of accountability and governance.
Cowed clinical professionals.
Oppressive.
Authoritarian.
Most people believe in fundamental principles, try hard to do high quality job, but feel obliged to
compromise to meet political objectives and retain positions.
Driven to defensive behaviour and compromising principles.
Endemic, top-down bullying culture in DOH suppresses constructive dissent.
Enforcers

18 Problem, all stems from central political pressure.
Have to do what Number 10 wants, Prime Minister, Cabinet wants.
Culture of fear pervades NHS management, managers ‘look up not out’.
Looking to bosses not patient needs.
Allocation/distribution resources only pure form of communism. Communism, very central domination.
Central domination; major problem; worsening.
Particularly worse under last government [Labour].
Fear.
Culture of fear pervades NHS and problem of whistleblowers.
Still gagging clauses, preventing speaking.
Problem of centralisation.
Use centralised bullying tactics via very strict management system, dominated from centre, to regulate system.
Not much scope since 1983, Griffiths report, for involvement clinicians/patients.
Political decisions can have negative impact on trusts and delivery of patient care.
Culture of fear of the management.
Managers dominated from centre, deliver what bosses want, eventually things delivered by SHAs and regulators, to what secretary of state, number 10 wants.
Goes right down, very difficult, tension between managers and clinicians.
Managers have a duty, a pressure from above.
Managers large pressure on doctors.
Junior level, few jobs, can influence, as can consultant.
Consultant, large influence, committees recommend clinical excellence awards; large sums of money.
Pressure on senior doctors.
At very top power of patronage; knighthoods, honours.
CE of NHS very powerful political position, more powerful than Secretary of State.
Political struggles.
All did what No 10 wants.
Managers have control over clinicians via jobs, funding, clinical excellence awards and patronage.
The Bill gives power to managers.

19 Very top down, driven by macho culture, emanates from Whitehall, down political, management, administrative side.
Covert bullying culture from end to end.
Huge opening up of gap in salaries between ordinary folk working as cleaners or porters, other lowly occupations and people on fabulous salaries at the top.
Bullying.

20 Culture at the top is controlling rather than liberating.
Opaque rather than transparent.
More concerned with reputation than delivering safe care.
Culture created where get on by never making a mistake can be pinned on you.
Creates, one of worst aspect of culture, blame culture.
Distorts behaviour.
Senior positions blame lower down management chain, in turn, to avoid blame, act inappropriate ways e.g. manipulating waiting lists, concealing clinical incidents.
Top down oppressive.
Distinction between leadership local level and national.
Local level (e.g. CE Trust or PCT) depend on individual capacity to shield organisation from overarching culture.
Top level NHS leadership intolerant, unforgiving, does not value even constructive challenge.
Local level constructive challenge often encouraged.
Years of political control distorting conducts.
Size of NHS, spend so high civil servants/ministers do not want to let go.
Almost soviet style of central control to keep budget etc in check.
With that comes culture of soviet style of political control.
Time to time mythically liberate the service.
Reforms supposed to be liberating but still *work in straight jacket*.
Rhetoric not reality.
NHS effectively one employer.
If fall out with them, *get blackballed* nationally.
If career in NHS *blackballing* is devastating.
[Rat/justifications] Get into positions of power, got there through adopting that mind-set and becomes over-arching culture.

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| **Culture shift.**
| Delegated authority to centralised control.  
| Local target setting to national and organisational performance targets.  
| Status and hierarchy important part of culture.  
| Status influences how much listened to.  
| Medical staff more influence than others.  
| Control.  |
| [L&M] Needing to respond to political agenda.  
| Set values, working principles for staff, often undermined by acute pressures under from [Country] Government to achieve performance targets, meet public expectations.  
| Leaders do not have full control need to lead, translated down hierarchy; inhibits taking services forward.  
| One person serves *'attack dog' function*, if challenge, probably need to leave because is quite powerful.  
| Trying to move services into community but not in control of destiny. |

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| **People behaving badly in positions of power.**
| Those beneath fear *reprisals* if speak out.  
| Fear, especially if most senior managers won't tackle issue. |

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| **Paternalistic cultures, senior leaders try to “protect” junior staff, leading to disempowerment or centralising and controlling.**
| Paternalistic.  
| Controlling.  
| Individuals in teams of different status.  
| Bullying if senior individual uses hierarchical power to reflect poorly on junior staff.  
| Instances where junior staff look to undermine authority of senior staff, reliant upon specialist ability/capability not use hierarchical power. |

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| **Paternal.**  
| **Too target driven.**
| Innovation not encouraged.  
| Culture of blame immediate response when something goes wrong.  
| Uninspiring leadership, driven by politics, not patient needs.  
| Absence of any strategic planning.  
| Blame.  
| Uninspiring leadership.  
| Senior managers not taking enough responsibility |

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| **Very hierarchical organisation.**
| ‘Griffiths Report’ encouraged team working all levels.  
| Open communications, avoidance of ‘blame culture’ evident.  
| Changed; Labour into power NHS target driven.  
| Bullying culture began to permeate through NHS.  
| Significant pressure on CEOs from top down i.e. DOH.  
| Top-down culture.  
| Target driven.  
| Still harassing.  
| More pressure staff in clinical care settings experience from top-management more likely cycle of negativity between staff.  
| CE of NHS and DOH general attitude bullying; will be setting tone and agenda.  
| Important to see how relates to new Secretary of State for Health.  
| Knows little about job, not seen much.  
| Whole way organisation functions depends how Trust Board operates. |

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| **2012 HSC Act defined change in fundamental purpose of FTs.**
| “protecting and promoting the interests of people who access health care.”  

| 27 |
New powers for Monitor can bring in failure regime for FT’s. Regulator, at last, looking at patients’ point of view and not organisations.

28 Hierarchical domination.

29 Consultants have the say. Everyone follows the consultants. **[Image of the NHS] Hitler in his bunker.** Optimises secrecy, colluding and non-consultation. All public services. People on the ground floor don’t have any say. Are people behind doors, down corridors, don’t know who they are, make decisions affect everyday practice. Consultants have the say. Everyone follows the consultants. **[Image of the NHS] Hitler in his bunker.** Optimises secrecy, colluding and non-consultation. All public services. People on the ground floor don’t have any say. Are people behind doors, down corridors, don’t know who they are, make decisions affect everyday practice.

30 Current culture quite dictatorial, concerned with numbers, targets and money, rather than clinical excellence. Culture hierarchical. End often justifies the means (R&J). Subtle forms of bullying often took place. Dictatorial. Uncaring. Bullying. Cover things up, defend those in power, put more pressure on [person]. CE - ‘It is good to sack a few consultants now and again, it makes sure the others toe the line’. Very senior people who get lots of power, like using it, if bring in lots of money, if smooth talkers, contribute to culture. Terms such as CE, [other titles] does not help, remind is hierarchy. There’s power, arrogance and financial things. Power matters; important people matter. Manager doesn’t want to upset person, because bring in money. Regarded as God and very powerful.

31 NHS so political when failings reflects upon government. Person tried to stop it but couldn’t. Shows how difficult it is, shows is at higher level. Coming from higher level. Putting pressure on employers, then employers trying to ‘bury bad news’. If employer doesn’t bury bad news, get sacked. Level refuse to ‘bury bad news’, get sacked, lots of places. [Powerful force?] NHS monopoly employer, huge resources, so you’re finished in NHS. People who support senior managers get promoted then have more power [sad L]. They are all in power, we are all ones at the bottom. Power imbalance. Bullying linked to power differentials; why so much bullying. Bullying is awful; bullying experienced was absolutely dreadful. SHA said wasn’t bullied; absolutely ridiculous. Don’t find it stunning because seen how behave senior level. Know prepared to lie. Know prepared to bury reports, to do whatever. Supported with funds to do whatever have to do, legally, to sort people out. SHA support, possibly next level too; because authorised, allowed to spend the money.

32 Person at the top ‘jumping ship’. Another referred to GMC, alleged unprofessional bullying conduct. Looks upwards within hierarchy rather than outwards to population serves. Centralised rather than devolved. Driven not led. [re neg beh] Starts from the very top. NHS not being led, being driven, very big difference. Cascade of maladaptive behaviour all way down organisation. Selective pressure, only ones who enjoy or thrive in environment, stay, become manager’s move on up hierarchy. Self perpetuating dysfunctional system. Survival of un-fittest. No encouragement of informed dissent, or challenge, too top down.
If wrong at the top, filters all way down organisation.

[What’s driving it, underneath this?] Self-preservation.
Protection for people senior positions want to cling onto power, privilege, earn a lot of money.
Well paid
Want to protect lifestyle, privilege, power.
Who wouldn’t?
Human nature.

[Why does it appear protection of organisation, its image more important than welfare of staff or patients?] Ultra socialist entirety.
--’s a communist.
The state knows best.
The state is the best provider.
All about centralisation, one size fits all, absolute control.
Obedience to the state mechanisms.
Not about local democracy or individuals, taking individual responsibility.
Very, very collectivist model.
[HR?] Ought to be managing human resource, but role, survival of un-fittest

Perceived model, get to the top and survive.
People suffering in organisations because of prevailing culture.
Top people, CEO, Chair, SHA set culture, tone, but it's the staff who deliver for them.
Set tone, are responsible.
Need to listen what staff telling them; just dismiss it, poor response.
Leaders change culture.

Mediocrity, mismanagement and learned helplessness direct result of failure of leadership at the top.

Prevailing culture bullying, command and control leading to fear, insecurity and cover up.
Constructive challenge or inquiry seen as disloyal; frowned upon.
Dissenters not welcome as agents of change; marginalised as trouble makers.
NHS has become institutionally dishonest.
No longer serves patients but next level up in hierarchy.

Distressed.
Decisions made without taking people with management.
Say, keep informed, consult you, management come to meetings to feed back; but not doing consultation.
Tell you to contact, but do not respond, gets totally ignored.
Rhetoric not reality.
Lack of confidence in politicians.
Labour brought in internal market; Tories progressed it.
Lack of trust.
Oppressive.
Incestuous.
Not caring for the people.
Very oppressive system because of people who are there.
Do very good job, lot of goodwill, long hours, happy to do, because love NHS.
No organisation in world like it.
Distressed by what happening to it.
People say, it’s about the system.
People make systems.
Abrogate responsibility by saying it’s the system; don’t buy that! (R&J)

It’s not the system that makes decision, people make decisions.

Other places dark, blame orientated, leaders not taking responsibility for poor decisions, blaming others; including political leaders.
Political leaders critical, without evidence, impacts directly with poor self-esteem, self-worth.
Politically reactive teams.
Very responsive to political commentary.
If supportive, even when acknowledging progress essential but praising good work done, is holistic/effective.
When politicians critical and negative about NHS, leadership becomes blame orientated, curt and ‘business-like’, not person centred.
Recent research shows positive staff morale direct impact on patient mortality and experience in
general.
Need to show to politicians who set out to de-stabilise NHS for private sector gain. (Did start Tony Blair’s govt so not Tory bashing!!!)

35 Traditional medical hierarchies overlay power struggles and alliances (strategic and tactical) resulting from competition between groups.
Organisational culture is homogeneous, re-creates itself in terms of power bases, works against learning and change.
[Country], NHS more compliance based.
Avoid decision making; reliance on doing what regulations or guidance require.
If not clear, refer it up.
Defensive.
Hierarchical.
Cautious bordering on fearful.

36

37 Poor quality management; long standing issue.
Lack good quality leadership.
Reflects prevailing culture of organisation and/or management of organisation.
Although ‘sick’ culture at top ultimately tends to filter down throughout organisation.
If bullying culture within management, unlikely to challenge bullying culture within staff, or perhaps recognise it.

38 Culture influenced heavily by tone, messages set at the top of organisation.
As CE, fed back, achieved more personal, supportive, open organisational culture, whilst still delivering agenda, changes and targets.

40 Top of organisation definitely culture of corporate bullying.
Corporate Thuggery at the highest level.
Previously believed could raise concerns.
When concerns relate to wrong doings at the top are sabotaging own career.
Leadership, good management talked about, however softer management skills; no place at top level.
Competitive environment of NHS management breeds negative behaviours.
Many top level managers do not have social skills to understand impact of behaviour on others.
NHS is arrogant and elitist at the top.
Middle managers very frustrated group, forced to carry out actions do not always believe correct.
Put downs at meetings regular occurrences for anyone not in agreement.
Culture of bullying in NHS starts at the top.

41

42 Very centralised, controlling, hierarchical, closed, intolerant of criticism.
Not open and transparent, although claim are.
Rhetoric not reality.
Frequently, bullying.
Centralised.
Controlling.
Closed.
Hierarchical.
Huge centralising pressure, like trying to import model of corporate loyalty, Japanese firm, superimpose it, on complex world of clinical care.
Not appropriate; individual patient, specific issues, problems, range of technical issues, practically infinite, combinations of problem.
Best of clinical care; having questioning analytical mind, don’t want to accept formulaic responses, medicine isn’t like that.
Head on conflict with management view of world.
Is way to do it, it’s efficient, you will all do it.
Raising intelligent questions about problems of central edict not popular with management, throughout NHS.
One of reasons clinical staff sometimes give up on it, then shock horror at Mid Staffs.
Why didn’t doctors and nurses speak up?
Those who speak up, in trouble or slapped down.
Don’t know how get round this.
Cannot imagine not having health service in public sector. Political nature of NHS results in centralising controlling culture. Adversarial political system. Whichever group out of power wants to be critical of group in power. Publically funded NHS, since 1948, but horrible centralising controlling culture more recent. Down to rise of general management in NHS, Griffiths; terrible disservice. Clinicians, doctors in particular, could in past resist government pressure for change. Powerful group, if something wasn’t right, resisted. Now doctors just like everybody else in society, but paid better than a lot; all ‘checks and guises’. Some wonderful, some nightmares. Rather have control of spending in hands of doctors, than hands of politicians. Latest reforms not going to deliver that. Be devolved to management consultants, worse than previous models. Introducing powerful management structure in NHS, has allowed tentacles of DOH to reach down into every organisation and control it. Where horrible culture comes from. Deadly combination. Adversarial political system. Whoever in opposition casting about for criticism to hurl at whoever’s in power and whoever’s in power does not want to hear from front line staff about problems. Say they do, but actually don’t. Rhetoric not reality. Leadership too much centrally controlled; lot of bullying. Horrific descriptions, e.g. CE of NHS, phoning up CEs, effectively threatening them with the sack if don’t deliver. Wrong sort of people end up leading NHS. ‘Corporate bullies’ end up leading it. ‘Good news culture’. Everything always has to be seen to be working, positive. If anything isn’t right, isn’t working, as opposed to rational analysis of it, has to be quickly blamed on something, somebody. It’s all part of that picture. Same thing, central controlling, the ‘good news’, politically driven, must be seen as success. Exact opposite of analytical, reflective, open, transparent, learning.

Hierarchical.

### Theme 4. Bureaucracy/policies

[Added from ‘HR/Other roles’]

Supposed to direct manager follow policy. But taking side. Not following policy.

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<th>FG</th>
<th>Categories for Framework Theme 4. Bureaucracy/policies (Focus groups)</th>
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<tr>
<td>1</td>
<td>Good implementing policy, bad in not following it.</td>
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<td>More paperwork orientated, duplication.</td>
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<td></td>
<td>Hard to raise.</td>
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<td></td>
<td>Don’t hear. Don’t want to hear.</td>
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<td></td>
<td>Targets to achieve.</td>
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<td>Paperwork taking us away from providing good service.</td>
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<td></td>
<td>Lack of connection.</td>
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<td>None computers will ‘talk’ to other services.</td>
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<td></td>
<td>Each fill another piece of paper in separate places.</td>
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<td></td>
<td>Not patient centred.</td>
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<td></td>
<td>Patient’s following paperwork round.</td>
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It’s ridiculous.
Paperwork bogging people down, can’t do hands down clinical work, too busy writing.
Inefficiency.
Staff try very hard to raise issues.
Now going down path of disciplinaries because isn’t completed.
Triggers checking of competencies.
Communication so bad.
Higgledy pigglety communication services.
Lost 2 members of staff.
OCP very precise, interpreted, implemented differently.
One manager does by the book.
Others do what they want, ignore policy.
Use of policy to move/remove people.
Where is message from up there to here?
Like a glass ceiling was lifted. Isn’t good.

2
No paperwork in place to tell us what to do; but doing the work.
Bureaucratic because good intentions.
Suddenly hit wall, paperwork, forms, process.
Something totally changes way going to deliver, outside influence.
Start all over again.
No one sits down says 10 year plan like any other business.
No looking back at 10 year plan, changed 10 times.
Constant change.
Disciplinary, in limbo.
Nothings agreed, so nothing’s happening.
Social enterprise, don’t have HR department’ felt free.
Managers did what needed instead having to pussyfoot around.
Stunned could manage without HR department, really free.
Pander too much to rules.
Go from naughty, straight to disciplinary, not much in between.
Don’t trust, use whistle blowing policy.
Raise concerns, straight into disciplinary process.
Should be more advocacy.
Lack of informal process.
Straight into formal puts people off.

3
Red tape (often). High bureaucracy levels.

4
Controlling, bureaucratic organisation which is constantly changing/reorganising "creating the illusion of progress whilst producing confusion, inefficiency and demoralisation” Petronius AD 66.
Bureaucratic.
Very bureaucratic, needs to be due to size.
But frustrating all levels.
Often very negative culture.
‘Bureaucratic’, ‘clinical’ and ‘negative’.
Staff very demoralised.
People downgraded.
Business side totally unfocused.
Lack of decision making in decent time frame, so many committees.
Paralyses.
NHS not used to line, performance managing, holding individuals to account.
Individuals not used to it.
Although lot best practice in systems, very new, difficult, challenging, not part current culture.
Impression private sector Boards work well.
In NHS no reward, incentive to lift their game, or recognition if lifted your game.
Way managing appraisal process not effective.
People pretty much drop through.
Natural progression, expectation.
Few fail appraisal process.
Get stuck, unless disciplinary process.
Does best practice guidance fit?
Big organisation, needs to be bureaucratic, systems in place. But complicated, time consuming, organisations, cultures not used to that.

Systems, don’t work.

Appraisal process too cumbersome, complicated.

That stems all other problems

NHS very good at, ticking the right boxes.

Should be about doing right things, which ticks the right boxes.

Good at ticking boxes, to say have done this.

Meaning of appraisal irrelevant because ticked all the right boxes.

Rhetoric versus reality.

Bureaucracy, so much for managers to do.

So many policies, measured against, trust reported against, CQC, everything else.

Vital have right scores in right boxes.

Pressure, to tick, tick those boxes.

Very little time to sit back, say, what trying to achieve?

Thankfully trust redone appraisal process, paperwork, previously incomprehensible.

KSF ticks all right boxes.

Best practice, not best fit.

Just didn’t make sense.

Individuals don’t have experience doing it, remote, difficult, complicated.

On top of backdrop of my patients.

Appraisal, should be simple discussion. What set out to achieve, what working, what change, what objectives?

If doing right things also ticking right boxes.

Shouldn’t be setting out to tick the right boxes.

Should be setting out to do what is right.

Need to do to achieve objective.

Doing that, will be ticking the right boxes.

If not, boxes are not in the right place.

Managers should have autonomy to authorise.

Going to executive to get ticked off incredibly ludicrous.

Frustrates managers.

Workload high.

Don’t get opportunity to ‘walk around the ship’.

Overseeing the systems, reactive.

No forward planning, no forward thinking.

Very much fighting the fire.

Tied up.

Slow recruitment process.

HR starts getting bad name.

Processes become very restrictive and tick box.

Managers need freedom to manage operation.

Understand team and what needs to achieve

Not the experience, need somebody to authorise.

Get HR in, they’ll rubber stamp.

Lack of involvement.

Not allowing to be proactive.

[Hospital] management style, to railroad things through.

Not facing up to things.

Think ticking the boxes need to tick, but until something crumbles nothing is done about it.

Have to fail before gets better.

Funding is an issue.

5

Bureaucratic.

Absence of informal interventions, may rely on formal processes.

Team always informal.

Formal processes, often expensive and difficult.

Certain incidents have to be pursued formally.

Encourage HR to send cases for attempt at informal, cost effective resolution, rather 6, 12, 18 months investigation, pain, possible lawyers, all the rest.

People never want to make it formal.
Although whistle blowing policies people won’t do it, because potential outcome.

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<thead>
<tr>
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<th>Categories for theme 4. Bureaucracy/policies (Interviews)</th>
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<tbody>
<tr>
<td>1</td>
<td>Don't do NVQ properly; it's paperwork.</td>
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<td>See people sat at computers.</td>
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<td></td>
<td>Computers &amp; writing; patient has to wait.</td>
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<td>Was never like that.</td>
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<td></td>
<td>HR got guidelines.</td>
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<td>Tunnel vision, just go for what have to do.</td>
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<td>Don't look sideways at the staff.</td>
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<td>Too much paperwork.</td>
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<td></td>
<td>Everything geared to computers &amp; paperwork</td>
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<td>2</td>
<td>[Key blocks to addressing neg beh?] Money, time &amp; belief that trust has put in place policies.</td>
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<td></td>
<td>[HR] Set up meetings, follow procedures but few answers for staff.</td>
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<td></td>
<td>When strong staff side management find it more difficult not to honour staff side agreements.</td>
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<td>3</td>
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</table>
Senior manager breaching policy, HR become powerless

Resort to disciplinary procedures and politically correct action as soon as any dispute. *Hiding behind* policy & process.

Overly bureaucratic.
Run by policies, rule rather than common sense which could rely on moral judgements and empathy.

Bureaucratic. Any issue can be raised through processes. Increasingly difficult to get grievances, other issues dealt with quickly. Difficult to discuss any issue not covered by a policy/agreement. Free thinking not prevalent. To get response based on sensible moral argument is difficult. Appears little leeway outside of the rules. Lack of experience when making decisions outside of set procedures. Can take long time to get through layers of management to get common sense response. Policy driven. Policies overwhelmingly full of rules/specific guidance rather than allowing for discretionary action. Partly TUs strive for more specific guidance and blanket polices on most issues. When considering bullying issues need more discretion. If employers felt more responsible/liable for workplace relationships would be higher priority. Unions say if feel bullied, are bullied. Some employers used to apply this thought process, now very rare.

Grievances increasing. People forced through capability. Infection control protocol and procedure not followed. Make it up as go along. *Just a tick box*. Do it my way or not at all.

Hardened approach to industrial relations/case management.
Disciplinary action used as controlling mechanism by management, e.g. management of sickness absence.
Changes to terms and conditions of employment look to place additional pressures on staff, and curb reward.
Poor procedures and practices; [neg beh] cases often don’t fit into grievance procedures. Need to ensure management trained, appropriate policies in place.

Employment Law and organisational policy complex. Clear processes to follow, could be very daunting for inexperienced managers.

Responding in a consistent way, following boundaries of HR policies, formally performance managing for sickness. More confident dealing with every stage. Gives framework to work with that is fair and consistent. If haven’t got that, very hard to be fair and consistent.

Can feel powerless against an insensitive bureaucracy/system. [More] Individuals may have very good reasons for wanting/ not wanting something. Managers don’t always respond as individuals want. Individual feels not been listened to. Grievance pursued, not successful, may feel even more aggrieved. Rationale for ignoring concerns, have to have system that’s fair and applies to all *(R&J)*. Often feel its not fair individual concerns not accepted. Sickness absence policies managers have no discretion, have to apply process. Individuals with good long term attendance receiving disciplinary warnings for unavoidable short term absence. Quite common approach, totally insensitive to individual’s particular circumstances. Organisations want matters raised in accordance with procedures e.g. bullying and harassment policies. Approach taken in formal complaints, generally ineffective as interventions.
Few individuals appear prepared to make operational decision and take responsibility. All decisions require committee and formal minutes. Process requires time in advance. In private sector individual managers given authority and expected to use it to make operational decisions quickly. Policy matters require higher level decision, depending on nature of topic involved will go to the board. ‘Bureaucracy and red tape’ have driven public services in the wrong direction’. NHS relies on inspection culture to function. Non-knowledgeable inspectors led by inexperienced CQC demanding adherence to specifications; may not be appropriate.

Let’s do a review, a policy. Waste more time. Change the system. Don’t demand people perform. Number of hospitals 3 to zero in 2004; don’t challenge performance. No clear message; will not put up with this. Change the wretched system, so can be fiddled more easily. Couldn’t make it up. Action plans, lot of them meaningless; because nobody cared. Trammelled by the rules. CE/individual clinicians very little freedom to do as wish. Assume most execs/plenty of clinicians too, very willing participants in this game. “Yes” on the forehead, is good’. Everybody’s trammelled by the rules.

Become too bureaucratic. Less patient ‘hands on’ care

Get rid of regulations/guidance when inconvenient. Too easy to avoid PIDA, failure to enforce codes of management practice, no sanctions. CQC inadequate with bureaucratic tick boxing. Do not recognise organisational pathology.

Light handed regulation. HCC method self-reporting. Hospitals at risk incorrect in two thirds cases. Light handed and not effective. HCC gives no improvement advice, or expectation of use of core standards to drive improvement. Poor use of clinical data. Virtual absence of mention of patients. Insufficient data for patients to make informed choices.

More paperwork and recording. Will free you up, more contact time. No, it never does, never does. [Bureaucratic?] Pretence of consultation, do it afterwards; wrong way round. [Why?] Money; it’s all about money, and budgets. Constantly balancing improve services with less real money. Say more money, but it’s not real. Doesn’t come through as more resources. Waste. Lot of tiers, finance, and administrators. Finance people, lots more tiers; ‘non jobs’.
Are everywhere.

30

31

32 Appraisals all tick box.
Lack of appraisal on positive values e.g. care compassion, support of staff, listening learning, etc.
Need values demonstrated approach not just outputs, outcomes deliver.
Appraised on numbers.
Only thing valued and rewarded are delivery of targets.
Huge clash with values most clinicians espouse.
What does NHS value in staff and managers?
Values ‘delivery’ over more human characteristics of care and compassion.
Bureaucratic machine; lack of humanity.

33

34

35 More constrained by procedures and legislation re making decisions.
Fear getting it wrong, having complaint against them.
In [country], more compliance based over past 10-15 years.
Rather than make decisions, reliance on doing what regulations, guidance require, if not clear refer it up.
Lack of independent thinking.
Avoid taking responsibility.

36 That much bureaucracy and red tape.
Systems to underpin it.

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42 Need different method of planning, how use resources.
Process of commissioning very second rate/poor.
Commissioners don’t know what doing, costs awful lot of NHS money, all to sit down on fat salaries pretending to do it.
Back to more, centralised allocation, still centralised now; commissioning groups get money centrally.
Handing money over more directly to providers.
Giving them autonomy; less centralising control.
Purchaser provider split, just introduced trolley loads of unnecessary bureaucracy.
Lot of pretence commissioners would make sure needs of population met.
If had robust analysis, shows hasn’t happened.
Still have mess.
Commissioning not delivered what meant to deliver.

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Framework Theme 5. Finance/business/targets

<table>
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<tr>
<th>FG</th>
<th>Categories for Framework Theme 5. Finance/business/targets (Focus groups)</th>
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<td>Page</td>
<td>Text</td>
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</tbody>
</table>
| 267  | **Cuts in services** - lack of public knowledge.  
Lack of staff.  
Service varies.  
Business, pure finance focused.  
Boards hold financial purse strings.  
*Push on* volunteers.  
Down-skilling and demoralisation.  
Particularly unqualified staff lack up skilling.  
A for C worst thing, divisive idiotic scheme, waste of money.  
Cost so much.  
Avoidance of equal value claims.  
Was about people; is a business.  
Too big.  
Unless change focus back to people.  
Business driven attitude, common wherever work.  
How going to remove business driven attitude? |
| 2    | Needs to change, but not in way proposed.  
Lack of commitment GPs down at shop floor level.  
GPs independent businesses; conflicts of interest.  
Down grading of risk at executive level for political, appearance & financial reasons.  
Government cutting resources.  
Trusts being publically 'noticed'.  
*Bad news* published outside could impact on funding streams. |
| 3    | Busy, Target – driven.  
Money centred.  
Rhetoric versus reality.  
Influence by frontline staff not happening due to decisions around cost savings, budgets, government ideas.  
Feel like *cogs in a machine* – just told what to do.  
Culture very much target driven, patient care, morale, wellbeing, training or workforce no longer matters.  
Financially constrained.  
Money, not patient.  
Money orientated. Forget the patient.  
Lot of talk about improving quality and patient care yet all decisions financially motivated.  
Frequent *lip service paid* to improving patient services and staff working conditions; decisions don’t reflect this.  
Management focus cost savings not supporting staff, providing best care.  
Pressure, cuts, time.  
*Constant hoops to jump through.*  
High pressure to meet government targets.  
Anxiety on job security.  
Sickness, more scrutiny.  
*Rallying around* to support one another: Increase strength to *fight - brave face* to public, attempting to increase morale.  
Decreased job satisfaction.  
Large emphasis cost effectiveness.  
*Higher up level go, not got clue* about patients; all to do with money.  
Not about services.  
Impossible to offer true service.  
*Running with skeleton service*; very high levels patients unseen.  
Solution withdrawal but political fallout considerable.  
Happens unofficially  
Rhetoric not reality.  
One thing said another done/accepted.  
Acceptance of decrease in quality of service.  
Government say no cuts, but already cuts.  
*Drip feed effect* less noticeable to public.  
Care receive well below level deserve. |
| 4    | Large amounts money spent on KSF for work done. |
Now what doing worth less.
Staff demoralised, downgraded.
Business side totally unfocused.
Can’t get decision, in decent time frame, so many committees, paralyses business.
Making mistakes particularly costly ones aren’t looked at favourably.
Mistake is failure.
Private sector more prepared to take risk.
Absolutely ‘copper bottomed guaranteed’ business case before move forward.
Slow things up.
Very controlling, with budgets.
Managers aren’t able to make decisions.
Everything has to be approved, even 50 quid.
Limited autonomy.
Investment developing managers faded over years.
Not seen worthwhile investment.
Almost apologetic about investing in staff.
Seen as taking money from frontline, lost money.
Private sector recognise investing in staff can see real profit and return.
Resources huge issue for managers.
Any recommendation from OH, struggling to accommodate.
Organisation shrinking.
Staffing down to lowest denominator can get away with.
Tough out there for everybody.
Trying to deliver gold-plated service but, continually going down the scale; probably bronze service.
Expectation gold service; when, how want it.
Reality and expectations don’t meet.
Staff struggling.
Don’t have opportunity to give care like to give.
Budgets very tightly corralled.
Things not joined up.
Cuts in one place produce increase costs, work elsewhere.
Joined up thinking not there.
Roles changed but still expected to do old job.
More for less.
Human nature is human nature, pay cut to do same job, but wrapped up in efficiency programme, which isn’t efficient.
Cuts in admin services impact patients.
Private hospital wouldn’t happen same extent, consider very carefully, resources in place to deliver.
Symbolic of everything goes on.
So much time, energy trying to control finance to nth degree.
Lot of time, energy and finance is wasted.
Always short-termism.
Vision, this financial year, got to hit targets.
Limited, financial structures.
Trying to invest to grow or update, a complete nightmare.
Inflexibility.
Disconnected.
Complexity.
Inefficiency
All hear negative stuff got to save more money this year.
Negative impact of government initiatives (PFI) e.g. saddled with huge debt.
Poor decision making.
Lack of internal marketing, promotion of benefits.
Health and wellbeing initiatives could make difference to staff.
No money to fund anything, do everything on the cheap.
Expectations huge what OH can deliver.
Needs to be realism, instead of nannying.
Employer expected to provide pastoral care.
Fantastic benefits of working in NHS, forget very quickly.
Other organisations may get better terms and conditions, higher salaries. Quid pro quo, lost in
equation.
Very, very difficult, if not impossible, to get trusts to invest in wellbeing of staff, if financial cost.
Redirecting money from elsewhere.
Taking money away from front line, should be going to treat patients.
Healthy happy staff more likely to provide better treatment.
Difficult to get NHS, of all people to recognise that.
Like sacking people, can’t do it.
Need staff to be at work, need preferential treatment.
Private sector, over to Nuffield something done.
Theoretically changing, around rapid access for staff.
[Boorman?] Yes, but ‘putting legs on that’, making a reality within organisations, particularly if cost involved incredibly difficult.
Almost impossible, to prove value of individual treatments.
To retain funding absolute nightmare.
Weren’t cost savings to be made, already streamlined.
Limited by funding have.
Part of problem funding streams.
Often need to invest in one stream but pay back somewhere else.
Almost impossible, to measure pay back.
Lots of change, biting where people realise term on protected pay, realisation down-graded, job offer changed.
Salary going to take a hit, they’re already struggling.
Counselling service going up and up; can’t get additional funding.
Demand on service increasing.
Almost got to fail in NHS before get support need.
If got resources now could keep on track, it’s like getting blood out of a stone.
Don’t have capacity, all of us quite lean now.
Concept of the brittle organisation.
Becomes so lean, so stretched does become brittle, only needs a slight fracture.
Real potential danger parts of NHS becoming so stretched is becoming brittle.
Real danger, start collapsing.
Can make it more efficient but need thing to grow in first place.
To put invest to save together, almost have to be 100% watertight, to get through.
Don’t have resources in primary care.
Admission rate very high, cannot get them out.
No joined up thinking.
Siphoning things out to private sector.
Orthopaedic stuff siphoning off to Nuffield.
All relatively straight forward noncomplex cases.
Complex stuff always be coming into [Hospital].
Siphoned work off to private providers, hasn’t been very well done, come back have re do’s.
Short term savings, not comparing like with like.
OH competitors private health.
Suck out clean office bits in the corner.
Cherry pick bits can deliver on.
Strip.
[Politicians] All point scoring, not about what need to do.
Not making difficult decisions, back tracking all time.
No confidence able to deal with crisis.
No work experience, rest wouldn’t trust them with household budget.
PFI concerns raised, still railroaded through.
Wonder what relationship is/was of government ministers with people organised, in charge of PFIs.
Focus on finance not on what needs to be in place.
Staffordshire not isolated situation.
Huge financial pressures, only way save money reducing numbers, temporary staff, down banding.
[Brittle?] Like that some time.
Have to fail before gets better.
Community and acute lack of resources.
Lack of joined up thinking.
Lack family support networks.
Ongoing care problematic.  
Private providers same problems e.g. huge turnover.  
Finances always issue, still are, despite what government says.  
Rhetoric not reality.  
Technology costs more.  
Got to have experienced people to use it.  
Patients at times aren’t given care deserve.  
Don’t have time to talk to them.  
Is shrinking.

5 Not homogenous.  
*Macro patterns market focused behaviour and ideologies clashing* with public sector ideals of service without profit.  
Market, conflict, politics.  
Accountability – financially & litigation.  
Pressured.  
[OST] Good value for money  
Conflict, tremendous financial cost.  
In absence of informal interventions reliance on formal processes.  
Team designed to help organisation *come out ahead* financially by reducing costs.  
Organisational performance payoffs.  
Not just to *prop up* performance indicators.  
People doing complicated jobs very difficult circumstances, often without many resources.  
Often lifesaving, important work, want to support them.  
Can over focus on outcomes, targets, ways has unintended effects, like way people relate.  
Outcomes, targets planning important to find way forward.  
Can mask what’s actually going on, how to get along.  
Transformational outcomes always looking for, are emergent in those relationships.

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<th>Int</th>
<th>Categories for Framework Theme 5. Finance/Business/Targets (Interviews)</th>
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<tbody>
<tr>
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<td>2</td>
<td>Management, complete obsession with cost.</td>
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<td></td>
<td>Each government means change.</td>
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<td></td>
<td>Changes time consuming and costly.</td>
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<td></td>
<td>Most staff dedicated, give patients best service available in restraints of finance.</td>
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<td></td>
<td>Cost orientated.</td>
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<td></td>
<td>Culture; need to be efficient, cost effective.</td>
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<td></td>
<td>Don’t want to spend any time, money supporting staff when working to tight budgets.</td>
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<td></td>
<td>Constantly having to save money.</td>
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<td></td>
<td>[Key blocks?] Money, time and belief put in place policies.</td>
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<tr>
<td></td>
<td>Constant changes mean emphasis of budgets, not dealing correctly with staffing issues.</td>
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<td></td>
<td>Focusing on budgets and costs.</td>
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<td>Lack realisation; unhappy workforce worst effect on productivity.</td>
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<td>[HR?] Work within reduced budgets.</td>
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<td>Strong staff side; even then budgets/peoples jobs frequently in negotiations.</td>
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<td>3</td>
<td>Business orientated ethos permeates.</td>
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<td>Coalition’s determination to introduce high degree of competition.</td>
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<td>4</td>
<td>Targets, how achieved; difficult to raise.</td>
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<td>5</td>
<td><em>Nature of the beast</em> cannot be run like business.</td>
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<td>Realisation; managers thwart efforts of staff to maintain good service.</td>
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<td>Patients, staff suffer whilst managers try to meet targets.</td>
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<td>Managers wish to control clinical staff, remove clinical freedom from doctors.</td>
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<td>Control expenditure, but at detriment of patients.</td>
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<td></td>
<td>Constant conflicting pressures demands.</td>
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<td>Some managers, initial interest in patient care.</td>
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</table>
Opposed to primary aim; deliver service on budget.
NHS needs more money; should not be spent on managers.
Clinical teams are the caring professions, managers not.
Managers activity around reducing costs created by caring professions.
Only way to save money; provide less or make staff work harder for no more pay.

No resources.
Most refuse to buy in mediation expertise.
Managers preoccupied with cost savings/targets.
[Why resistance?] Use lot of time, resources, no good outcome.

Clinicians DIRECTED BY RESOURCES IN STEAD OF CLINICAL NEED; CONFLICT.

Nicholson Challenge £20bn cut of resources, root of redundancies, re organisations, outsourcing of services.
Instructed reduce level of administration/senior management; ‘efficiency’ savings.
Result; culture of uncertainty, rise in negative behaviours.
Expectation of ‘more for less’.
Unsafe levels within caseloads.
Work alone; increased risk, less support.
Work above clinical competencies.
Carry out practice not in accordance with regulatory body.
Resistance; impact on wellbeing and mental health.
Resource management increasingly determining how issues resolved.
Little experience how to manage decline in resources.
Middle management; increasing patient needs on reduced budgets.
Detriment to staff/patients.
Training needs, how manage dignity at work issues, every level.
Tightening of resources, redundancy programmes targeting administrative grades, expertise diluted.
Cuts to services, financial pressures, re organisations need to be risk assessed in light of impact on behaviours.
[Case] Need to consider stewardship of public resources.

Very target driven.
Not always clear direction.
Constant change.
Target driven, financial driven culture.
Sometimes a small investment, other times [L] no investment.
Time is investment; everybody too tired, too hard worked, to do those changes.
Priority is around cost savings, efficiencies, productivity.
Focus on finance, constant change.
Main deliverable finance, even though, as clinician, clinical side much more important.
Understand importance of money; comes down to cost.
Project doesn’t deliver the finances; going to blame project manager.

Funding cuts, services under pressure, reduction in higher graded posts.
[clinicians] feel undervalued, overworked.
Pressurised.
Keen to address, however limitations of resources, time and personnel.
HR frequently under-resourced, unable to give managers support.

Lack of financial expertise.

Whole NHS, utter chaos on the move, all the time, nobody wants to admit that.
How the hell do we ‘keep a lid on all of this’?
Too much for them.
Dangers of over trading.
Promising things can’t do; doing too much.
Work within capability.
In NHS it’s ‘come all ye’ so capability not word used.
Real, literally killer things was Blair’s introduction performance, process targets.
People into the system, without regard to capability.
| 16 | Perverse financial incentives to focus on input/outputs rather than quality.  
Top down target culture.  
Mixed messages because conflict between top down targets and local commissioning.  
Bullying intolerance of failure to meet irrelevant targets.  
Consequences don’t matter.  
Financial management, viability of institution comes before anything else.  
Corrupting impact of the context (e.g. perverse financial incentives). |
|---|---|
| 17 | Funding by taxation, resource allocated according to need very admirable.  
Not worried about payment |
| 18 | Progressively adopted commercial values; bastard culture.  
Very highly paid managers, often don’t know the business.  
Hybrid thing of a social mission, but with, attempts mimicking private sector; peculiar.  
Imperatives, not much to do with quality of care.  
Financial considerations that work backwards from what year-end financial statement got to look like.  
[CEO 8% pay rise] Discussion, recommendation to board.  
Contrast to ordinary employees re %  
As the top team not done it; how can you when all this stuff going on?  
Notion purchaser provider split, or commissioning get to [Different service].  
Arguments against, very well-rehearsed.  
Finish up massive massive transactions costs.  
Spending 20 or 30% every health pound on administration, other costs didn’t used to spend.  
Used to spend, 5% or 6% on administration, now over 12%, getting more by the day.  
Finish up much less efficient service, fragmentation.  
Greater unwillingness to cooperate; commercial environment.  
Wanting to look after own contracts, contain them.  
Don’t want to collaborate.  
Unmitigated disaster.  
Failure of leadership. |
| 20 | Years of political control  
Spend in NHS so high civil servants/ministers do not want to let go.  
Almost soviet style of central control to keep budget etc. in check.  
With culture of soviet style of political control. |
| 21 | Transactional processes geared up to achieving performance targets, ensuring budgets, other resources well controlled.  
Performance.  
Local values undermined by acute pressures from [Country] Government to achieve performance |
targets, meet public expectations.
[Neg beh] Sometimes behaviour serves organisational need; people can make things happen. Behaviour ignored so long as continue to ‘perform’, bring in on budget, making difficult cuts in services. Action prompted by high turnover and/or sickness, financial implications; hurts organisation. Massive financial pressure. Careers completely dependent on achieving financial targets. Cannot hear message, cannot do anything, because of financial position. [Neg Beh] costs the organisation, although trying to save money. Erosion of ‘good will’, costing them, but cannot measure it. If cannot measure it, cannot count it, it doesn’t count. Soft stuff, very hard to track pathway; virtually impossible, complicated.

22

23 Culture, significant time to effect. Government targets have impact upon organisational feel. Changes in organisations approaches (possibly not culture) driven by these required outcomes. Where required outcome/target aligns with culture of organisation is harmonious outcome and good achievement. Where outcome does not align with cultural base then outcome and culture conflict; one tries to bend to meet the other. Sometimes cultural norm wins, sometimes cultural norm starts to shift. Depends on message delivery about need to change, interim point where clash, leads to turmoil in organisations.

24

25 Too target driven. Does not encourage innovation.

26 Target driven. Delivery of service at most cost effective is focus. Quality of service is secondary; concern to patient groups. New treatments, cost money, not much around. Patients/relatives excellent services. Post-code lottery, likely to increase e.g. IVF. More commercialisation, privatisation; will continue. NHS not changing way delivers services fast enough. Not focusing on quality delivery of services i.e. not sufficiently customer centred. Private companies show how much better can do it. £20 billion savings; shift to ‘private companies’, other models. Increased possibilities reduce staff.

27 Dramatic shift to defensiveness. Significant difficulty balancing needs, availability, and requirement to stay within financial limits. Easier to stay within financial limits and reduce services/quality. Vast majority costs linked to staff (70% average DGH) Security of NHS contracts very difficult to release staff quickly [Euphemism]; significant redundancies costs. Duties on Trust Boards (FT) to put need of organisation in front needs local community. Regulatory regime, Monitor, lack of assessment overall competencies, strategic planning of local health economies. Works against concept of integration and developing intelligent systems to respond to local pressures. Financed on system of penalties for non-achievement rather than rewards for achievement. Entire approach creates behaviours less likely to produce innovative and positive results. Monitor purports to make FTs more commercially aware. Conveniently ignores commercial freedoms allowed in private sector.

28

29 Target driven. Finance orientated. Resource led. Better treatments; can’t/won’t access because of cost. Constraints of government funding all time, not necessarily better treatment.
Other countries, much more choice effective treatment; but pay more. Notorious; we don’t want to pay.
Discharge; end of the day, usually driven by wanting people out. Protection of resources and funding. [Care trusts?] Shared budget? Who holds the budget? Everything runs around the budget.
Money. All about money, and budgets. Constantly balancing, improve services with less real money. Government says, more money, but not real. Rhetoric not reality. Doesn’t come through as more resources. Waste. Lot of tiers, finance, administrators; ‘non jobs’, everywhere. Maggie Thatcher, privatisation, to take away cost from government. Quango’s, administrators, finance people managing budgets instead of health professionals. Gone, all a bit crazy. [R&Js] Money and resources, money and resources (R&J). Meet needs not wants (R&J).

30 Culture dictatorial, concerned with numbers, targets and money, rather than clinical excellence. Money often talks, guiding principle rather than excellence in patient care. Bringing in money, grants, publications, research, mattered. Conflicts of interest. Dependent on flowing of money, lots of money in form of grants; inhibits speech. Can’t say anything about people if money coming in. Manager behaviour affected by money coming in. Regarded [them] as God and very powerful. Surgeons often regarded as Gods, bringing in money and money speaks. Spend lot of money to get rid of people, could be spent on patient care, but don’t care; achieved goal.

31 Middle managers under pressure to meet targets. Not met; have failed. Constant pressure of squeezed budgets. Most patient safety issues related to low staffing and resources. If no money to recruit, managers feel powerless. Culture is set of values and beliefs. Current culture driven by financial constraints and targets, not what best for patients.

32 Struggling to cope with business model no-one in clinical field understands or accepts, causing tension with “management” and “commissioners”. Lack of understanding. Mixed economy of tariff-based and block contract activity, public, voluntary and private. Lack of incentive for prevention and support. Too much incentive for hospital activity. Appraisals all tick box. Lack of appraisal on positive values e.g. care compassion, support of staff, listening learning, etc. Need values demonstrated approach not just outputs, outcomes deliver. Appraised on numbers. Only thing valued and rewarded are delivery of targets. Huge clash with values most clinicians espouse. What does NHS value in staff and managers? Values ‘delivery’ over more human characteristics of care and compassion. More driven, business model imposed; purchaser and provider split. Alien to culture and value system of people in NHS. Business mentality, performance targets not trained in it, not very good at it. Targets sent down from above. Not doing what intrinsically good; just following targets.
Driven by what have to do, start cheating, do silly things; sub optimal care. 
Wrong model, driven by targets don’t accept, believe in. 
Push towards inappropriate behaviours. 
Causes stress, *snap at people.* 
To deliver targets, *pass it on down, pass on the pain down, on down line.* 
Lack of SHA leadership compounds problems. 
Some SHAs don’t care how make financial balance, meet targets, just want to know are met; don’t want *‘bad news’.* 
How much money do we get? 
Lack of clarity where money goes. 
Reluctance of finance directors to explain. 
Major fraud exposed; people *sacked,* financial irregularities. 
Move money around without telling Board/auditors. 
Misbehaving; serious dishonesty. 
CE taking bribes, just given *rap over the knuckles.* 
People who raise concerns, made to resign. 
Bad managers going onto subsequent trusts. 
Absolutely shocking. 
Most clinicians/staff do not subscribe to internal market, business model. 
Own professional code of ethics and service model. 
No proper financial checks, lack of governance/control. 
Prevailing culture of no accountability. 

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36 Overzealous cost improvements. 
Not just efficiency any more, it’s madness. 
Unsafe madness; dangerous madness. 
Patients, not static entity on production line. 
Lack of humanity. 
Savings are the focus; patients put at risk. 
No one listens. 
A shame; it’s probably unaffordable. 
End up with private system because health care companies, *queuing up* to take over. 
Possibly NHS set up to fail in order for that to happen without too much public outcry. 
Possible ulterior motives. 
Reverse psychology going on. 
Private companies picking the easy stuff; doing it better. 
Move towards, not free at point of delivery. 
Will be *costing ‘arm and a leg’*, excuse the pun. 
American model, only way fundable. 
Public health to local authorities; might save money. 
Not right place. 
GU services disjointed. 
Result in sexually transmitted diseases. 
Result, end cost; expensive fertility treatment. 
Lack of knowledge of services. 
Public Health, Im and Vac, *hived off.* 
On-costs of outbreak; no saving of money. 
Local authorities will prioritise, whoever shouts loudest. 
Pothole in roads will win. 
Problems of prioritisation. 
Increased end costs. 

37
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42 Waiting times rather than waiting lists,
Constrained resources.
Very heavy focus on keeping waiting times short, detrimental effect on emergency care.
If give clear understanding, public would rather be sure good 999 service; many say this.
Trade off 2 or 3 months more for hip op.
Not what’s said; no open debate.
Steady erosion in resourcing and quality of emergency care to keep waiting times at levels very
difficult to maintain within current resources.
Need different method of planning, how use resources.
Process of commissioning very second rate/poor.
Commissioners don’t know what doing, costs awful lot of NHS money, all to sit down on fat salaries
pretending to do it.
Back to more, centralised allocation, still centralised now because commissioning groups get money
centrally.
Handing money over more directly to providers.
Giving them autonomy; less centralising control.
Purchaser provider split, just introduced trolley loads of unnecessary bureaucracy.
Lot of pretence commissioners would make sure needs of population met.
If had robust analysis, shows hasn’t happened.
Still have mess, still probably too little money going into health and community care side.
Too much into acute side, but in acute side perhaps too much diversion away from emergency
work.
Commissioning not delivered what meant to deliver.
Under enormous pressure e.g. ghastly staff survey, flagging up major problem, need changes.
Head on conflict with line of control coming down from centre.
You will save, eight and a half million pounds; only way is getting rid of nurses.
Most non execs just completely passive and useless.

Framework Theme 6. Change/variable

<table>
<thead>
<tr>
<th>FG</th>
<th>Categories for Framework Theme 6. Change/variable (Focus groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Restructuring.</td>
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<tr>
<td></td>
<td>Merger as big organisation; horrendous.</td>
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<td></td>
<td>Teach them, all time; nothings learnt.</td>
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<td></td>
<td>Everything do new, never same twice.</td>
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<td></td>
<td>No templates followed.</td>
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<td>Used to get training, now don’t bother to ask.</td>
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<td>Less taking of responsibility.</td>
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<td>Managers had awareness of staff; positive way to treat them.</td>
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<td>Need something to break the culture because hasn’t always been like this.</td>
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<td></td>
<td>Changing.</td>
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<td></td>
<td>Used to be clear structures in place, all knew part.</td>
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<td>Roles so blurred, unbelievable.</td>
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<td></td>
<td>Was about people.</td>
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<td>Too big.</td>
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<td></td>
<td>Now a business.</td>
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<td>Unless change focus of NHS back to people.</td>
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<td></td>
<td>How going to remove business driven attitude?</td>
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<td></td>
<td>OCP very precise, interpreted, implemented differently.</td>
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<td></td>
<td>One manager does by the book.</td>
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<td></td>
<td>Others do what they want, ignore policy.</td>
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<td></td>
<td>Use of policy to move/remove/displace people.</td>
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<td></td>
<td>Misuse of policy.</td>
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<tr>
<td></td>
<td>Anything goes.</td>
</tr>
</tbody>
</table>

276
| 2 | Variable.  
Constant change, focus changes.  
All stop, start something else.  
Never seem to finish anything.  
Don’t measure.  
New initiative, do that.  
*Suddenly hit wall*, something totally changes way going to deliver, outside influence.  
Start all over again.  
No one *sits down* says, is 10 year plan.  
Might got 10 year plan, but no one end of 10 year going back to look because changed ten times.  
NHS needs to change, but not way proposing.  
*Fear in light of changes.*  
Changes *driven from the top.*  
Don’t realise - lack of planning for safety of patients.  
This week, year, new priorities.  
Completely changing.  
How many times here before?  
Still dedicated and creative.  
Still *bounce back.*  
In end all down to patient safety.  
We, our families use health service, families, families, use health service.  
Because *caring* people, don’t want to see anybody hurt.  
Continue to *reinvent ourselves* to maintain patient safety.  
Resilience.  
Adaptability.  
*Top tier* not around long.  
No time to structure teams.  
Not many completer finishers.  
Reactive.  
Dealing with the immediate.  
NHS nothing like it was.  
Bears no resemblance.  
People in right jobs?  
We just move around.  
Will we be found out to be rubbish?  
HR role changed.  
Help management rather than staff.  
People don’t go to HR.  
HR more recruitment and workforce development, telling people to do disciplinar
dies.  
HR not planning for improvements 5/10 year plan, for change.  
Care should be devolving into community, not planned/prepared for that change.  
Not prepared, trained people. |
|---|---|
| 3 | Changed significantly in 10 years.  
Initially, felt valued, trusted, allowed to do what thought best for patient.  
Now, culture very much target driven.  
Patient care, morale, wellbeing, training, workforce no longer matters.  
Constant change.  
Support varies.  
Constant re-organisation of services leads to paranoia.  
Managers vary, depends whether working on *ground level with you*, understand problems.  
Teams vary, dependent on personal relationships.  
*’There was a little girl and she had a little curl right in the middle of her forehead. When she was good she was very, very good but when she was bad she was horrid’.*  
Huge variation in quality of senior management.  
Some managers very, very talented, *talent shines through.*  
Others detached, arrogant, paternalistic. |
<table>
<thead>
<tr>
<th>Int</th>
<th>Categories for Framework Theme 6. Change/variable (Interviews)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Culture, changed such a lot.</td>
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<tr>
<td></td>
<td>Changed a lot with NVQ training; don't do NVQ properly, it's paperwork.</td>
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<tr>
<td></td>
<td>Shift of focus from patient to paperwork.</td>
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<td></td>
<td>Direct learning; had to be seen to be doing it. Interviews used to be done better.</td>
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<td></td>
<td>Now have to sell yourself 'you are the best', greatest.</td>
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<td></td>
<td>Olden days told them what could do.</td>
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<td></td>
<td>Lot of people don't like to boast.</td>
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<td></td>
<td>Seen one got job, one most inappropriate to do job.</td>
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<td></td>
<td>Poor recruitment process.</td>
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<td>Not as flexible now.</td>
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<td></td>
<td>So different.</td>
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<td></td>
<td>Staff; lack of connection, even wards don't connect now.</td>
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<td></td>
<td>Not a whole anymore.</td>
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<td></td>
<td>The patient has to wait; was never like that.</td>
</tr>
<tr>
<td></td>
<td>Totally different.</td>
</tr>
</tbody>
</table>

4 Reorganisation.
- Controlling, bureaucratic organisation which is constantly changing/reorganising "creating the illusion of progress whilst producing confusion, inefficiency and demoralisation" Petronius AD 66".
- Still relevant.
- Always been about changing, it’s going to get better, it’s never got there.
- Re-organisations continually imposed.
- Little, no time for consolidation.
- Paralysis of organisation.
- Changes in NHS like trying to run through treacle.
- Constantly changing, but very slow to change.
- Change of terms and conditions, down grading; now biting.
- Community trusts to PCTs, PCTs to providers.
- Now another change.
- Change, but nothing changed.
- Same people, job titles changed.
- No cost effective saving.
- Finances always issue, still are, despite what government says.
- Patients at times aren't given care deserve.
- Don’t have time to talk to them.
- Is shrinking.

5 Constant change, traditional to more corporate.
- Re grading – posts cut/not replaced.
- Increased workload → fear, pressure & uncertainty.
- Changing.
- Current climate and changes.
- (OST) Helps to restore ownership, ability to change environment working in.
- Lot of teams changed, put together, restructured.
- Allowed to grieve process going through, have that recognised.
- Help to move on.
- Constant change making work irrelevant, useless, wasted.
- No one cared.
- Change happens very quickly, is very dynamic.
- Focus on targets, outcomes in ways become irrelevant, very fast.
- So much talk about change, talk about lots of restructuring.
- People more fearful.
- Try to protect position.

6 Lot of change obviously.
In my day if did not do right, got told; you took it.
Modern day person does not like being told.
Would be called old fashioned if said something wasn’t right.
Nobody’s taught anything anymore, by senior staff.
My day, to make patient comfortable, now old fashioned.
Complete change.

2 Change in government means "Changes for the NHS".
Constant organisational changes.
Emphasis on budgets, not dealing correctly with staffing issues.
Role of HR changed; not "staff support"; another management tool.
[Why lip service?] Management & HR focus on constant changes imposed by government.
Feel truly offering staff good service.
Constant changes mean everyone can say do not have time to make necessary changes to truly support staff (R&J).
Most staff too frightened lose jobs if demand ‘rights’; 'keep their heads down’.

3 Business orientated ethos permeating.
Political drive to introduce degree of competition.
Varied.
Changing.

4 Significant cultural shift.
Non punitive to punitive.
Culture of learning from mistakes lost.
Openness discouraged.

5 Personnel taken over by “human resources”.
HR source of problems.
HR name a problem - denigrates human beings to ‘resource’; how modern HR acts.
Move to utilitarianism; lack of humanity.
No longer loyalty to long serving staff.
No deference to scholarship, position.
All staff treated equally; sadly, usually equally badly.

6 Lack of stability.
Frequent change leads to feelings of uncertainty.
Lack of knowledge about future organisation direction/purpose.
Strategies change too quickly; leave staff behind.
Unstable.
Increasingly difficult to get grievances, other issues dealt with quickly.
Lack of HR staff.
Shift in priorities, focus on structural change and future commissioning.

7 Staff worried about jobs.
Moved HQ; everyone applying for their jobs.
Grievances increasing.
Blasé attitude to change.
Don’t do assessments like used to.
[Overall impression of chaos, constant change, almost self-destruct in organisation].

8

9 Undertaking radical, unknown change in difficult environment.

10 State of change.
Cut of resources root of redundancies, reorganisations and outsourcing of services.
Reduction of administration and senior management to assist in ‘efficiency’ savings.
Culture of uncertainty leading to rise in negative behaviours in workplace.
Expectation to do ‘more for less’.
Carry unsafe levels within caseloads.
Work alone, where previously support provided.
Work above clinical competencies, carry out practice not in accordance regulatory body.
Employees trying to resist; impact on wellbeing, mental health.
Hardened approach to industrial relations.
Changes to terms and conditions.
Additional pressures on staff; curb reward.
External pressures around reorganisations, outsourcing causing unrest.
| 11 | Lack of control over decision making processes.  
    | Reorganisations need to be risk assessed in the light of impact on behaviours. |
| 12 | Change common; been constant change.  
    | Culture changed particularly last 10 years, very target driven.  
    | Not always clear direction.  
    | Role of HR changed dramatically.  
    | HR changed to being there for employer; less for individual.  
      | *Big swing* other way.  
    | Not sure right or wrong for business; but all for fairness and justice.  
    | No fairness and justice; when see what happening.  
    | Focus on finance and constant change. |
| 13 | Funding cuts, services under pressure.  
    | Reduction in higher graded posts.  
    | Experienced [clinicians] feel undervalued and overworked.  
    | Pressurised.  
    | Increasingly HR focused on organisational change, not ensuring effective working, good management. |
| 14 | NHS & society changed dramatically.  
    | Variation.  
    | Teams doing most extraordinary things.  
    | Contrasts; wonderful things going on, but very serious whistleblower problems, covering up failing medics, handling complaints utterly appalling.  
    | Variation; fantastic things, *down corridor* utter absolute chaos.  
      | [How live with contrast?] Get used to it; inured to it after while.  
    | People who go into it don’t know any better.  
      | [Comparison then and now] Nurses; all neat.  
      | Different time.  
      | Beds far apart, *spick and span*.  
      | Virtually no equipment, no technology; simpler time.  
      | Society not noticed more complex.  
      | Society changed, young people different.  
      | Beds lined up, all these pillows.  
      | No reclining beds, iron beds.  
      | Floor sparkling, bet quiet.  
      | Of course it’s for the camera.  
      | Whole NHS, now in acute care particularly where elderly.  
      | *Chaos on the move*, all the time, *utter chaos on the move* all the time; nobody wants to admit that. |
| 15 | Culture different departments differs greatly!  
    | Departments differs greatly!  
    | Managers run or manage areas differently!  
    | Generally lacking, leadership, vision, accountability, honesty and respect. |
| 16 | Continuous restructuring driven by political ideology.  
    | Disruption of organisational processes, experience and continuity.  
    | Loss of organisational memory and maturity.  
    | Erosion of trust, stability and constructive relationships.  
    | Managerial energies diverted, sapping of morale. |
| 17 | Too much change and restructuring.  
    | Variable.  
    | Not all organisations, parts of NHS are bad. |
| 18 | Lots of NHS’s.  
    | *Bastard culture*.  
      | *Turned our back*, on original culture born of social solidarity second world war.  
      | Paternalistic.  
      | Consultants; lot institutional authority; backed up by administrators.  
      | Staff motivated by mission of belonging to great social experiment, an adventure.  
      | *Turned our back on that*, with introduction general management.  
      | Progressively adopted commercial values, led to *bastard culture*. |
Introduction very highly paid managers; often don’t know the business.
Peculiar situation.
*Hybrid thing of a social mission*, with, peculiar attempts mimicking private sector.
Parody on the original.
Investors in people, a joke.
Morale progressively downhill.
Loss of goodwill.
Didn’t used to be well paid, but content, part social enterprise.
Morale very low.
Insecurity.
In past weren’t highly paid, had job security.
‘Agenda for Change’ has ‘been and gone’ now being taken apart.
Fragmentation of service into private contracts.
Increasing unwillingness to share what going on.
[Driving it?] NHS needed to change more than 20 years.
Changed health needs, population.
Need very different service.
The agenda, but inertia massive.
Failure of leadership.
Politicians always *shied away from it*.
Always support own hospitals staying open; needed to close.
Clinicians wound public up, whenever threat to rationalise.
**Got** to happen.
Refocus, reinvest money in strong community services, strong general practice.
Turned to private sector way to achieve same end.
Haven’t got guts to provide leadership; governments 20, 25 years.
WHO 1970s; known agenda.
Not had guts to lead it.
Notion purchaser provider split, commissioning can get to that point.
Arguments against, very well-rehearsed.
Massive transactions costs.
Spending 20 or 30% every health pound on administration, other costs didn’t used to spend.
Used to spend 5%/6% on administration.
Now over 12%, getting more by the day.
Less efficient service, fragmentation.
Greater unwillingness to cooperate; commercial environment.
Wanting to look after own contracts, contain them.
Don’t want to collaborate.
Unmitigated disaster.
Failure of leadership.

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20

21

Not sure NHS organisations same.
Own; culture shift recent years.
Most frequently cited changes: From delegated authority to centralised control.
Local target setting to national and organisational performance targets.
Change is a constant.
[Change] Frequently talked about, quite often happens but not always.
Staff recognise can appear lacking in energy for change because invested time in past on things don’t happen.
Feel like inertia, resistance but not necessarily.
Encourage people to take care of themselves, to protect them, separate out from organisation.
Long history in NHS of staff feeling organisation will look after them.
Sense of in ‘NHS family’; would be looked after.
Last 10 years definitely changed.
Consistently encourage people to take care of own careers, take care of themselves.
Move from personal to impersonal.

22

Organisations are variable.
Widely different findings annual staff survey, but common themes.
Variable.

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<table>
<thead>
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<th>24</th>
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</table>
| **26** | Very hierarchical.  
Some change when ‘Griffiths Report’ implemented; general management flavour of month.  
Encouraged team working, open communications, avoidance of ‘blame culture’.  
Now all changed.  
Labour into power, target driven.  
Bullying culture began to permeate.  
Significant pressure on CEOs from *the top down* i.e. DOH.  
Again, very considerable change.  
Pressure on all managers considerable.  
Delivery of service at most cost effective is focus.  
Quality included is secondary; concern to patient groups.  
Post-code lottery; likely to increase. |
| **27** | Last two years dramatic shift to defensiveness; based on significant difficulty balancing running public service, need to stay within financial limits.  
Easier to stay within financial limits and reduce services than maintain services at quality level required within *financial envelope* allowed.  
Monitor, change in fundamental purpose.  
Change of primary purpose to “protecting and promoting the interests of people who access health care.”  
Allied to new powers of Monitor (from Nov 2012) failure regime for FTs, first time key regulator looking from patients’ point of view rather than from individual FT’s. |
| **28** | **Striking me, forcibly.**  
Admission procedure, absolutely *gob smacked*, straight away almost before *got their coats off*, the patient.  
Planning for discharge.  
First questions, when expect to discharge.  
*Where are good old days* when somebody *given a bed*, settled in, will go when you are better? [LoFL].  
Powerful impact.  
Focus on exit.  
NHS doesn’t want patients. |
| **29** | 2 organisations, different experiences |
| **30** | 2 organisations, different experiences |
| **31** | 32 |
| **33** | Mixed workplace culture.  
Some places supportive, learning orientated, focussed on evidence based progression, sharing knowledge.  
Others *it is dark*, blame orientated with leaders not taking responsibility for poor decisions, blaming others. |
| **34** | Public health to local authorities; might save money.  
Not right place.  
GU services disjointed.  
Result in sexually transmitted diseases.  
Result, end cost; expensive fertility treatment.  
Lack of knowledge of services.  
Organisational changes potential negative impact on services, patients.  
Public Health, Im and Vac, *hived off*.  
On- costs of outbreak; no saving of money.  
Local authorities will prioritise, whoever shouts loudest.  
Pothole in roads will win.  
Problems of prioritisation.  
Increased end costs. |
| **35** | Culture enormously variable.  
Variable. |
Continual re-organisations. Besetting problem particularly past 25 years, revolving door managers. Career managers' move posts every couple of years. Failure to see through changes put in motion. Not conducive to working as collective team with common understanding/goals. Not creating effective managers committed to organisations, staff, patients. Creating managers committed to career progression.

Clinicians, doctors in particular, could in past resist government pressure for change. Powerful group of people, something not right; wouldn't do it.

Framework Theme 7. HR/other roles

[Added from ‘Hierarchical/top down/power’]

Bullying when 2 or 3 managers, HR around table. Bullying at top level; HR in the middle of it.

<table>
<thead>
<tr>
<th>FG</th>
<th>Categories for Framework Theme 7. HR/Other roles (Focus groups)</th>
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<tbody>
<tr>
<td>1</td>
<td>Even in rooms can’t get access, special, digital locks.</td>
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<td></td>
<td>Supposed to direct manager follow policy.</td>
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<td></td>
<td>But taking side.</td>
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<td></td>
<td>Not following policy.</td>
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<td></td>
<td>Management pay their wages!</td>
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<td></td>
<td>Conflict of interest.</td>
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<td></td>
<td>Should support as well; be neutral.</td>
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<td></td>
<td>Shift from Personnel to Business Partners</td>
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<td></td>
<td>New titles indicate lack of neutrality; tells all.</td>
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<td></td>
<td>Don’t come to meetings, direct, advise from offices.</td>
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<td></td>
<td>HR not doing their job.</td>
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<td></td>
<td>Not instructing proper way of doing things.</td>
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<td></td>
<td>Against the law.</td>
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<td></td>
<td>Pull her in, pressure girl into sickness policy.</td>
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<tr>
<td>2</td>
<td>Very supportive HR team.</td>
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<td></td>
<td>Big push respect behaviours</td>
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<td></td>
<td>People do raise things formally, followed through.</td>
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<td>Good response on relations.</td>
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<td>HR aware, but nothing is happening.</td>
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<td>Still in post doing same things, other people move.</td>
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<td>Complaints, so stressful.</td>
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<td>Not letting two bullies push me out of here.</td>
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<td>Repeated behaviour nothing done.</td>
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<td></td>
<td>Lack of effective response/action from HR.</td>
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<td></td>
<td>[HR] Way it is (R&amp;J).</td>
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<td></td>
<td>Can’t do anything about it (R&amp;J).</td>
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<td>Whistle blowing policy not much benefit.</td>
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<td>Risk assessment type process, as tool, better.</td>
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<td>Managers, not enough support from HR.</td>
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<td>Different pictures around the room re HR.</td>
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<td>Employment law, formal processes, the threats, doesn’t help.</td>
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<td>Non-NHS HR coming in; suddenly very different vibe, different advice.</td>
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</table>
Sometimes 'NHS think', isn’t how done outside.
Bullied to extent can’t raise formally.
Fear of raising; will deny it.
HR view always unless complains cannot do anything, forget it (R&J).
No HR in Social Enterprise; felt free.
Not having to pussyfoot around.
Stunned could manage without.
Pander too much to rules.
Threat of litigation etc. keep HR going.
Saving money by no HR.
HR limits action.
See just put pressure back on manager.
HR role changed.
Help management rather than staff.
People don’t go to HR.
HR more recruitment and workforce development, telling people to do disciplinaries.
No support for staff.
Go from naughty, straight to disciplinary, not much in between
HR not even getting workforce right.
HR not planning for improvements 5/10 year plan, for change.
Care should be devolving into community, not planned/prepared for that change.
Not prepared, trained people.
Lack of surety how far can go.
Need freedom.
Not bothering to go to HR.
Not useful.
Make things harder, stressful.
Just get on and sort it.
HR helpful, supportive in difficult situations.
Performance management; horrendous, time consuming.
Good HR, sounds like Personnel.
Transformation away from lead manager, to being away at arm’s length.
Not allowed to do work, advise.
Key pads on front entrance [L].
Everyone else same.
E-mail them.
Heard of litigation?
Never heard of it.
Very angry, HR see things, they know, but don’t do anything about it.
Don’t see as their job/role (R&J).
Part of organisation so just as culpable.
Like RMs. Meant to be neutral.
With foot in both camps, makes it difficult.
Rarely telling managers good news; bearers of bad news.
People don’t want to hear negative information.
Negative responses come back.
They want to stay away from the problem.
We stay with the problem.
We won’t let it go; a difference

3 HR takes lead bulldozen inexperienced staff/manager.
Doesn’t have say.
HR does what they want.
Advisors very, very, good, very, very, supportive individual staff.
Only problem HR Director, driving through her agenda, causes lot of trouble sometimes.
Few rogue managers.
Not looking at/own interpretation of policies.
HR trying to back up manager at formal stage; easy win.
End of the day not done what should.
Higher up HR culled quite a bit, so none of them.
HR advisors, hard to get hold of cos all just disappeared.
HR managers under phenomenal pressure.
HR advisors pretty good, help & support.
HR directors ‘they’re corporate’ they’re, ‘singing a corporate tune’, detached as those bad detached
NHS managers.
Two varieties; Supportive HR advisor.
HR Director determined to push policies through, reduce staff, cost, because of corporate attitude.
Detached from real people doing their jobs.

SHA, HR director real vision for staff wellbeing and OH.
Leading it within region; an exception.
Very for HR, if done well incredible asset.
Not done well in NHS.
Unable to identify root cause of issues.
**Keeps falling back to either institutionalised culture or such large organisation.**
**Just can’t turn that ship round.**
Almost weak reasons, explanations.
**Burns me, gives me appetite to continue in NHS; can be changed.**
Want to influence changes, make it a different place; so **big thumbs up.**
**HRs hands tied slightly because of changes.**
Caught up with reactive stuff.
Not managed in past; now saying being bullied.
All disciplinary processes take so long to sort.
Overseeing the systems; reactive.
No forward planning, thinking; **fighting the fire.**
Really **tied up,** recruitment process lengthy.
So many large systems restrain.
**Make us big whale.**
HR act effectively as fish within national guidelines.
Some HR teams manage it quickly and efficiently.
HR tends to cover manager inadequacy.
HR should be centralised for transactional stuff, advertising, recruitment process.
In-depth legal advice.
**Get caught up** around individual performance management; should be manager.
Cover manager short comings; HR starts getting a **bad name.**
Processes become very restrictive, **tick box.**
Need freedom.
Lack of autonomy.
Not given autonomy, so **second question** yourself.
Fear of making mistakes, incredibly important.
Off-loading onto HR to reassure, authorise; to **rubber stamp** process.
Lack of training in having difficult conversations.
Lack confidence.

OST always informal.
Formal; expensive and difficult.
Work with HR, so organisation not split.
Encourage HR attempt informal, cost effective solution.
Formal; lengthy, 6, 12, 18, months investigation, pain and possible lawyers

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<tr>
<th>Int</th>
<th>Categories for Framework Theme 7. HR/Other roles (Interviews)</th>
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<tr>
<td>1</td>
<td>[HR] HR got their guidelines. Have tunnel vision, just go for what have to do.  <strong>Don’t look sideways</strong> at staff. They are going to do this; they decided. HR rule. Not supposed to argue with them; if do are nasty guy.</td>
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| 1 | Think can change rules/policies.  
I’m the HR, think are God’s gift, like sat on a pedestal.  
Sometimes more evident than CE.  
[Controls organisation?] Don’t know, probably HR [L] and cronies.  
CE just poddled along, didn’t know what talking about.  
HR throws all the spanners in works. |
| 2 | [HR] Good HR department, good policies can be very supportive to staff in negative behaviour situations.  
End of day have to work within reduced budgets.  
Set up meetings, follow procedures, few answers for staff.  
Staff go off work with stress, whole situation never properly conducted.  
Role of HR changed.  
No longer “staff support”; another management tool. |
| 3 |   |
| 4 | [HR] Senior manager breaching policy.  
HR powerless. |
| 5 | [HR/OH] Personnel, taken over by “human resources”; have own negative behaviour.  
Resort to disciplinary procedures, politically correct action as soon as any dispute.  
HR are a source of problems.  
Even name is problem - denigrates human beings to role of resource; how modern HR dept acts.  
No loyalty to long serving staff.  
No deference to scholarship, position.  
All staff treated equally, sadly, usually equally badly e.g. removal of titles from name badges.  
HR, managers taught to manipulate people, situations in Machiavellian way.  
Not there to help workforce.  
There to keep workers working whatever way deemed necessary by CE.  
OH dragged into this, become tool of HR.  
Disagreement with management viewed as disciplinary matter by HR; same in schools. |
| 6 | [HR] Increasingly difficult to get grievances, other issues dealt with quickly.  
Lack of HR staff.  
HR, no skills or understanding.  
HR departments reduced.  
Staff expect HR to be independent mediator, confidant, source of support.  
Reality, not role; HR do not see this as role.  
Confusion re role.  
More often business partners there to ensure organisation running successfully, achieving objectives, ensure personnel issues not obstructing that purpose.  
Staff often unprepared for this.  
HR want to work with manager to get quickest easiest resolution (even if manager person being complained about).  
Will not want to help/make it right for individual, deal with root of problem.  
HR look for quickest, easiest resolution.  
Member goes off sick, Trust not too concerned makes problem disappear.  
Longer someone off, less likely return; resolves difficulty.  
Little focus on getting member back to work. |
| 7 |   |
| 8 | [HR] If HR seen truly independent works well. If perceived as organisations hatchet men all falls down. |
| 9 |   |
| 10 | [HR] Leadership, key role employer must play, negative behaviour, whole dignity at work agenda.  
HR should be responsible for training (Trust Board, CE, staff, volunteers) |
| 11 |   |
| 12 | [HR] Want HR to be fully against, fully support individuals either experiencing, perception experiencing negative behaviours.  
HR don’t have resources, capability.  
A lot first line HR, often quite junior, don’t have training or awareness.  
Role of HR changed dramatically.  
HR changed to being there for employer; less for individual.  
Big swing other way. |
Not sure right or wrong for business; but all for fairness and justice.  
No fairness and justice; when see what happening.  
Need for cases to be handled better; much more supportive way.

| 13 | [HR] Key role in advising, supporting managers.  
    | HR frequently under-resourced, unable to give managers support need.  
    | Increasingly HR focused on organisational change, not ensuring effective working, good management. |

| 14 | [HR] HR director unduly relaxed.  
    | Lack of answers.  
    | Should come with timed action plan to improve. |

| 15 | [HR] HR, utterly, absolutely useless wherever.  
    | People Management, read same articles today about HR got to show leadership, modern phraseology, as 30 years ago.  
    | Nothing’s moved on, can’t lead anything.  
    | Manager ought to do bulk own HR.  
    | HR experts some legal technical stuff.  
    | Leading is leading own people.  
    | A lot of it just left to HR; not up to much. |

| 16 | [HR] Are corrupted, embroiled with organisational failures!  
    | Need independent sector for it to work; advise with legal, organisational matters!  
    | Should be neutral and impartial.  
    | Not neutral, impartial when in receiving end!  
    | Lack clinical knowledge, poor judgement when dealing with complex issues.  
    | Exercise concept ‘one rule for you and a different rule for the organisation’.  
    | Expressed significant failures within management of staff; not been acknowledged or mitigated!  
    | Unresponsive to concerns. |

| 17 | [TUs] Failure to tackle systemic bullying, articulate concerns collective level, support whistle blowers.  
    | Clinical professionals can be cowardly.  
    | Tendency to try achieve settlement of individual cases as employment issues.  
    | [HR] HR is, should be, specialist agency of management  
    | Not advocate of staff.  
    | Good management encourages HR to seek out, interpret discontent, express objectively, professionally to ensure problems pinpointed, addressed. |

| 18 | [HR] Implement manager’s wishes, top managers, CEOs wishes. |

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| 26 | [HR] Trouble getting support from HRD.  
    | More concerned about claim for racial harassment than unsafe clinical aspects of performance.  
    |Wrong focus; organisation not patient. |

| 27 |

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| 29 | [HR] HR there to help staff and support.  
    | Sometimes nice, kind but behind backs actually supporting managers right left and centre.  
    | Not honest.  
    | Write letters for managers make sure right side of employment law.  
    | If manager says [person] to be sacked, for XY & Z reasons, HR write letters; on losing battle number 1.  
    | Number 2 union official, totally useless, occasionally giving support.  
    | Needed best most expensive legal advice/support.  
    | [Managers] Huge network of support, HR know about employment law.  
    | From start, [person] a losing wicket.  
    | One sided; power with managers. |
Nice, helpful, kind but two faced, going back using information to support managers.
100% in league with managers.
Write letters even up to CE. CEs just sign it.
HR 101% in league with managers, with aim.
If aim, get rid of [person], are there.
Biased as hell; just under instructions.
Goal managers have, to get rid of person, just tell managers how to stay on right side of employment law.
HR just other side of coin.
In theory supposed to be there to support staff, unfortunately, just there to drive agenda of manager; awful.

31 [HR/CE] NHS very poor at investigating allegations of bullying.
Wonder if many HR departments know what bullying is or any idea how to investigate.
Encourage, facilitate bullying many occasions.
In cases where organisations want to silence or get rid of a whistle blower process can be driven from the top.
Examples, clear CE driving attempts to dismiss staff.
[TUs & HR] Need stronger unions.
Have to build up relationship with employer around negotiating pay scales etc.
When whistle blowing, tricky.
Conflict of aims in relationships.
Case, senior people suppressed information.
Have to be really, really strong and tough and take them on.
Some unions find challenging difficult.
Benefits of reps from outside; independent, can speak mind.
Local rep may have cosy relationship.
Compromise agreements often through unions, HR coming to agreement, behind the scenes.
Not listening to member.
Against public interest, because sorting something out, between themselves.
Person making the stand ends up feeling aggrieved because getting paid off.
Doesn’t promote safety.
Wrong focus.
Knowledge of wrong doing.
TU have to stop this happening.
Put foot down say no longer going to go along with compromise agreements.
Not brave enough to do it; ridiculous.
[TU] sign, [£00] a year, compromise agreements; could be many more.
Many nurses bullied, don’t get as far as that, just go quiet.

32 [HR] Ought to be managing human resource.
Back to survival of the un-fittest.
Perceived model, will get to the top and survive.
Self-interest/promotion.
People leave because not proper/good HR.
Met a -- business manager, lovely gentleman, left in tears.
Said shouldn’t treat our customers like this.
Lack of respect.
Good people get well worn down.

33 [HR] Incestuous in NHS.
Promote people you like.
HR Director, workforce profiles, see who’s not getting up the ladders.
Need focus on how can help people to access education and training, develop skills.
Not into all that, into talent spotting.
[L] What does that mean, what is criteria?
How make sure fair, who are talent spotting?
Are there identified people in HR talent spotting?
That’s where we are, that’s what we are doing (R&J).
Deflection; no answers.
Managers like their secretary, suddenly becomes something else; commissioning manager.
Why? Somebody really liked them; goes on a lot.
Lot of bullying and harassment.
Staff, feel harassed because manager saying deliver it on time, want it tomorrow.
Have you dug deeper into harassment element, is harassment around disability, learning disability, race, nobody is tackling?
Said have to look into it, get back to you, months now.
Possible delaying tactics/avoidance.
Nobody said anything, nobodies done anything.
[Why no action?] Perhaps don’t know how to, or reputational risk.
Lack skills, frightened; don’t know.
Unless tackle issues head on cannot deliver a fair system.
Perceived unfairness/injustice.

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<th>34</th>
<th>[HR] HR most value, managing risks of employing people, ensuring gets best from them. Developing policies, procedures to meet obligations placed on it by legislation and stakeholders. Further risk assessment when e.g. negative behaviour, apply strictly procedural approach or address another way. Procedural approach more defensible at Tribunal, but re-enforces positions, more likely to get you there. More facilitative approach may resolve matters. Needs to provide non procedural tools such as mediation; ensure available. Enable appropriate decisions. Requires knowledge of culture operating in, but willingness to stretch its boundaries. Corporate role. Sometimes HR member of management team assumes peace-broker role.</th>
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<th>38</th>
<th>[HR] HR people either on way up greasy pole or plateaued (Peter Principle). No, or any recent clinical experience. Jealousy thing applies, as does ‘rocking the boat’. If find in favour junior member against senior, never know what friends senior - now enemy for life - may have. Lack of independence. Flag to bosses (dangerously) principled and independent. Principles/independence not valued; a threat. [TU Reps] One for 6 years, excellently supported by FTO. TU reps - overworked volunteers. Reluctance to pursue bullying cases unless 100% clear cut; very, very rare. Tone things down, do a half arsed job. Gives signals to members won’t be supported if bring things up.</th>
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<th>39</th>
<th>[TU's] Culture attacked by nature of relationship between staff side representatives and managers. Staff side/management relationship not viewed as positive. Conflict.</th>
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| 40 | |
| 41 | |
| 42 | [HR] HR depressing [L] Some members of HR, managers other areas first rate. Overall, HR as group not impressed. Often too much ‘tool of management’, to drive management agenda. Supposed to be about, maximise, human resources in best interest of patients. HR, very difficult job. Very tricky nasty characters clinical, non-clinical. Some very, very difficult consultants, HR probably at wits end. Sad, genuine whistle-blower raising concerns about standards of care, HR always on opposite side of line to individual/individuals. Supporting hard line management approach rather than, providing best safest care for patients. Supposed to be providing best safest care for patient not, delivering government agenda come what may. Wrong focus; meeting needs to organisation and government. Focus on figures, anxieties, staff sickness up/down, turn over. Critical staff survey, something wrong how managing staff, running organisation, very seldom |
advocate for staff.
HR immediately shift into taking *management side of this line*.
Don’t have great deal faith.
Faith some individual HR managers totally *heart in right place*.
Overall function, often dysfunctional.
Sadly, when staff impossible, very difficult for HR to do anything.
Neither function effectively to get rid of destructive individuals, nor bring about change, *so front line* staff feel are effective channels of senior management.

[TUs] Always have to *tread fine line*, look like pushing particular political agenda, weakens argument.

RCN still *bit more clout* than Unison, seen less party political.
Need more evidence of malign effect of certain decisions.
If research, never gets highlighted in national press.
Does *flag up*, retrospectively, consequence of particular decisions.
[Non Execs] Most NE’s *waste of space*.
Don’t represent *voice of patients* on boards; ought to.
Become part of executive team.
Are a few good ones.
If raise too many questions, pressure put on them, views putting service into disrepute or being difficult.
Part of problem, not the solution, *‘Go native’* very quickly, might as well be executive team.
Don’t keep independence, questioning minds.
Need different people, but whole thing under enormous pressure.

Ghastly staff survey, *flagging up* major problem, things have to change, *head on conflict with line of control* coming down from centre.

You will save, eight and a half million pounds; only way, getting rid of nurses.
Most NE’s completely passive, useless.

[Good one once [L]]
Some good ones
[suddenly wasn’t there [L]]

Often, impossible situation; so much *driven from centre*.

Very little room local level, to do anything.

Lack of influence, autonomy, power.

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**Framework Theme 8. General lack/dysfunction**

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<tr>
<th>FG</th>
<th>Categories for Framework Theme 8. General lack/dysfunction (Focus groups)</th>
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| 1 | Chaotic.  
Understaffed.  
Unequal.  
Demoralised.  
Deskilled.  
Defeated.  
Patchy.  
Unmanaged.  
Inequality.  
Lack of morale.  
Management patchy; some good, some very, very, poor.  
Not adequate training; particularly nursing assistants.  
*Struggle* enough as qualified staff get training.  
Deskilling of staff.  
Skills of qualified downgraded, dismissed.  
Unqualified staff not viewed in positive way/not valued. |
Don’t increase standards; it’s just to get by. Manager from biscuit factory, no clinical experience, may as well be from Mars. Lack of interactions with patients. More managers than staff to do job. Instead get rid of managers, reduce staff, serious impact on patient and member of staff. Lack of management training. Don’t give tools to do job. Consequently ignore it cause think too busy focusing on saving all this money, not part of my job (R&J).

Nobodies told me have to do that (R&J). Downward pressure to have people do what’s expected. Don’t take responsibility. So many people promoted, but not trained, Lack managerial training. Not familiar with policies, procedures, legalities, good communication. Learning curve. Don’t learn. Constant change of managers. No mandatory training for managers; choice. *It fell on its face* because nobody’s priority. Everything do, it’s new style, never same twice. No consistency. Trust thinks mandatory training covers NMC guidelines/professional development. Given up asking for training. Lack of time for mandatory training. Mainly e-learning, not valuable method of learning. Can’t up skill. Budget’s used by May

Un-dynamic. Dysfunctional. Slow. Complacent. Dissilationed [sic]. Worried. Something very plodding, despite change. Sense things that don’t change, *sort of frippery going on around edges*, core work, problems, still persist. Very entrenched. Very difficult to *turn that ship, tanker?* Like a family, loads of cousins going off doing different things. ‘Hickey cousins’ some disown each other [L]. Always *black sheep in the family.* Dysfunctional, *weird dysfunctional family.* Frustrated unable to do jobs efficiently, effectively. Organisation, *almost cripple ourselves* within wider NHS. *Buffeted* by government priorities, director politics, SHA level, higher up, or even internally. NHS overall is dysfunctional; top word. Reactive. No time to work out/design a team. Get it done tomorrow. Lots of ability no time to do it. Reactive. Striving to be proactive, never seem to get there. No thinking reading time. Juggling so much. Busy whole time, *just firefighting.* The ‘t word [L]. Don’t do training, learning. Lack of knowledge. No training in finance, team development, basic management. *Just bumbling along,* being promoted.
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| **Next big step, nobody helps them.**  
Lack of understanding.  
Aggression because **scared**.  
No knowledge; unable to ask.  
Lot of people don’t have general management skills.  
Lack of training to know how.  
Fear of being found lacking.  
Senior managers – clearly don’t care about patients. | **3**  
**Poor support from management.**  
No reward for good practice.  
Un-caring.  
Short term thinking.  
Uncoordinated (e.g. between services).  
Rushed (don’t always feel time to do best treatment)  
Inefficient (too much money spent on managers who make decisions without knowing how things work on ground level).  
Fine words, but consistent failure to engage with staff all levels.  
Managers assume know best, have all the answers.  
Arrogance.  
Avoid research evidence when points in another direction.  
Resistance to research evidence.  
Lack appreciation of clinical lower banded staff.  
Lack of accountability.  
Lack of clarity around responsibility.  
Quietly accepting failure.  
Slow to adapt.  
NHS organisation ...is an oxymoron.  
Lack of understanding because not on ground level with you/is clinician.  
Lack of appreciation, understanding of difficulties around implementation.  
Distancing from situation/effects of decisions.  
Often things passed down end up with staff struggling on the wards.  
Situations not correctly managed.  
Conflicting priorities.  
Lot of part time management.  
Lack of coordination.  
Lack of communication.  
Trust directorate very detached.  
Lack of intelligent planning.  
Lot of plans look very, very, good on paper, sound incredibly convincing.  
*Haven’t got clue* about what it is to treat real conditions.  
People making decisions, reorganising, don’t know what real life is like, caring for patients.  
Lack of connection/knowledge  
Increasing pressures/demands on services.  
Flawed logic.  
Getting silly.  
Some people starting to get pushed out of the door a little bit early.  
Pressure to get them out.  
Negative effect on patient care.  
Patients, ones lose out with management decisions.  
Senior management. ‘*When she was bad she was horrid*’.  
Detached, arrogant, paternalistic.  
Failure to engage.  
People get fed up, disenchanted, that’s when problems arise | **4**  
**Confusion, inefficiency and demoralisation.**  
Blaming.  
Lack of adequate support for staff.  
Bullying is a problem.  
Negative.  
Demoralising.  
Unfocused. |
| NHS struggles with helping own staff. |
| Divisive. |
| Reorganisation. |
| Poor consolidation. |
| Disjointed. |
| Very negative culture. |
| Disjointed. |
| Lack of improvement. |
| Lack of appreciation; people don’t realise *what goes on behind the scenes*. |
| Demoralising, don’t feel valued. |
| What doing worth less. |
| Business side unfocused. |
| Lack timely decision making. |
| Reorganisations continually imposed. |
| Little, no time for consolidation Divisions. |
| Parts of organisation paralysed. |
| Make changes like *trying to run through treacle*. |
| Very slow; not responsive. |
| Resistance to making decisions; scared. |
| Risk adverse. |
| Innovation stifled. |
| Not given/equipped with skills/competencies. |
| Always got to come up with absolutely ‘copper bottomed guaranteed’ business case before move forward. |
| Slows things. |
| Managers, lacking confidence and competence will alter behaviour. |
| Have to *fight their own way* through |
| insecurity leading to bully or bullied. |
| Manager mental wellbeing affected. |
| Insecurity of staff |
| Staff feel bullied. |
| [Someone short time in NHS] Only now starting to get training. [disagreement]. |
| Training reduced over years. |
| Investment in developing managers *faded* over years. |
| Training not seen as worthwhile investment. |
| Not allowed to function as managers because someone else making decisions for them. |
| Talking about management training for long time. |
| Short bites of training, or access on-line training not always adequate. |
| Managers don’t know how to look after their staff, effectively, *haven’t got a clue*. |
| Lack of awareness. |
| Not equipped to help their staff. |
| Recruit wrong people; not capable. |
| Almost apologetic about investing in staff. |
| Training not valued. |
| Investment in staff seen as effectively *lost money*. |

| Wrong attitude to training. |
| Cancellation of training. |
| Support to staff not appropriate; empathy not management. |
| Issue clinicians *struggle with*; difference in role. |
| Difficult to talk about performance issues. |
| Doctors training, doesn’t cover organisational elements. |
| Budgets very tightly *corrallled*; not joined up. |
| Lack of consideration to impact of decisions elsewhere in organisation. |
| Lack of *joined up thinking*. |
| Action taken in isolation. |
| Pay cuts to do same job wrapped up in efficiency programme; not efficient. |
| Futile actions. |
| Negative impact on patient care. |
| Poor people, communication skills. |
| [Devalued?] Staff feel devalued. |
Not made to feel valued, empowered.  
Not able to make own choices/decisions.  
Not allowed to perform to maximum potential.  
Not challenged.  
Lack of objective and direction.  
Mentally left, still employed.  
Relaxed.  
Not engaged.  
Inadequate management role.  
Very difficult, impossible to get NHS of all people see wellbeing of staff priority.  
Brittle organisation.  
So lean, so stretched; becoming brittle.  
Danger of collapse.  
[Repeated disasters?] Key elements lack of management and supervision.  
Siphoning off areas of services, to private sector, look at lowest denominator of staff.  
Bringing in lower grades, bands.  
Lack training, management experience, knowledge of health care.  
Health care assistants, practitioners band 4, band 5 registered nurses, all supervising people.  
More for less.  
Responsibility pushed down.  
Band 5 nurses not given management training.  
Greater expectations.  
University course not skilled them.  
Less resilient.  
Not coping with change.  
More difficult to get voices across, communication skills.  
Managers focus on finance; lack of focus on what need to put in place.  
Staffordshire not isolated situation.  
Across country huge financial pressures.  
Only way save money is human resources.  
Cuts in services, but emergency services can’t cut.  
Only way save money is reducing number of staff, using temporary staff, or down banding staff.  
[Brittle?] Brittle for some time.  
Ticking boxes,  
but until something crumbles nothing is done.  
Have to fail before gets better.  
[System under stress?] Something has got to give.  
Lack of joined up thinking.  
Lack of clarity, confusion re funding.  
Lack of funding.  
Action inhibited.  
Lack of family support networks impact on services.  
Pressure on private providers; same staffing issues.  
No hope of change.  
Finance always an issue.  
Technology and advances are expensive; need experienced people.  
Inadequate care.  
No time to talk to patients.  
Infection control issues inevitable; not rocket science.  
Providing inferior service to private sector.  
Need more planning re provision.

Managers not always equipped.  
Don’t achieve aspirations.  
Lack of learning.  
Lack of ability, knowledge.  
Need support for relationship problems.  
Same problems crop up, because don’t think through way dealing with staff and communication.  
Problems around themes of conflict, power, dynamics of inclusion and exclusion, communication.

People not performing as should be; just getting away with it.  
Protected by organisation.
Get people openly awful.
Underachieving, underperforming.
People want to turn up, do acceptable job.
How does manager accept, an acceptable job, rather high performer?
Entrenched, embedded behaviour /attitudes.
Lot of change.
Resolute -Think unable to influence.
Knee jerk reactions, impulsive through NHS
Impulsive.
Guilty of knee jerk reactions throughout NHS.
Frantic.
*Knee jerk response*, doesn’t fit what happening in practice.
Frantic responses, covering things.
Committed.
NHS full of committed staff sometimes lack of support.
Whole atmosphere, committed staff; resolute about what happening to them.
Lack of motivation; disempowered.
Exhausted.

<table>
<thead>
<tr>
<th>Int</th>
<th>Categories for Framework Theme 8. General lack/dysfunction (Interviews)</th>
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<tbody>
<tr>
<td>1</td>
<td>One got job, most inappropriate.</td>
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<td></td>
<td>Not as flexible.</td>
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<td></td>
<td>Listen; don’t always know what to do.</td>
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<td></td>
<td><em>Too much on their plate.</em></td>
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<td></td>
<td>Care not as good.</td>
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<td>Some people very lazy; will never change.</td>
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<td></td>
<td>Problems not dealt with.</td>
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<td></td>
<td>Common knowledge, people moan, but nothing said.</td>
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<td></td>
<td>Nothing done.</td>
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<td></td>
<td>People treated differently.</td>
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<td></td>
<td>Don’t tell somebody off.</td>
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<td></td>
<td>Never get dismissed for not doing job; but very, very, very rare.</td>
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<td></td>
<td>Not caring professions.</td>
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<td></td>
<td>Not caring to the workers often.</td>
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<td></td>
<td>Depends what position; difference.</td>
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<td></td>
<td>Always higher grade person come off better.</td>
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<td></td>
<td>‘little people’ don’t count sometimes.</td>
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<td></td>
<td>[Why no care about staff?] Haven’t a clue.</td>
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<td></td>
<td>Not the caring profession.</td>
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<td>CE, too widespread area on their plate?</td>
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<td>2</td>
<td>Staff needs given <em>lip service.</em></td>
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<td>Rarely changes taken place truly support staff.</td>
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<td>4</td>
<td>Lack of support.</td>
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<td>Non punitive to punitive.</td>
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<td>Culture learning from mistakes lost.</td>
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<td>Openness discouraged.</td>
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<td>5</td>
<td>Patients, staff, suffer; managers try to meet targets.</td>
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<td>Dysfunctional, inefficient, damaging.</td>
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<td>Many ways excellence discouraged, mediocrity encouraged.</td>
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<td>Disagreement with management viewed disciplinary matter by HR.</td>
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<td>6</td>
<td>High blame culture.</td>
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<td>Complaints common but lengthy, drawn out experiences.</td>
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<td></td>
<td>Seek to attribute blame.</td>
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<td>7</td>
<td>Stress factors gone up.</td>
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<td>Content</td>
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<tr>
<td>296</td>
<td>Staff worried about jobs.</td>
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<td>[Managers] pretend interested but don’t care.</td>
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<td></td>
<td>[person] got to where wants to be.</td>
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<td>Want to get rid of H&amp;S.</td>
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<td>Ethos not there anymore, where going, lost purpose, the value.</td>
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<td>Supposed to be ‘patient centred care’.</td>
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<td>Not quite right, don’t do assessments like used to.</td>
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<td></td>
<td>Holistic approach gone out of window.</td>
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<td>Staff going off sick left, right and centre.</td>
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<td>Something’s not quite right, cannot put your finger on it.</td>
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<td>Replacing with people don’t know what is going on.</td>
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<td>Difficult to feel enthusiastic.</td>
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<td>Meetings held when rep not there; disempowering, undermining.</td>
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<td>No continuity of care.</td>
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<td>Staff come in just for shift, then clear off.</td>
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<td>Disengagement.</td>
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<td>Communication non-existent.</td>
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<td>Morale low, very low.</td>
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<td>Nobody cares.</td>
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<td>Difficult watching, being.</td>
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<td>Simple things blown out of proportion.</td>
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<td>Crazy stuff.</td>
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<td>What want to achieve, arguing over policies?</td>
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<td>It’s a joke.</td>
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<td>One day 3 staff saying ‘I am being bullied’.</td>
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<td>[trust] ‘awful’ ‘staff are bitches’.</td>
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<td>[Overall impression chaos, constant change, almost self-destruct. Disorder, work not done properly. Deeply concerned what saw. Frustrated little could be done]</td>
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<td>8</td>
<td>Challenged, overstretched, nervous.</td>
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<td>9</td>
<td>Pressurised, regressive, chaotic.</td>
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<td>Morale falling.</td>
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<td>Little experience how to manage decline resources.</td>
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<td>Management of bullying long term problem; lack of expertise.</td>
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<td>Line manager/dept manager responsibility.</td>
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<td>Normally totally untrained, unable to bring satisfactory resolve.</td>
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<td>Higher authority, even HR; skills woefully lacking.</td>
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<td>Mixed experience, negative behaviour.</td>
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<td>Some employers totally engage, others not know what to do, poorly manage.</td>
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<td>Cases reps need further training to ensure management manage appropriately, expeditiously.</td>
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<td>Mass training need, how to manage dignity at work issues, every level.</td>
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<td>With tightens resources, redundancy programmes targeting administrative grades, expertise diluted.</td>
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<td>Do not have skill sets for identifying issues, knowing how to manage.</td>
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<td>Organisational-wide training needs in positive/negative behaviours.</td>
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<td>Uneducated, don’t know what to do.</td>
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<td>Poor procedures, practices.</td>
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<td>Cases often don’t fit into grievance procedures.</td>
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<td>Some organisations clearly incompetent, ignorant re negative behaviours cases.</td>
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<td>Some wilful way manage cases.</td>
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<td>Witnessed mismanagement, way see someone break or leave.</td>
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<td>10</td>
<td>Slow to respond to requests for change.</td>
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<td>Reactive rather than proactive.</td>
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<td>Very frustrating for staff, like involved with plan, clearly defined timescale, clear purpose.</td>
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<td>Changes agreed in principal, sometimes ages to implement.</td>
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<td>[Why?] Everyone own agenda.</td>
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<td>Many managers not had experience, education to equip with leadership skills essential to inspire workforce.</td>
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<td>Duty to organisation to ‘manage’ finite resources, forever changing objectives.</td>
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<td>Better just to get on with it, pretend everything is OK!</td>
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</table>
People/managers, not necessarily bad managers.  
Don’t have training, expertise to do change, way takes people with them, includes them, isn’t threatening, and provides training, support for those need to deal with changes.  
Often don’t have training to manage people.  
Learn it on the job.  
If lucky good ‘in house’ training programme.  
Staff lose out.  
Don’t know how to do it.  
Way managers deal issues poor performance.  
Ignoring people, giving other people tasks.  
Manager doesn’t know how to address performance issue, positive way.  
Identify, to rectify, support individual to improve.  
Occasions, go down formal performance route.  
Time, time again, way handled, not what needs to be handled.  
Way approached.  
Training for managers how deal with, support individuals.  
Often NHS does very badly; having regular meaningful appraisals.  
Clear objectives, so very clear what meant to be doing.  
Name NHS organisation got 100% appraisals.  
None of secretarial staff ever had appraisals.  
Broached subject, complete, utter terror.  
Performance review, punishment as opposed to, support/develop.  
When stand there, completely ignored.  
2 nurses conversation not about work, get ignored.  
Get attention, always too much trouble to get individual need to speak to, or tell, or direct in right way.  
Is negative.  
Difficult go into department, don’t know staff.  
Member staff and public.  
People not shouting horribly, but being ignored, left standing there, not very pleasant experience.  
Incivility/lack of respect.  
Lack of basic standards.  

Even highly skilled managers may lack skills, training, support to feel can intervene successfully.  
Lack time, large workloads.  
Lack of information, training for managers on effective interventions.  
Perhaps lack effective management skills generally.  
Do problems in relationships between team members develop/get out of hand because not well managed?  
Big focus on leadership, detriment of good management.  
People often promoted into management posts without all desired skills.  
More needs done to train, motivate managers.  
Are a few very poor managers.  

Good writing story lot of detail but story no synergy what problems really are.  
Grossly poor management.  
First objective should be not to harm, be systematic.  
Exec’s do not ‘sit back’ look at things should be looking at.  
Not disciplined.  
Not focused enough.  
Focus on good things.  
Way run, top down.  
Major requirement, training of management.  
CE is not CE, is chief administrative officer.  
Indecisive, (excluding clinicians, nurses on medically related matters).  
Poorly educated (as managers).  
Lack of financial expertise.  
Lack of training, personal leadership qualities to deal with subordinates' personal challenges.  
Suspect subordinates do not respect management supervisors as leaders.  

Need NHS to face up to mess our beloved institution in.  
[Why don’t ‘face up to mess’?] Evidence, begins to paint brutal reality life in NHS.  
Instant answer "Because British"; what defines us.
Not nation good at facing up to harsh realities.
Promote people not performed well.
Cannot manage; just pathetic.
Do some bizarre things as society.
Operate as machines do, without any humanity often.
No human factor in operation.
NHS operates, whole era, behind in understanding, practices, safety and quality.
No proper regulation.
Processes complaints; utter chaos.
It’s Victorian; should be on database.
No need for this.
Why all behind?
Want it to be all behind, because don’t want to give the game away.
Let’s do review, a policy.
Let’s waste more time.
If in doubt, change the system.
Don’t demand people perform.
July 2004, up to then system inspecting hospitals giving out stars.
Number hospitals 3 to zero, 2004.
What do?
Don’t challenge performance, say up with this, will not put.
Change the wretched system; be fiddled more easily.
Couldn’t make it up.
In ‘the thick of it’, how Whitehall operates.
[Person] bullied press, whipped into submission.
We are in The Thick of it’.
Cause nobody cared. Nobody really.
[Citadel?] Citadel notional home big secret.
NHS cannot do better than killing awful lot of people.
Treating tens if [not] thousands, largely elderly, appalling manner.
Metaphor for NHS.
Primary purpose is to protect itself.
Public believe there solely to make them better.
When individuals see what’s going on in Citadel, try to advertise it, generally repulsed.
[Organisation] broke down walls of Citadel, suited new ruler to help break them down.
Many insiders wondering how to respond to being on display.
First response, pretend nothing happened, hope walls can be rebuilt.
[‘Quietly accepting failure?’] Spot on; NHS in mighty mess.
[People] treated with contempt, by all and sundry.
[---] never had guts.
Nobody in politics, government ‘gets’ patient safety.
[rid of people performing well] Probably, yeh, the perverse.
Got to fit in, is a machine, it’s a machine.
[People try raise standards, get clobbered].
Absolutely can, seen so many examples.
All managers, front line staff, executives, under pressure all of time.
Cannot be surprised things happen.
Moral fibre look to in people in situations, isn’t there, vast numbers of people; a million players.
Patients pushed from pillar to post for months.
Utter, absolute shambles.
Amateurish beyond belief.
[Organisation with a memory]
Fundamental misunderstanding statement p84 led to ongoing increases in numbers of incidents reported, ‘good thing’; wrong!
Fundamental misunderstanding safety issues.
Redditch doesn’t surprise.
Universal?
Be sure if harmed 38 harmed 38,000 or more.
Ann Clwyd as well.
If managers not NHS background, clueless!
Recruitment process flawed.
More robust interviewing techniques should be adopted rather than target focused.
Lacking, leadership, vision, accountability, honesty and respect.
Dishonest, lack leadership.
Some managers don’t have skills, ability to effectively manage conflicts.

| 17 | Lack of comprehensive planning, long term strategy.  
Don't stand up to politicians.  
Senior SHA staff limited operational experience.  
Opportunities for careerists.  
Inability or lack of inclination to read warning signs.  
Maybe wilful blindness.  
No focus on quality.  
Lack of high calibre senior managers.  
Confusion around accountability of Exec and NE Boards.  
Lack of accountability, governance.  
NEs, similar roles, poor representatives of community.  
Lack of understanding of NHS.  
Get career NE’s with financial, career interest.  
Can use role as stepping stone.  
Fail to promote quality.  
Have to toe party line, is ‘ethical fading’.  
Should not have removed CHC's.  
Inadequate NHS complaints system.  
Lack proactive management of complaints.  
NHS confederation ineffective.  
Regulator inadequate with bureaucratic tick boxing.  
Do not recognise indicators of organisational pathology.  
Fail to respond adequately with speed, effectiveness.  
Failure to understand complexity of organisational pathology.  
Some organisations manipulative.  
Continuous restructuring driven by political ideology.  
Leading to disruption organisational processes, experience, continuity.  
Loss of organisational memory, maturity.  
Erosion of trust, stability, constructive relationships.  
Managerial energies diverted; sapping of morale.  
Dishonest. |

| 18 | DOH not interested in regulating quality of care.  
Monitoring quality of care, DOH not fit for purpose.  
Why not regulating properly?  
Model of independent regulator, regulating services provided by government minister never going to be satisfactory model.  
Torn between good regulation, health care, and being found wanting.  
Responsible for providing, also monitoring; impossible situation.  
Government hated idea regulator criticise it, by criticising one of hospitals/services responsible for.  
Cannot have responsible for providing and monitoring.  
DOH responsible for quality, but not monitoring it.  
Problem, not doing it because politically difficult to do so; responsible for providing it.  
Culture of NHS, particularly hospital sector; not to embarrass the minister.  
Constantly have to do what Number 10, Prime Minister, cabinet wants.  
[Re Mid Staff] regulators kept saying mid staffs good.  
Pressures, origin of things.  
Difficulty of structure, way NHS is, between government, DOH, NHS providing service, also monitoring.  
Politically difficult to accept have poor hospitals.  
Culture of fear pervades NHS management.  
Managers ‘look up not out’.  
Focus on what bosses saying, not what patient needs.  
Light handed regulation.  
Self-assessment; hospitals at risk incorrect in two thirds cases. |
Light handed and not effective. 
HCC, no improvement advice, or expectation of core standards to drive improvement. 
Poor use of clinical data. 
Virtual absence of mention of patients. 
Insufficient data for patients to make informed choices. 
Too much change and restructuring. 
Minister told to lie about information; very dangerous situation. 
Comparisons quality of care, other countries, appalling situation. 
Terrible. 
Very bad hospitals, some extremely good. 
When good comparable to best US. 
Some very bad hospitals. 
Mid Staffs inquiry CE of NHS accused taking very dangerous approach to regulation NHS [suggesting Mid Staffs isolated case]. 
Poor governance, poor care, systems duty to uncover. 
Approach supported by many letters Inquiry received all over UK, failures of care other trusts. 
Very damming assessment of CE of NHS. 
If didn't affect people's lives, if English hospital care not so poor, international comparisons, wouldn't be so concerned. 
Dismissal of US reports. 
If things suggested true, misuse of entrusted power for personal (i.e. intended political advantage) gain. 
Difficult to devolve down because NHS paid for by national taxation, approved by parliament. 
Most governments tried way of devolving responsibility for provision down to lower level. 
Just wants to monitor. 
Problem, last government; got rid of CHC's. 
CHCs done away with. 
CHC opposed some closures which government didn't like; tragic. 
CHCs replaced by completely ineffective PALS/other patient groups. 
All shown to be ineffective. 
Dropped deprivation payment/other things. 
Privatisation from 2006 onwards. 
Liberating the NHS; improving quality judged by outcomes and involvement of patients/clinicians. 
Bill stage, DN, civil service very involved. 
7 layers of management, very, very little mention of clinicians. 
Bill completely different. 
CE of NHS very powerful political position; more powerful than Secretary of State. 
Political struggles, ruining Areun Bevans potentially excellent NHS. 
Lack devolution of responsibility to clinical groups. 
Last government not successful; managers always take over from doctors. 

19 Progressively adopted commercial values led to bastard culture. 
Introduced very highly paid managers, often don't know business. 
No proper training for managing health services, public health, prevention. 
Don't understand prevention. 
Understand some extent beds, staffing issues, bricks and mortar. 
Don't understand philosophically what trying to do. 
Could be putting to make anything else work. 
Wouldn't last few minutes private sector. 
Large numbers nurses going into management. 
Some good, lot of them second rate as managers. 
Lost. 
[L&M?] Generally poor; very poor. 
Recruitment, management training part of that. 
Move back towards much more involvement clinicians desirable. 
Remember why moved away from, in theory, consultants in charge 1948. 
Wouldn't take responsibility for change, prioritisation. 
Why brought in general management. 
Problem, general managers don't understand business. 
Now smattering consultants, people from nursing, other clinical backgrounds have, some managerial training.
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<td>Removing local control, focusing on performance, undermine workplace relationships, erode employee engagement. Approaches not incompatible but managers typically do not have enough training, support this difficult area work. Historically when times hard training, development often regarded soft targets for budget cuts. Operational managers moved around a lot. Need to perform quickly in order to be safe next promotion. Lead new managers introducing changes to <em>make their mark</em> in short time; some consolidation more useful. Pattern managers put in charge of highly challenging areas, failing to turn them around, moved on. Manager tends to get blame. Another manager brought in as <em>saviour</em>, pattern repeated. Often clinical staff promoted to management roles. Just get on with it without appropriate support, development. Pressures on NHS managers; extraordinarily difficult job. Merit much more input receive at present. Work environments make behaviour increasingly more likely. Poor management development, performance targets, diminishing resources, job insecurity create work atmosphere lends itself to negative behaviour. Sometimes senior people don’t know what to do about behaviour; goes unaddressed. If addressed, sending on training course rather than ongoing tricky conversations about behaviour change. Busy managers often <em>put this stuff in ‘too difficult box’</em>. If focuses on ones <em>little bit of jigsaw</em>, get on with it. Once <em>raise head up</em>, sense frustration. There’s lack of understanding. Management of sickness absence. Very strong, narrow understanding of interventions at corporate level. Managers need to manage sickness better. Return to work interviews, closely monitoring staff. Make sure staff held to account for absence. Struggle to understand, what frustrates clinical staff. Sometimes sickness absence response to volume of work, dynamics, almost unsustainable. Cannot hear message because cannot do anything; financial position. Nobody evil. Unfortunate dynamic. <em>As long as staff keep running faster and faster, will be ignored.</em></td>
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<td>Rigid. Strong public sector ethos; positive and negative connotations. Negative: sense of entitlement based on application rigid set of rules.</td>
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<td>Elements of immaturity to culture of organisation/leaders. Organisations don’t seem to celebrate successes well. To degree self-deprecating. Often associated, are public service. Celebration of excellence <em>frowned upon</em>. May be reflection of UK society.</td>
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But now talking about compassion.
If don’t respect staff, don’t respect patients.

Learned helplessness accounts for (does not excuse) behaviour Mid staffs
Doctor, nurses let frail elderly die, appalling neglect.
Rule by mediocre people.
Deeply institutionalised, slow uptake of innovation.
Risk-averse.
“Learned helplessness” good summary.
Struggling to cope with business model, no-one clinical field understands/accepts.
Tension with “management”, “commissioners”, don’t understand either.
Mixed economy tariff-based, block contract activity, public, voluntary and private.
Too little incentive for prevention/support.
Too much for hospital activity.
Particular stress, doctors, management roles; compromises calls for.
Not learning organisation.
Characteristics learning organisation, admitting don’t know.
If made mistake, haven’t got enough time, don’t understand how system works.
Say it, when say, can get fixed.
NHS doesn’t work like that.
Encourages best guess, a stab.
Make up figures, in order seen to deliver.
Doesn’t encourage innovation, risk taking, in case goes wrong.
Something goes wrong, get blamed, big time.
Instead saying reasonable risk, worth it, but didn’t work out.
So what learnt, share learning?
Should share bad practice i.e. learn from mistakes.
Sharing good practice.
Why don’t do it this way?
Why don’t we?
Not culture where people allowed to admit, don’t know.
If don’t admit don’t know, how learn?
Not enough learning, changing of behaviours.
Doesn’t encourage informed dissent, or challenge, far too top down.
Not listening organisation.
If doesn’t listen how learn?
If not learning organisation, dead in the water, just fossilise.
Senior managers not necessary qualities; selective pressure past 10 years.
Favouring those deliver targets rather than innovators, challengers, provide informed dissent.
Appraisals all tick box.
Not appraised on values.
Care, compassion, support of staff, listening learning, etc.
Should be approaching it values demonstrate not just outputs, outcomes deliver.
Just appraised on numbers.
Only thing valued, providing, rewarding; delivery of targets.
Huge clash with values most clinicians espouse.
What NHS values in staff/managers.
Evidence values delivery over more human characteristics, care and compassion.
Now about healthcare e.g. hospitals, scanners etc.
NICE just pills and procedures, not prevention.
Stopped being a service; became a business.
Rot set in, put in wrong people.
Weak and ineffective person, replaced by strong and ineffective.
Wrong things, done with great vigour.
If wrong at the top, filters all way down.
Failure of recruiting processes.
New ideas not welcomed, people expected to conform.
Cronyism and word of mouth bypasses proper checks/balances.
During transition easier manipulative people to move greater freedom.
Incompetent/failing people shuffled around system.
Not properly managed for own, and services good.
| Number of staff struggling with illness, not able to admit. |
| Difficult to get work life balance. |
| Dreadful culture of struggle, isolation and despair. |

33 | Older women, ethnic minorities excluded ignored. |
| Distressed about culture. |
| Morale so down. |
| Walk in building, everybody’s a stranger, doing own thing. |
| Nobody smiles, at each other, says good morning or hello. |
| Horrendous. |
| Although -- talks about humanity, caring during transition. |
| Lost out on that. |
| No-one cares for me. |
| Colleagues, feel nobody cares. |
| Everybody fighting own battles. |
| When feel not valued, affect, confidence. |
| Affect performance, all things heard this morning. |
| It’s not caring for the people. |
| Rhetoric not reality. |

34 | Cautious bordering on fearful. |
| Often managers talking about ‘my staff’. |
| Paternalistic disposition to management style. |
| Some clinically qualified managers respond to staff, as if manager’s patient, particularly Mental Health environments. |
| Managers perceive more constrained by procedures, legislation, terms of making decisions. |
| Particular, fear getting it wrong having complaint against them. |
| Level of support receives; very variable. |
| Senior leaders expect middle/junior managers capable taking tough decision. |
| But not very good themselves when confronted human consequences of decisions. |
| NHS managers not particularly resilient dealing with ‘HR crap’. |
| I.e. difficult issues, staff, suppressing emotional responses unhealthily, displaying them inappropriately. |

35

36

37 | Not conducive working collective team, common understanding, goals. |
| Nor create effective managers committed to organisations, staff, or patients, opposed to career progression. |
| Career progression comes first. |
| Poor quality of management, long standing issue. |
| Lack good quality leadership. |
| Reflects prevailing culture of organisation, management of organisation. |
| ‘Sick’ culture at the top ultimately tends filter down throughout organisation. |
| Bullying culture within management, unlikely to challenge bullying culture within staff, or perhaps recognise it. |

38

39 | Difficulties across professional silos. |
| Not always address what team-working looks like. |
| Sometimes distant. |
| Represent amongst largest organisations in UK; budget, workforce terms. |
| Controlling and empowering, often conflict between two. |

40 | Leadership, good management is talked about. |
| Softer management skills do not have place top level. |
| Rhetoric not reality. |

41 | Senior staff not especially effective. |
| Even worse, reputation of bullying, maintain position; do not appear to be challenged. |
| Sometimes exceptional skills other areas; override failings. |
| Complex organisation, needs maverick managers as well as traditional managers, to deal with ‘wicked’ problems facing (? R&J). |
| If unusual managers viewed more useful; will stay. |
| Length of service, experience valued. |
Will become more so; NHS reforms in south.
Restriction on recruitment across UK NHS.
Experience, knowledge can trump other negative aspects.
Staff not fully engaged by organisation in complexity of it.
Not equipped with resilience need to work in it.

42 Overall culture lot organisations very unhealthy.
Role, slightly distorted, maybe particularly negative view.
Saw just more extreme examples, found over - years.
Prevailing culture unhealthy.
Failing organisations, various reasons culture more evident, extreme.
 Probably very few organisations where isn’t widespread, endemic.
 [Evidenced based action]
Same not true management, initiatives, come in, breeze in.
Don’t listen to concerns even when clearly counterproductive.
Very seldom, real proper evaluation, learning.
People introducing never held to account, whatever chaos followed.
 [L&M] Leadership far too keen seize on latest trendy notions from world of business, private sector.
Health not market commodity.
Don’t want loads appendicectomies, unnecessary, because can make money.
Is different.
Rubbish, half-baked business ideology moved across from business to health sector.
Not evaluated.
Words, buzz words, jargon, everybody switches on to it.
Latch on to latest fads.
Distraction from main issues
Nursing bad, as general managers.
Great enthusiasm for, leaping on some concept.
Usually worth nothing in reality.
Virtual ward, whatever.
Maybe bit of value, particular circumstances.
Not materially improve nursing care, majority patients.
Despite rhetoric, therapies, drugs, evidenced based.
In management no need.
Different rules; in management anything goes.
Wouldn’t have what we’ve got.
Provide evidence base for different approaches poor NHS gets dumped on it.
Leadership too much centrally controlled.
Lot of bullying.
Horrific descriptions, individuals, such as CE NHS.
Phoning up individual CEs, threatening, the sack if don’t deliver, imperative.
Wrong sort of people end up leading.
‘corporate bullies’ end up leading it.

43 Where lack of effective leadership, no clear purpose or vision, environment where staff feel disconnected; mistrust and de-motivation

Framework Theme 9. Raising concerns/communication

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<tr>
<th>FG</th>
<th>Categories for Framework Theme 9. Raising concerns/Communication (Focus groups)</th>
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</table>
| 1  | Deaf, uncommunicative.  
    | *Were deaf.*  
    | Don’t listen.  
    | *Deaf.* |
Doesn't listen to shop floor workers, service users. 
Fixed business plan in head; deaf. 
Lunatics are running the asylum', nobody running anything.
If lucky good manager, handle on anything.
Creative with budget protect staff; few and far between.
Lots of managers, 'yes person'.
Knock on effect, huge caseloads, increased sickness, lot B&H.
Restructuring, mergers, horrendous, many staff at risk.
Lack of accountability.
Bullying management style.
CE, circus ring master, school of management acceptable.
Middle layer of very, very, grateful managers; no one questions.
Staff so defeated.
Expertise to deal with problems, but no confidence to speak up.
If doesn't fit business plan, what want to hear, don't hear it.
Shortage of staff, incidents, feedback always, no, bad skill mix, not lack of people on the floor (R&J).
Possible rationalisation, deflection.
Frightens staff; disempowered.

Lack of responsibility.
Complaint; come down on member of staff.
Duplication of paperwork, inefficiency, bogging people down.
Not interested in what problem is; what are you doing?
Director deflecting responsibility down.
Faced with brick wall.
Very hard to raise issues, if facing that brick wall.
Try very hard raise issues; particularly about paperwork.
Communication so bad; really higgledy pigglety.
Don't like to hear duty of care.
Switch it round to you, it's not, it's yours (R&J).
Nurse professional registered, says in NMC.
Transfer duty of care to their staff, not their problem(R&J).
Not their duty of care to care for staff either (R&J).
Transfers duty to Union (R&J).
Whole attitude not interested.
Managers 'happy' for units to be low staffed.
If patients, would start to lose my rag.
Somebody leaves, don't replace; vacancy control.
Hard to raise re more paperwork.
Don't seem to hear.
Targets to achieve, don't want to hear.
All cutbacks and saving money.
Raise concerns, accuse person making complaint offensive way; recognised management defence technique.
Lots of complaints to senior management about manager, nothing done.
CQC visit highlighted not forwarding H&S data.
Don't know why nothing done.
Filled in forms re staffing, disciplined.
Unofficially told 'don't send anymore forms in, making me look bad'.
How things look more important than patient care.
Bullying, grievance, manager moved.
Such a mess.
Staff on the floor, feel insecure and upset.
Something's not right.
Head of Nursing seen all forms.
Expect 'you are short staffed'.
Head of Nursing not behaving as expected.
Reduced staff further.
All that hassle.
How feel about making complaint again?
Some dropped out of it.
2

[Difficult to raise?] Yes: 7; No: 1
When raising issues may not lead to immediate change.

[Yes] Interpersonal conflict.
Slowness to change.
Politics of organisation.
Poor leadership.
Value of workforce.
Reality.
Poor performance.
Competency other colleagues.
Performance individuals.
Creating realistic targets.
Change in direction.
Poor performance.
Career progression (outside trust).
Communication only at senior level.
Bands below dismissed – makes feel your decision not valued or controversial.
Anything may highlight problems with performance, show negativity.
The truth.
Through NHS don’t want the reality.
Want to hear what want to hear.
Shocked what saw; making it look certain way, to tick boxes, rather looking at the reality.
Saying right things instead actually looking what real issues are.
If table openly, not committed to organisation, fearful of being overlooked.
[The truth?] Something our roles experience?
Manager instantly try to de-escalate severity, too hard to address, or looks bad.
Personalisation; sometimes its competition.
Don’t want to hear it, anyone else to hear it, because looks bad on them.
If want to be open, honest, just get shot down by PCT or SHA.
[Why difficult to raise?] In mental health tolerance of ‘unacceptable’ behaviour.
Boards don’t wish to hear reality.
Operating from position of blame.
Divisive governance.
Too hard to resolve.
Difficulty finding solutions.
Time taken to manage individuals.
Executive director demands.
Team ‘by in’.
Managers responsibility deal with issues, several other priorities.
Managing people challenging, stressful, time consuming.
If not done well, manager often seen performing poorly, does not want to be in this position;
Fear being overlooked;
Can raise with immediate manager; good relations
Managers probably don’t want to know negative views deviate from ‘the party line’.
[Why?] If open and honest, tell, declare all externally.
Get so much flak, interference, penalised.
So won’t bother telling.
Have to kind of say it as it is, not really.
Not a rosy picture, but have to give positive spin on things.
If don’t penalised by government.
Why report ‘never event’?
If whole culture about learning.
Don’t report anything negative; so safe.
Don’t want to know; implications how seen on organisation.
Not seen as open and honest; sad, going to learn.
It’s Oh God, your organisation!
Why mistake? Come down on you like a ton of bricks.
If high, just honest or others not reporting.
Don’t know if everybody totally honest.
Outsiders/outliers get told off.
Competition; don’t want to be seen outsiders.
Key; it’s to be seen.
Top to bottom; all about being seen.
Everybody, it’s seen to be doing this.
Operating from position of blame.
Its fear, fear.
Fear of not being seen to be something are not.
Say want patients treated as individuals.
Things patients allegedly want
Conflict between government agenda and what patients actually want.
Let’s face it.
[Truth?] Doesn’t meet own individual agenda or that of organisation, or that paid to present.
Doesn’t demonstrate results supposed to achieve.
Targets focus on, aren’t right targets.
Say it’s about patient safety, but not, it’s about getting organisation appears to run smoothly, no hiccups, is perfect, government will get no flak from in media.
All image.
Way presenting data not lying, is truthful, but couple more questions; different answer.
Risk Managers point out next 2 questions.
Prefer to live with answer, not put head above parapet, will make you look OK.
No-one else reporting so we’re not going to.
RM’s point out things don’t necessarily want to hear.
Most trust don’t lie in reporting, but ways of manipulating figures honestly.
Matters little next 2 questions.
Executive de-scored/reduced risk score so wouldn’t come up on Board framework, corporate risk register.
Finance/budgets, personal position affect risk scores.
Arguing constantly with executives, fighting for risks highlighted to remain at score.
Care groups, divisions want to make score high, directors want to keep it less.
Tension/conflict within organisation
[Topics more sensitive?] Anything CQC covers, might look bad in press about reputation.
Anything if hit Daily mail would crucify organisation; very sensitive.
No come back from bad press.
STEIS, reporting serious incidents system, not about it’s serious, about telling DOH might hit the press, only reason designed.
Awareness might hit the press.
It’s all wrapped up about patient safety, being open.
Nothing in place to make learning happen across NHS.
Some SHAs, the lovely, used to play the game, some don’t.
Not going to report because don’t do anything.
No mention of good care.
Everybody fearful organisation going to be named and shamed.
No press around when good.
Constant fear.
Hospital scandal front page, good, small column page 5.
Press changes priorities/alleged public interest.
Hard to anticipate next thing criticised for.
Constantly reactive.
‘Not being criticised’, key thing to manage.
Answer question at the top level, because so heavily monitored.
Media is big one.
Forgotten HSE, all CQC.
‘Keeping your head down and out of the press’ is the big game; priority.
[Why willing forget H&S] It’s not H&S, is looking at who monitoring us.
Fear CQC most.
More likely to be picked up by CQC than HSE.
H&S is joke, publically; blame for silly things.
When prosecuted by HSE not big issue; just turn page over.
CQC different.
It’s how it looks; presentation.
Culture: Poignant, best agency, NPSA, disbanded; too raw, too close to the truth.
Telling people what nobody wanted to hear.

STEIS what reporting, renegotiate; constantly changes.
Hospital acquired infections reported even though no lasting harm.
Because infection control big media story.
Suicide of community patient, not reported; not same level news story as infection control.
Any notion to do with seriousness; hogwash.
Decisions particularly around resources, direct detrimental effect on patient care, can’t stay quiet.
Negative behaviour in response.
One to one apology, but publically slapped down.
How dare you challenge.
Acted on information at time (R&J).
Even though incredibly diplomatic, understanding, just giving more information, ask if wish to continue along line taking.
Almost bullying, almost bullying.
Very difficult still address negative behaviour senior clinicians.
Easier specific, direct action around nurse behaving inappropriately.
Doctor/consultant, much harder.
Possibly around structure in nursing, established.
Medical profession, far less defined.
It’s about who manages person.
Some responses from senior clinicians re incidents; amazing stuff.
Most what hear is negative.
Matters sort of management, leadership team like.
Now get it, not horrible person, always telling them off, telling them things don’t necessarily want to hear.
Their conscience [L], protecting them.
Do see as telling us to keep us safe, look after us.
Got safety net, will feed things up.
Very, very long time for them to understand.
RM’s maybe not as close to that level of management should be, because hierarchical.
If part directorate board team view different.
2 or 3 tiers down, it’s just her, don’t know, and don’t want to hear.
Lack of respect for information going upwards.
Different acute trusts and PCTs.
No difference whatever role; not saying what want to hear.
Don’t want to hear it.
Get the treatment again.
Always same behaviours, if not saying what want to hear.
Takes time to get you due to element of trust.
Not there as enemy to make life difficult.
Very lucky, very atypical.
Providing information for informed choices.
May go against but cannot say didn’t know.
If management team gets it, it works.
Depends on size and what organisation like.
Management team in acute keep changing.
Consultants don’t move, think managers will go, get another lot in.
Depends who it is.
Quite quiet, not well-known different response somebody seen as negative lot of time, because questioning things.
Difference who it is, which team.
New, left fairly quickly, seen as negative.
Were saying how it was, but weren’t ‘in the team’.
Were correct, team was wrong.
Left, thought can’t hack this.
 Comes out were right, others wrong.
Quite a bit that goes on.
People raise issues, seen as trouble makers.
Years down line were right.
Maybe should taken notice.
Matters who raises it.
Difference between formal, informal processes, talking about very informal sort of process.
Very supportive HR team.
If issues raised.
Big push respect behaviours; on ID cards.
Covered in induction, respect behaviours.
People do raise formally; followed through.
Have good response on relations of staff.

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<tr>
<th>Why bullied?</th>
<th>Other people just toddled along, I used to challenge things.</th>
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3 Case load gone up.
Not being managed correctly.
Not often willing to listen when raise early stage, often go ahead, Implement, then, ‘told you so’ later.
Detached, arrogant, paternalistic.
‘Know best’, work characterised by failure to engage at all levels.
Distance and separation.
Problems raised about colleagues, ‘it’s just hearsay’.
Deflection.
Not being able to address simple but negative things; big impact.
Need strength to take forward.

4 [Difficult to raise?] Yes: 2; No: 2.
Resources.
Training.
IT.
Staffing- lowest denominator, workload.
Slow decision making.
Financial.
Resilience.
Lack of engagement.
Lip service.
Bullying.
Addressing inefficiencies.
Poor performance.
Recurrent sickness absence, knowing how to help staff effectively.
[Why difficult to raise?] Money not available – slash and burn attitude for short term solutions.
OH unable to meet expectations, make everything “better”.
Might incur costs/can’t afford it.
Lack of experienced ‘people’ managers.
Professional jealousies.
Lack of decision making.
Raising issues around inefficiencies very difficult with managers
Poor performance, last 10 years.
Original NHS managers never had to do that.
Not difficult to discuss, but not being changed.
Resources huge issue for managers.
Any OH recommendation, struggling to accommodate, because organisation shrinking.
Temporary redeployment maybe aren’t available.
Staffing now down to lowest denominator can get away with.
Workload is issue, shift patterns difficult.
Very tough out there for everybody, trying to deliver gold-plated service but continually going down the scale.
Probably bronze service with facilities, resources got.
Expectation from public gold service, treatment when, how want it.
Reality and expectations don’t meet.
Staff are struggling.
Is around communication and engagement.
Sometimes executive teams perceived to be in a silo in headquarters.
Not ‘at one’ with workforce.
Real challenge for individuals.
Lucky; get exposure to some senior executives.
Worked in organisations never met executive team.

Giving lip service, doing team brief once a month, putting pictures in newsletters, doesn’t tick the right boxes.

In reality not sure how many even recognise CE.
Walking down corridor, go to say hello, head is down.
Now bunch of people don’t have those, when times get tough prepare cascade, do the communication, but it’s all, just words.
No humanity behind it.
No, we walk around hospital daily basis, pick up something hasn’t been cleaned.
Don’t go in and speak to patients, hear patient view.
Rely on patient groups coming to them.
No difficulty having conversation with managers, managers have difficulty with difficult conversations.

Knock on effect, impact on OH.
Lot of managers, don’t have confidence to have difficult conversation.
Unclear referrals to OH, unclear what wanted.
Clinicians got fantastic skills, telepathy not one of them [L].
Lack of autonomy; second question yourself.
Fear of making mistakes incredibly important.

No autonomy other areas, so even more fearful about making mistakes.
Need reassurance, is ok.

Anxiety.
No experience, training, re difficult conversations.
Need somebody to authorise what doing.
Get HR in, they’ll rubber stamp.
Shifting/Displacing responsibility
Lack of involvement.
Disenfranchised, because nobody’s listening.

Government not listening?
Government not listening to what’s gone before.
All just trying to make own mark, put something new in.
Nothing is new.

See same problems cropping up.
Haven’t thought through way dealing, communication with staff.
Same problems cropping up another department.
Same themes arise, organisational process iterative.
Repeats itself, themes deal with.
Conflict, and power.
Dynamics of inclusion, exclusion, communication.
Communication, sender receiver model is theme.
Lot of problems arise when assume what got in head is going to arrive in another’s persons head intact same way.

When manager sends e-mail, someone magically take it up, same meaning sent.
A sort of deafness goes on.
Can only make guesses about “deafness”; what might be threatening.
What might be threatening, hear criticisms about organisation/senior management.
In senior position invested in one-sided rhetoric printed in trust monthly newsletter.
May see our work has value but also motivated to silence dissent.

Everybody in disagreement, but everybody frightened to speak out.
Spoke out.
Saying to me know should said something, but too frightened.
Was horrible.

Comes at all levels, but starts at the top, permeates down.
If isn’t that ‘caring’ for staff, involving them.

Goes with ‘command and control’.
Whole new management structure brought lots concerns delivery of service, competencies etc.
Again nobody would speak up.
Don’t put your head above the parapet.

Best way to survive is to keep your head down.
If things go wrong for patients, not my fault, it’s theirs (R&J).
Justification/Rationalisations for inaction.
I spoke up.
No intent to become *whistle blower* just raising concerns.
Expectation managers to take action.
*It goes on up the chain.*
Suddenly realise are *whistle blower.*
Just set out to say isn’t safe, sort it; nobody will look at it.
Very, very detrimental to career, no doubt about it, no doubt about it.
Now, unless clear going to harm patients don’t report; breach of registration.
Even staff frightened to complain at ward levels.
People have their directives, what going to do.
*Push, push, push,* don’t want to listen to, actually *creating unsafe structure.*
*Going to fall down about our ears.*
People going to suffer because managers not got competencies need.
Don’t want to hear.
*Muddying the water, so shut it up, silence it.*
Manager are in *in-between bit.*
Lack of time.
Staff raise concern, have to make time; lot of work.
Understand why *just, try and cover things over.*
Complexity of what happening in NHS.
People don’t understand what concern is, unless *come up through the front line.*
*Layers of management, haven’t been down there; don’t understand job right through.*
Raising a concern, *just don’t get it.*
Don’t understand, even what it is.
Concerns, *sent it all round wrong tracks.*
*Not about whistle blowing policies*  
*Whistle blowing policies in place, but nobody paying any attention to them.*
Concern hasn’t been listened to; quite frightening.
All saying will get listened to.
Awful, unbelievable.
Concerns passed from place to place.
No one taking responsibility.

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<tr>
<th>Int</th>
<th>Categories of Framework Theme 9. Raising concerns/communication (Interviews)</th>
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| 1   | B&H difficult to raise.  
Don't believe any B&H their area.  
*Lower working staff,* cannot voice.  
No opportunity to voice.  
People doing work can see where can be improved.  
Can raise problems about patient care and H&S.  
(B&H) Don’t want to know goes on; very awkward, *could snowball.*  
Management not forthright.  
Poor communication with different staff.  
[Why not interested neg beh?] Nature of thing.  
Lots of things bring up, bring up, bring up, nothing gets done.  
[Why?] Don’t know.  
*Too much on their plate.*  
Should be interested.  
Lack of connection.  
Not a whole anymore, even wards don't connect now.  
Communication not as good. |
| 2   | [Diff to raise/discuss] Any issues directly related to working ability.  
Concerns with colleagues. |
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| 3 | **3** | **Diff to raise?** Issue dependent.  
Requires understanding how organisation works.  
Common barrier.  
Work of TU rep, HR seeking solution; undermining by more senior level management.  
CEOs frequently remote.  
*Minions* do good job, but no authority/freedom to make decisions.  
Always way to raise issue even delicate/sensitive ones.  
Some methods sensitive e.g. off-record conversations, quiet conversations with media. |
| 4 | **4** | Culture of learning from mistakes lost.  
Openness discouraged.  
**[Diff to raise?]** Targets/how achieved.  
*Silo working*, sharing of information across divisions.  
* Lip service* paid to "corporate working and ideas".  
Each out for own/jobs for the boys.  
Staff unable to challenge, but told to challenge; mixed messages.  
*Feel unsafe.*  
Lack of trust; don’t know who to trust.  
Fear have black mark if speak out.  
Senior manager breaching policy, HR powerless.  
Person responsible for HR, needs challenging.  
No one in organisation/unions prepared to challenge.  
Positions of, authority, power, control, inhibit challenge.  
Conflict of interest, nobody dares challenge.  
Any "open & frank" discussions reported back, culture of openness lost. |
| 5 | **5** | **Diff to raise?** Hard to get managers to listen; any criticism of policies wish to implement.  
Reluctant to listen to staff believe not *disciples.*  
Disciples follow whims of managers religiously.  
Something seriously wrong, managers try to silence *whistle blowers.*  
Especially silence, if criticism implies extra expense.  
Managers wish to control clinical staff.  
Trying to remove clinical freedom from doctors, to control expenditure; detriment of patients.  
Doctors who argue, disciplined for arguments.  
Attitudes widespread, worse in larger/teaching hospitals.  
Small district hospitals may get on well with clinical staff.  
If leads to problems with finance, manager considered to ‘gone native’, be moved on.  
Managers do not like to know if problems with plans.  
Resistance to knowledge/problems.  
The more absurd; less likely want to hear opposing ideas.  
Management silence critics.  
Similarities local councils/EEC. |
| 6 | **6** | Any issue can be raised through processes.  
Increasingly difficult to get grievances/other issues dealt with quickly.  
Lack of HR staff.  
Shift in priorities; focus on structural change, future commissioning.  
Difficult to discuss any issue not covered by policy/agreement.  
Free thinking not prevalent.  
Trying to get response based on sensible moral argument difficult.  
Little leeway outside of rules.  
**[Why?]** Lack of experience making decisions outside set procedures.  
Long time to get through layers of management to get common sense response.  
Bureaucracy/process limiting thought and common sense.  
**[Diff to discuss re neg beh?]**  
Subtle actions; most complaints long history subtle behaviour, undermining over length of time.  
Single incidents rarely seem significant to witnesses, others not affected.  
Single serious actions in breach of policy, rare. |
<p>| 7 | <strong>7</strong> | Communication non-existent |</p>
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| 8    | **[Diff to raise?]** Workload and priorities.  
      | **[Re neg beh]** Staff treated inappropriately by managers.  
      | Feel negatively impact jobs, prospects. |
| 9    | **[Raising concerns]** Most places fairly open, transparent.  
      | Managers, restricted time, resources to resolve issues prior to formal stage. |
| 10   | **[Diff to raise?]** Varies between employers.  
      | *Whistle blowing* continues to be issue.  
      | Very poor management of bullying.  
      | Racism, not well managed, leads to institutional issues.  
      | Management less inclined to negotiate, facilitate win-win outcome.  
      | More draconian measures e.g. Sickness absence.  
      | Some issues, management little room to manoeuvre.  
      | **[Why diff to raise?]** Resource management increasingly determining how issues resolved.  
      | Little experience how to manage decline in resources.  
      | Management of bullying, long term problem.  
      | Lack of expertise.  
      | Increasingly training own mediators.  
      | Non-professional mediation frequently makes matters worse.  
      | Lack of redress for perpetrator.  
      | Expects target to continue work in challenging environment.  
      | External pressures around reorganisations.  
      | Outsourcing causing unrest.  
      | Lack of control over decision-making processes.  
      | Middle management manage increasing patient needs on reduced budgets.  
      | Outcomes of decisions detrimental to staff and patients.  
      | Growing *feud culture*: no longer feel secure.  
      | Know consequences to raising issues.  
      | **[Diff to raise re neg beh?]** Reluctant to bring cases bullying to attention of management until target not able to cope.  
      | Many cases, target personally resolved to resign if process fails.  
      | Uncomfortable raising issues, afraid perceived ‘unable to cope’/’weak’, found not have serious case.  
      | Concerned about politics taking case.  
      | How viewed by line/dept manager, peers.  
      | Issues of confidentiality, own mental health, ability to cope with process. |
| 11   | Not much input regarding how services managed.  
      | Although ideas may be elicited, more often than not, not acted upon.  
      | Rhetoric not reality.  
      | **[Diff to raise?]** Resources, including human ones.  
      | Not enough people employed to fully meet needs of patients.  
      | Staff competence.  
      | Reality.  
      | **[Why?]** Everyone own agenda.  
      | Many managers not had experience, education to equip with leadership skills essential to inspire workforce.  
      | Duty to organisation to 'manage' with finite resources, forever changing objectives.  
      | Better just to get on with it, pretend everything is OK!  
      | **[Re neg beh?]** Difficult; *‘telling tales’* frowned upon.  
      | Personally criticising others does not come easily.  
      | Often easily look for reasons why behaviour occurring, try and justify what clearly wrong *(R&J)*.  
      | Collecting 'evidence' seems underhand.  
      | Most aware of negative behaviour; dealing with it daily.  
      | On occasion raised it with managers.  
      | Only raised concern formally once, staff member bullied.  
      | Not addressed fully, person left to find another job. |
| 12   | When raise concerns, don’t get support.  
      | Investigations, but action very rare.  
      | Only when trend, different people complaining; even then, doesn’t always happen.  
      | Meant to be *open whistle blowing* culture, not really like that.  
      | Very hard to raise manager behaviour.  
      | Lack of people management training for managers; learn it on the job. |
If good clinician, expected to be good manager.
If lucky got good ‘in house’ training.
Staff lose out.
Personalities, way come across, way speak to people.
Telling manager bullying, very hard discussion.
Very hard raising it, very hard to be told.
Reaction; acceptance or complete denial.
Very hard if feel line manager incapable.
Often line managed by somebody don’t have faith in; difficult to raise.
Repeated negative behaviour, frequently people lose confidence, feel responsible.
Communication always big issue.
Repeated whistle blowing.
Clinical Leads; blame somebody or put it right without looking at root cause.
No focus on prevention.
Lots senior people/nurses left; if whistle blewed (sic) targeted.
Slowness of response to problems.
Lengthy, time consuming expensive process; serious incidents.
Ultimate concerns governance.
Afraid to bring stuff up.
Consequences personally; seen people shafted.
Mistakes not learned.
Failing patients; no different to Staff, other trusts, Bristol.
Couple of bullies at top of department, don’t believe any problem, or refuse to listen.
Make any kind of hassle; get watched, get pushed out.
[Why so long?] Weak board, weak medical director
[Big turnover] Very junior board, executive team; like lots of hospitals.
When put your hand up, having problems, expect support.
Suddenly taken down capability route.
Nothing worse than not having voice heard.
Not being able to give your voice, in position can’t; last 6 months, until got out.
Takes a while to deal with that.

13
No issue couldn’t raise; but might require more preparation, time.
Advise stewards how to do it.
[Diff to raise re neg beh?] Not involved until formal; deal with specifics.
Organisations want matters raised in accordance with procedures e.g. B&H policies.
Approach taken in formal complaints, generally ineffective.

14
Can be career ending move to raise concerns with NHS managers.
Culture, ‘keep the lid on’, ‘don’t expose your dirty linen in public’.
If do attack them professionally, personally, make them go see psychiatrists.
If beat you at industrial tribunal pursue for costs.
No end to what NHS will do to people who try to break open ‘the citadel’.
Pathetic attempts to do something.
Current government could stop it at a stroke, if wanted.
‘keeping the lid on’.
Thou shalt not let the public know how many people NHS kills because of negligence, errors, harm each year.
Killed by very basic things.
Does not want to expose, gradually coming out, appalling care deliver to elderly people.
That’s way the culture, society works; not very good at challenging institutions set up.
Hans Anderson story ‘The Emperor’s New Clothes’.
King’s new clothes.
Takes a little boy to say look what’s going on.
All that drives culture of NHS, thou shalt not break the golden rule’.
[Golden rule is?] The golden rule is keep stum, don’t let it out.
[Don’t they care about patients?] Proportion of people who run NHS, do not prioritise safety of patients, quality of care, above finance, political targets.
Story of Stafford Hospital set out by HCC, Robert Francis Inquiry 1 & 2; for all to see.
If complain about service, PALS supposed to be advocates, advice for patients, loved ones.
But then try to ‘keep the lid on it’.
If complaining will be treated as whistle blower.
Volume of complaints astronomical.
System, nobody independent to investigate.
HCC, up to 2009, didn’t work; too many.
Ombudsman service only looked at tiniest, fraction of cases.
Number found for complainant vanishingly small.
Hospitals, managers, doctors, do not ‘give the game away.
Doctors driven by medical unions’, ‘do not admit liability’.
Prevaricate, procrastinate.
Urban legend, Whitehall, keep complainant going 7 years, get fed up go away.
Medical negligence bill, billions of pounds.
Is something to hide, something being hidden.
Public never notices.
Vast majority get good care; doesn’t make up for bad care.
People who get good care, don’t want to look too much, into what happens to other people.
Going to get increasingly difficult with new executive team to raise issues.
May close Board meetings.
People who raise concerns victimised.
[Organisation] broke down walls of the Citadel because it suited new ruler to break them down.
Insiders wondering how to respond to being on display.
First response, pretend nothing happened, hope walls can be rebuilt.
Clinical Excellence Awards buy silence.

16 [Diff to raise?] Lots of bullying, staff scared to speak out, fright of retribution.
Resources, bullying, financial issues, work load or pressures.
[Why?] Managers have own agendas, not entirely patient focused!
Sometimes own career of interest!
Selfishness.
Do not upset manager otherwise your life will be hell.
Do not challenge poor clinical practice, safety issues or whistle blow otherwise your life be made hell directly/indirectly!

17 Not open disclosure of problems, or culture of honesty.
‘Blame free’ culture not encouraged.
Failure to learn from earlier inquiries.
NHS is secretive and self-protecting.
Perverse incentives to focus on input/outputs rather than quality.
Suppression of clinical concerns.
Active suppression of whistle blowers and ‘people not on message’.
Lack of community and patient voice.
Dominant, pervasive bullying culture conflicts with need to protect whistle blowers.
Too easy to avoid PIDA.
Failure to enforce codes of management practice.
Lack of sanctions.
Active suppression by DOH and regulators of concerns.
Main overriding priority; protect politicians at any cost.
Personal interest in serving political objectives.
Elite closed circle of career driven managers.

18 [Complaints] First and second tier for making complaints.
Locally, they chop it off (discussion), or explain what went wrong.
Some not acceptable, don’t resolve, go to second tier.
2006, regulator weren’t able to analyse data.
All unresolved complaints never examined.
Put in national electronic wastepaper basket rather than local one.
(PHSO) accept 3% of complaints.
Hospital services, accepts 0.1% of written complaints.
Are whistle blowers; still gagging clauses.
Not clear to clinicians what do. Doctors fear penalised if do raise things with managers. Fear of punishment. Attempts to solve problems of whistle blowers; not totally effective. Steve Bolsin to Australia because blown the whistle at Bristol. Fear. Culture of fear pervades NHS, problem of whistle blowers. Still gagging clauses, preventing speaking. Even people at Mid Staff inquiry subpoenaed to give evidence. Gagging clauses in contracts. Culture of fear, unsafe in hospitals, possibly general practice as well. Presenting things not acceptable to management, use various mechanisms of blocking it being made more public, certainly not published. Things [scenario] do go on at times, don’t hear about them by definition. Whistle blower, refused to be gagged; Great Ormond Street Hospital Trust. Doctor refused to be gagged payment of 100,000 pounds. Many accept, have to accept if want career in NHS. Totally unacceptable; how things are. How get better health service when is situation? Will continue.

19 Knocking your head against brick wall most of time. Not willing to listen to external criticism or any external efforts to move in different direction. Moving towards closer to home services, slimming down hospitals; get passive aggression. Pretend to go along with it, then don’t do anything. Very internally focused, except where have to be externally focused, signing off balance sheets end of March. A collusion. In past always been able to do that; another reorganisation, government before long. Experience of decades teaches nobody real about doing things differently; carry on as before. Whistleblowers/protecting image of organisation? Organisation should be in disrepute. Somebody, position becomes intolerable, is parting of ways. Compromise agreements, gag people. Organisation should be being exposed to light of day, but it’s avoiding it. Protection of image/organisation more important than patient, welfare staff. Why? Democratic deficit (sic), deficit, lack of accountability. Fascist situation where technocrats running show without, democratic accountability. Own personal interest, dominate the agenda. Very understandable, because of democratic deficit. Grafted onto that, boards with NE often its supplement to pension. NE interested making sure get another 4 year term.

20 Significant difference between raising concerns low/local level v more senior (e.g. SHA) level. Issues can be resolved quietly and locally are, but reluctance to share bad news too far up management chain; especially beyond Trust/PCT to SHA or DOH. Significant cause for concern some clinical areas, colleagues reticent to challenge poor clinical practice by peers; not clear why. Get sacked for exposing [mistakes] hence concerns about whistle-blowers.

21 Status and hierarchy important part of culture. Status influence how much listened to. Many policies focus on importance raising issues with managers first. If not aware, cannot rectify. Managers need to create environment where possible. Stigmatising to talk about personal vulnerability to person appraising performance. In light of this important staff made aware other support mechanisms. Talking issue through with someone bit more neutral helpful but if issue not raised in service won’t be addressed. Neg beh] No matter how good policies comes down to one brave individual prepared to talk about it; extraordinarily difficult. Dedicated, hardworking executive team and fantastic clinical staff; something happens in between the two, things don’t get translated up/down, as should.
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<td>Conflict between hierarchies: strong perception of B&amp;H from management to staff. Weak/inexperienced management, may be linked to suppression of bad news or persecution of whistle blowers. Sometimes people behaving badly in positions of power. People beneath them fear reprisals if speak out, especially if perceptions senior managers won’t tackle issue.</td>
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<td>Lack of communication to all levels of organisation</td>
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<td>No longer open communications, avoidance of ‘blame culture’; changed. People do have problems raising concerns. No support from HRD to manage nurse, unsafe practitioner. HRD more concerned about claim for racial harassment than unsafe clinical aspects performance. Poor standards of care. Patients, carers not being listened to, patient care neglected. Concentrating on nurses, needs to be tackled on multi-professional team working basis. Some Trusts interactive websites feedback on patient’s experiences. More openness less likely Mid- Staffs take place. Some staff need to take risks, test whether Boards/managers want to know what is happening. [Why patients/carers not listened to?]. Glib answer, not enough time. No matter what pressures no right to neglect giving basic care to patients. Older people often neglected ones. [Why don’t Boards/managers want to know what happening?] Not simple, straight-forward answer. Sometimes depends who raises unpopular issues, whom speak to. Maybe think reflects on them, not want to pass it on. No manager or Board will say do not want to hear bad news as well as good news. Truly believe systems in place to facilitate this happening. Recent incident [patient] died. [Manager] acknowledged incidents still happened. Board meeting, clear failure of staff all levels recording, entering data into system. Slow to accept had computer system failures.</td>
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<td>Lack of respect for professional opinion. Senior doctors given much more respect than non-doctor. My profession often trivialised. Unfairness. Not given respect when raised professional concerns; expected to be respected. Inequity of allocation resources; some departments resources, lots of staff, others starved of resources. Problems with freezing, delaying posts, unfair working evenings, weekends, [staff] buying equipment. Unfairness permeated. Lack of involvement; dictated to. Only listening to senior doctors, medical director, just ignore. Managers regard them as God. Bias. Whole system biased against [people], trying to say and do things unfavourable to [people]. [Why?] Power, arrogance, financial things. Playing academic games. Links between different people, e.g. Marriage, close associates/academic colleagues influencing where money goes. Nepotism. Dependence on flowing of money, lots of money in form of grants. Couldn’t say anything against person. Manager didn’t want to upset because person bringing in lots of money; good at that.</td>
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Untouchable, beyond reproach.
Regarded [them] as God and very powerful.
Preference and favouritism.
Surgeons often regarded as Gods, bringing in money, money speaks.
Ignoring of flaws and limitations.
Bullying; telling lies to cover up.
Manager telling lies to cover up bullying.
Mutual protection.
If you support me I will support you.
Give me pat on back will give you pat on back; lot of that.
In the middle.
Twisting things round in terms of own agenda.
Question of fairness wouldn't come into it.
Playing political games.
Part of, not a power struggle, but situation where power mattered, very important people mattered.
Bringing in money, grants, publications, research mattered.
Clear conflicts of interest.
No declaration of conflicts of interest.
No consultation.
Decisions behind closed doors.
Allocated [space] to themselves, gross unfairness.
Self-serving.
Reasons: power, money, and nepotism.
[Getting worse?] Problem is if nobody stops them.
Nobody who stands up, just carry on.
Can get away with it, will just carry on; in that sense does get worse.
[Moral vacuum?] Question of morality doesn't come into it.
No moral, ethical stand; upsetting.
Supposed to be caring, taken Hippocratic oath, supposed to be, highly educated professional people.
Where is their moral standards?
Searching/hacking computers.
'The end justifies the means'. (R&J).
Just trying to dig dirt.
No morals; 'end justifies the means' (R&J).
Trying to find something, anything; don't care how it’s done.
Found nothing [L].
Don’t admit wrong, don't apologise.
Keep things secret, total lack of transparency.
Hide information/advice and actions.
Total lack of transparency, lack of honesty.
The ‘end justifies the means’ (R&J).
The mentality; the end is how can we make life difficult, to get [them] out.
Total focus on goal of getting people out.
Morality and ethics go out of the window.
Looking for own justifications (R&J).
Try to find people to say nasty things, evidence of fraud, money for personal gain (R&J).
Witch hunts.
When wrong don’t stand up, justify complaint.
No apology, no acceptance of ‘got it wrong’.
Happens all the time when try to dismiss somebody for no good reason.
Try to twist and turn, find something to nail [person] with.
That’s the depth, the end justifies the means; it doesn’t matter.
Don’t talk to people because don’t want to hear the truth.
It’s the agenda have got.
Decide want to get rid of troublemakers.
Set a trap; have it in for people.
Overall agenda.
If agenda is to get rid of employee everything else falls by wayside.
If patient care suffers, if staff wellbeing suffers, if upset people, if have to ruin somebody’s life, doesn’t matter.
Nothing matters except the goal (R&J).
Our agenda is, so focus on goal (R&J).
Maybe legitimate goal, maybe targets, person not reaching government targets; will be fined, get rid of them.
Semi laudable goal, but all driven by higher agenda (R&J).
Instead starting off from base principle, should have ethical and moral standards stick by.
Treat patients/staff with care and consideration, compassion, be truthful, compassionate all times.
Start with, what are our goals?
Distorted values and priorities.
Goals - make sure reputation of hospital doesn’t get damaged (R&J).
If person causing damage say bringing hospital into disrepute.
Shouldn’t be telling people outside problems in working conditions; none of your business.
Bringing hospital into disrepute (R&J).
Twist things round, scraping for crumbs.
Bringing hospital into disrepute, kept bringing up, used again and again (R&J).
Didn’t worry about own procedures.
Don’t give warnings.
Doesn’t matter only do something once.
Lack of proportionality.
All governed by own agenda (R&J).
Manager said, ‘won’t allow you to say anything about doctor’.
Suppress right to free speech.
Manager tried to say not allowed to freely express opinions, views.
All related, this power in situation and people decide because together.
The power of alliances.
One supporting the other.
Manager has access to space, other things, knows where spare money, doctor gets it.
Manager wants promotion, reference, doctor gives reference.
Lot of that goes on.
Mutual benefit from alliances.
Pretty awful.
Unless want to be part, play their games; end up in trouble.
People sacrifice whole lives, livelihoods speaking out, career is finished.
One hand, people trying to stand up and speak out, get the sack.
Other side managers who behave obnoxiously, and a few doctors, get balance.
In between is this sea, ‘a sea of silence’.
Why stay silent?
Avoidance of trouble.
Looking after themselves.
Lots of support from people, but a limit.
One courageous doctor.
Silence, driven by fear re own jobs.
Managers went to staff said no account are you allowed to talk to [person].
One or two people wrote letters, but ‘body of silence’ there.
Driven by fear.
Disappointment, people didn’t stand up and speak out; the moral majority.
Decent hard working, doing fantastic job work yet when comes to the crunch.
Everyone says what’s in it for me, do I want to risk the trouble?
People say don’t get involved, don’t put yourself in firing line, stay clear, stay quiet.
Difficult to make any [L] grand moral statement.
What moral courage do people have when don’t stand up and speak out?
Chances are if stood up, spoken out wouldn’t have made any difference.
(E.g. Kim Holt sacked from GOS.
People writing to DOH, ignoring letters).
Doctors wrote to BMJ request reinstated, ignored.
Powerlessness to influence.
Especially people in power, senior doctors, who could have changed things.
Refusal to support people.
People feel let down.
Silent negative force.
Obvious aggression from managers.
Very good support one or two people.
But it’s that silent aggression, silent doctors; should have more courage, should speak out.
[Silent majority] has to be addressed.
Managers, doctors have to be told.
Expect stand up, speak out; don’t want silent majority.
Requires huge change of culture.
Silent majority by nature often stay silent, won’t march, jump up and down.
Responsibility to take a stand, especially when see injustice.
Justifications for not helping/speaking (R&J).
I’m busy; sorry can’t (R&J).
Don’t want to get involved, nothing to do with me (R&J).
Was never around when this happened (R&J).
Sorry bleeding to death, got very urgent appointment, trains going in 2 minutes (R&J).
That’s the attitude, can behave in this way.
God, if I was dying in the street would you walk past me? [L]
Don’t realise all consequences.
Maybe if had, behave differently.
Very senior people who think are God’s gift to mankind, highly intelligent; moral pygmies.
Most brilliant people in world, but from morality point of view; moral pygmies.

31 [Raising concerns] Dangerous; most people do not realise.
A lot of fear.
NHS very poor investigating allegations of bullying.
Many HR departments don’t know what bullying is, no idea how to investigate.
HR encourage, facilitate bullying many occasions.
Where organisations want to silence or get rid of a whistle blower process can be driven from the top.
Clear CE driving attempts to dismiss staff.
Many managers poorly trained, supported; fearful when issues of patients safety raised.
Leaders not valued; feel that.
Reprimand for saying not meeting targets, one suggestion shouldn’t speak.
Attempts to silence.
Repeated complaints no action Manager; hopeless.
Managers have responsibility.
Many managers poorly equipped to carry out role; maybe unsupported by seniors.
Pattern of real genuine concerns brushed aside.
Need to ask why.
Too difficult to deal with?
Jimmy Saville furor along those lines.
Easier to let things go than sort out.
Probably conscious responses.
Concerted effort to shut me up/put me back in my box.
Element of jealousy involved.
Painful emotions; worked through that.
Hated in the end by manager; maybe narcissistic personality.
Mentality from higher levels wanted to ‘bury bad news’.
Mentality backfiring; more and more things coming out.
Jimmy Saville story typical; numerous organisations involved.
Retrospectively say ‘something definitely not right’, but nobody acted.
Some tried to report, young people, brushed aside or ignored.
Combination of culture, don’t want to cause trouble; not sure, so don’t say anything.
Ignoring people who try and speak.
Long way to go to see change.
To listen when telling something painful; difficult.
Different responses.
Told, colleagues out to get me.
Calls for people to resign.
[TU]/people saying things not right.
Number of issues/lots of people involved.
Way senior management treat doctors/staff not right.
Raised concerns about service; was bullied, made ill.
Offered money to leave with gagging clause in compromise agreement.
People started to trying to defend what had gone on.
Sat and watched.
Culture is very very powerful.
A few people tried to stand, disagree with masses, shouted down.
[person] slagging me off.
Try to stand up, do right thing, shouted at, abused.
Recognition 'is a moral issue' but didn't say anything in meeting.
Supported quietly.
Loads of support behind the scenes.
When have to say something to authority; difficult.
Reluctance to put themselves out there; takes guts.
Observed why in this mess.
Others trying to speak up at [hospital] hanging on for dear life.
Treated absolutely abysmally.
Would help if unions stronger; one of the issues.
[Gagging clauses] Things get buried; gagging clauses.
Because got gagging clauses can make sure it's all, buried.
Scandalous; can force doctor out, bully doctor, nurse, whoever, force gagging clause on them.
Gagging clauses not illegal.
Legal, but not what should be happening.
If everyone together makes a stand, would stop.
Need to empower frontline professionals to not sign.
Very scary not signing.
Had to consider outcomes; sack me, going to be big scandal?
Didn't sack me, how managed to hang on.
Realisation have authority to sign compromise; don't have to do it.
Lot of people so stressed, do it, just want to get out.
Regret.
Doctor really regrets signing gagging clause.
Knows it is wrong, wants to talk, can't; they've won.
Its NHS money; it's wrong, shouldn't be happening.
Disgust.
When in it just terrified.
Isolation.
Now thought about it, discussed it, completely wrong.
People know it is wrong.
TU's have to stop happening.
Put foot down say no longer going to go along with compromise agreements.
Not brave enough; ridiculous.
[TU] sign, [-00] a year, compromise agreements; ones know about.
Many nurses bullied, don't get as far as that, go quiet.
Whole iceberg thing.
Nothing said; see what happens.
Try to say something; get bullied, not going to say anything else.
People who go further, a lot end up gagged.
Very, very, few take to next level.
Only high profile cases, press get interested in.
If have good MP, but huge personal effort to take it that far.
If take the money, will be over.
If don't; continued stress.
Some just get sacked very quickly.
Means got no money, so end up being forced to take.
Sacking is employers view best strategy.
If sacked, desperate to take money.
It's easy to get gags out of people.
It is horrible.
Person sacked, offered money with gag, but refused. 
Financial loss, but fighting on.
Very difficult for younger people.
One case, sacked, trying to fight case.
Legal costs too much, took financial settlement, but what really wanted was the gag.
Tried to stop it but couldn’t.
Is at a higher level, coming from a higher level.
Putting pressure on employers, then employers trying to ‘bury bad news’.
If employer doesn’t bury bad news, you get sacked.
Level refuse to ‘bury bad news’, get sacked in lots of places.
Powerful force.
NHS monopoly employer, huge resources; finished in NHS.
If sacked; no other job in NHS.
Blackballing.
Still saying things, can see was all nonsense; quite powerful.
Emotional, to believe these people can do this.
Disregard you, say here’s some money, go away, don’t say anything.
Very difficult to believe.
Hard to believe and lived through it.
People who haven’t, don’t know facts, easier for them to brush it to one side.
Not a moral vacuum.
Agreement, but won’t say it, too scared.
Said to manager, need to tell the truth, no good lying.
Shocked when told her what happened, had no idea.
All kept under wraps; began to understand.
Most people know what right thing to do is.
Realisation is dangerous.
Attempt to see whistleblowers as trouble makers, moaning about their jobs; but not.
Whistleblowers trying to make health service safer.
Get sacked, so becomes employment issue.
The trick employers use.
Make it employment issue then very hard to keep patient safety aspect to front.
Lucky because [patient] reminded everyone all time, was about a [patient].
Most people gets buried as employment issue.
Unions still resistant.
Still going along with compromise agreements; still a battle there.

32

Does not encourage constructive criticism, informed dissent.
Actively discourages or gags whistleblowers far too often.
[People] raised concerns about patient safety.
SHA bullying to change clinical priorities to avoid bad press.
Financial miss-accounting.
Investigations but no individual accepted responsibility.
Suppression of learning.
Risk of reoccurrence high.
Not enough learning and changing of behaviours.
No encouragement of informed dissent, challenge; too top down.
Not a listening organisation, if doesn’t listen, how can learn?
If not learning organisation, just dead in the water; fossilise.
Mid Staff, why doctors, nurses so ground down with ‘learned helplessness’ didn’t care elderly patients dying in filthy beds?
Extraordinary.
Need to bear element of responsibility.
5 years hold up for report into MSs, bound to name senior people who carry responsibility.
Didn’t happen, was CAUSED.
Accountable people, running like crazy, hiding like crazy, hoping whole thing will go away.
Delaying it, until closer to/past retirement age, then bail out.
5 year delay absolute scandal.
Reason Francis hasn’t reported, very critical named individuals in management, clinical positions.
Doctors, nurses, senior managers, possibly up to -- himself.
Draft findings, lawyers involved to try and find, change, block, alter, defer report.
Moral vacuum is good word, exactly.
No sense of morality or values.
Where need to get back to.
Institutionalised dishonesty.
*Fiddle* waiting lists times, targets or finances.
People raise concerns made to resign.
Dishonesty, seen it over and over again; institutionalised.
Raised concerns with CE, management team, not welcome message, very difficult.
Not permissible to raise concerns about peers, fellow managers.
Prevailing culture is bullying.
Command and control leading to *fear*, insecurity and cover up.
Constructive challenge, inquiry seen as disloyal, frowned upon.
Dissenters not welcome as *agents of change*, marginalised as *trouble makers*.
Cronyism rife *senior levels*.
Failure dealt with by redeployment or redundancy, seldom by acknowledgement, discipline or dismissal.
Cynicism *lower down ranks*.
Culture of not raising concerns reinforced.
Attitude of why bother; nothing will happen.

| Distressed, decisions made without taking people with management. |
| Say keep you informed, consult, management feedback. |
| No consultation. |
| Tell you, call, send e-mail; lack of response, totally ignored. |
| Rhetoric not reality. |
| Poor performance; put aside Agenda for Change. |
| Because done little piece of work, management given titles like associate directors, higher wages, etc. |
| *Are* friends of friends at higher levels; will do everything. |
| Never challenge, never bold, never courageous, just go along with it. |
| Despite might know in heart, not right. |
| Put aside moral/ethical considerations. |
| People who do *speak up*, bold enough to *speak up, just left on the sides*. |
| People get into labelling. |
| Marginalises opinions, no matter how well opinions are; doesn’t suit management. |
| Really *incestuous* in NHS. |
| *Against grain* of equality. |
| Cannot address equalities. |
| People who raise concerns don’t get look in. |
| Promotion not based on experience/knowledge/merit. |
| Bring in people they like. |
| Promotion based on being part of same part of organisation; club mentality. |
| Am very open, very honest, say it as see it. |
| When spoke up, told, that’s how it is *(R&J)* |

| Depends on manager, some good, some take it personal criticism. |
| Some say is business, should all put our feelings to one side, concentrate on business *(R&J - compartmentalisation)*. |
| Mediation and facilitated discussions, no blame orientated place to start. |
| Some try, others insist following formal blame orientated grievance. |

| NHS Managers good *fire-fighters*, want to sort issues raised. |
| *Hard pressed* in time, rushing around; less approachable. |
| Default position use what worked before. |
| Tendency to impose solutions instead of really listening, invalidating member of staff. |
| Managers take ownership of issues raised, not always appropriately. |
| Lack of feedback: solution didn’t work, problem more complex, other priorities, confidentiality issues prevent. |
| Perception nothing done; what’s the point? |
| Lack of understanding about how difficult is to raise concern. |
| Sometimes seen as *troubleshooter*. |

| Patients, not static entity on production line. |
| Lack of humanity. |
Do things unusually/unexpected.
Might get out of hospital bed easier, if got time.
True story; cost savings.
Mid wife, one night shift from hell.
Bleep holder, 15 women in labour, 4 midwives, 10 epidurals; do the maths!
Trying to shut unit down.
Two didn’t want to do it.
Four o’clock in morning 4 women ‘on the go’.
Went mad.
Memo finance director says, ‘Due to fortuitous vacancies in maternity have managed to make savings of ---,000 pounds this year.
Went ‘ape’.
CE says, isn’t place to bring it up.
Went ‘shut up and sit down’, not going to stop me’.
---,000 pounds, ‘somebody’s going to die.
Litigation costs be lot higher than that.
Who listens?
Jump up and down, scream, shout, cry, write letters.
Who listens?
Passionate about maternity services.
Worse now than ever was.
Savings are the focus; patients put at risk.
No one listens.
[Why?] Multi factorial.
Problem, clinicians invariably become managers.
Don’t want to be clinicians anymore.
Don’t want to do shifts.
Want to move on, be manager.
Ain’t going to do all the ‘getting your hands dirty’, ordered around.
Do crap shifts.
Not trained.
Don’t take ownership of service.
Just want to move on.
Want innovative change on CV.
Competitive element.
Innovative change, is for them, not service.
To look good on CV.
Or look at us, save loads of money.
First behind ‘a crock’.
Seen it so many times.
Lot of inefficiencies in NHS, but not where staffs concerned.
Stupid things happening with NHS.
Half privatised out.
Right hand don’t know what left hands doing because all private companies.
Not run as hospital anymore.
It’s too big.
Massive big trusts.
Lost it, minute get that big.
Lost personal touch for patients/staff.
People do silo work, only way can deal with monolith working in.
Left hand doesn’t know what right hands doing.
Things get duplicated.
Multi-factorial.
Lot of problems, not just one thing.
Whistle blowers, people are ‘scapegoated’.
If raise concerns find themselves in frame for it.
It is to stop it.
Nobody’s allowed to talk about staff levels.
‘Elephant in the room’.
Lack of staff.
Trying to hide all the time.
Over zealous cost improvements.
Not just efficiency anymore, it’s madness.
Unsafe madness.
A dangerous madness
NMC, if unsafe to work, let manager know.
Let manager know, say get on with it.
Stop moaning, stop whistle blowing.
When you make mistake, because absolutely knackered, it’s your fault.
How does that work?
Things predicted, have happened.
Have stood up said to politicians about maternity services.
Would love waiting list.
Bloody luxury have waiting list.
Can’t say to people ‘hold on’ put on waiting list.
If got maternity, got to be there.
Should be lovely job, not anymore.
Set up to fail, nurses the same.
Bureaucracy and red tape, systems to underpin it.
It’s just, endless, endless, endless, endless.
Really sad, end of day.
It’s people’s lives, not only staff, patients.

Increasing healthcare professionals contacting involved in whistle blowing; patient safety issues.
Fact healthcare professionals seeking [organisations] support indicative still issues, NHS as whole, individual NHS organisations, in listening to legitimate concerns, trying to safeguard patients.
Experience trying to raise concerns often leaves them isolated, threatened, distressed, professionally compromised.
Significant impact on health and wellbeing.
Description some healthcare professionals what happened; Kafkaesque.
Mirrors experience some patients/families try to raise concerns about care.
Common feature how some organisations respond when challenged.
Both instances, almost have to become obsessional in order to fight your way through system.
When patients try to raise concerns about patient safety, response receive again very variable.
Involved in supporting patients, relatives in scandal.
Exemplified what happens when organisation not only lacks insight into standards of care being provided but closes its eyes and ears to any criticism, legitimate concerns raised.
Organisation developed very unhealthy culture filtered down from senior management to frontline.
Many staff, patients caught in crossfire.
In past not uncommon feature of cases, consultants challenged over inappropriate or poor treatment; BRI.
Healthcare professionals now much more prepared to report unsafe practice in relation to individual professionals.
Still professionally very difficult for those reporting.
Even more so when challenging organisational failures, putting patients at risk.
Still not insignificant risk those reporting end up before GMC, relevant professional body.

If management aren’t going to listen only go down route if desperate.
[Rat & just’s] There’s no point telling management; already know, aren’t doing anything (R&J).
If blow the whistle will be blamed for very failings trying to expose (R&J).
My record not unblemished, so just keep my head down (R&J).
How fragile our rationality is.
Prey to false memories, cognitive biases, logical leaps etc.
Book “You are not so smart”.
Those that challenge, break with organisation’s cultural norms tend to be isolated or victimised.
‘it’s not our problem, it’s yours’.
If managers out of depth, insecure, last thing want someone from outside shining a light on a problem.
Challenging prevailing belief system of organisation.

Don’t want to hear what say.
Do not value clinicians, is contradictory to them.
Believe general management superior and all powerful.
Regards to power, sadly appears to be case.
Previously believed could raise concerns.
Now know when concerns relate to wrong doings at the top are sabotaging own career.
Whistle blowing extremely dangerous thing to do.
Did not consider myself whistle blower.
Senior NHS manager, wealth experience, knowledge, expected concerns to be listened to, dealt with through normal line management procedures
Stunned nobody of NHS employers would speak to me about concerns.
Found whistle blowing policy great difficulty.
Raised it with line manager, their line manager.
Response was bullying and intimidation particularly in un-minuted meetings.
Wrote to several directors, requested meetings.
Could not believe would ignore situation and breach of legal duties.
Raised formal complaint with Chair.
Advised by Director of HR (had never spoken to me) not to hear concerns.
Told them concerns individual employment issue not issue of safety and governance.
Escalated concerns.
They embarked on sustained campaign of B&H.
Colleagues sympathetic but afraid to speak out.
Some people concerned about what happening but thought not accountable for serious errors.
One employee who raised concerns told not to take on Director or come off badly.
NHS employer refused to meet, listen, become involved.
TU sympathetic, understanding and supportive.
MP supportive, interested.
Support from elsewhere.
Culture stifles concerns, takes punitive action against those who raise them.
Appeared not to understand what to do with complaint.
Concern was about unsafe practice.
Is it deliberate avoidance or simply lack of understanding?
Passed from place to place.
One group said not known what to do with it under new policy.
Culture suppresses raising concerns particularly when involves most senior managers.
Concerns not fully investigated.
Personal consequences, personally, professionally, financially been devastating.
Health suffered, sick leave.
Suffered dreadful B&H.
Income suffered, running up debt.
Employer took action against me illegally.
Didn't follow normal procedure.
Contract breached, downgraded.
Punitive down grading disguised by organisation as redeployment without protection.
Excluded from lots of jobs own grade.
Reputation suffered untold damage. Personally devastated by way treated.
Feel like been savaged by mob wild dogs, still baying for blood around me; most senior managers in organisation.
Cannot be vindictive enough.
Intend to fight on.
Do not believe right to allow managers to behave in this way, no matter how senior.
Senior managers been given strong warning what happens if dare to raise concerns at this level.
Very unsafe organisation for patients.
Offered salary to go away, rejected it.
Severance agreements usually contain confidentiality agreement.
Do same again because impact on public put at risk.
Means more than doing as was told for sake of salary.
Further problems.
Would be unable to report financial fraud, B&H; not worth personal stress.
If thought patients endangered feel morally obliged to speak out.
Anonymously as now understand clearly how things can be turned to blame you, the raiser of concern.
Wouldn’t advise others to do same.
Am very resilient, but brought to the brink.
Still difficulty comprehending how could happen, for raising serious concern.
Expected remedied quickly.
Culture of organisation needs to change.
Until then, managers my level remain vulnerable if speak out about wrongdoings of seniors.

Very centralised, controlling, hierarchical, pretty closed, intolerant of criticism.
Not open, transparent, although claim are.
Frequently, bullying, not always, but frequently.
Raising concerns very unwelcome in NHS, put down as negative.
Even if immediate manager sympathetic, know whatever action concerned about, is ‘management must do’.
Often feel quite powerless.
May handle well, say to person raising concerns, sympathies.
May worry them, in case seen to be disloyal.
May just dismiss it out of hand.
Daren’t admit also have concerns.

Head on conflict with management view of world, is way to do it, it’s efficient you will all do it.
Raising intelligent questions about problems of some central edict not popular with management, or throughout NHS.
One of reasons why clinical staff sometimes give up on it.
Then shock horror at Mid Staffs.
Why didn’t doctors, nurses speak up?
Because those who did, in trouble or slapped down.
Give up doing it.
Some people uncooperative raise unnecessary difficulties, everyone see advantages.
Awkward people every walk of life.
Overall very unhealthy tendency to dismiss views of clinicians.
So many always worried, things like A&E target, but driven through.
Caused as many problems, deaths, discomfort, as not having target.
Like when clinician prescribes medicine.
Best of motives but lots nasty side effects, some worse than disease itself.
Same, lot of management initiatives.
Unfortunately unlike medicine eventually, hopefully rapidly side effects identified scientifically evaluated.
Not true management initiatives.
Come in, breeze in, people don’t listen to concerns even when clearly counterproductive.
Very seldom real proper evaluation, learning.
People introducing it never held to account for whatever chaos followed.
Don’t know how get round this.
Cannot imagine not having health service in public sector; but does worry me.
Is political nature of NHS results in centralising controlling culture.

Adversarial political system.
Group out of power wants to be critical of group in power.
Some of problems; ubiquitous.
Whatever side political spectrum should be worked on together.
Doesn’t happen.
If Labour introduced policy, have to show it’s a success because invested political energy demonstrating it to be success.
Don’t want to hear isn’t.
Message permeates throughout NHS.
From department through, up through from this point whatever outpost of departments, SHAs.
Replaced with national commissioning board.
Because government of day vested so much political credibility bringing in some new system.
Will have it all over again, reforms, this government.
Whoever in opposition, casting about for criticism to hurl at whoever’s in power.
Whoever’s in power does not want to hear from front line staff about problems.
Say do, but don’t.
Rhetoric not reality.
Say want doctors, nurses to speak up.
But if speaking up, problems they flag, relate to policy, often do, don’t want to hear that.
The increasing managerial control.
NHS managers, a group wouldn’t say as individuals commitment to, analysis and honesty high.
However start off, quickly learn questioning things not popular.
Providing information is fine as long as is good news.
A lot of time feeding the beast with what it wants to hear.
Not raising concerns, flagging up problems.
[Commitment?] Come in; graduates.
Quickly learn careers enhanced by ‘being corporate’.
Careers will suffer if not ‘corporate’.
Some, very clever people who can manage to influence things positive direction with lot of guile, at local level.
Sadly many of them take ‘Queens shilling’ follow directorates [sic] of DOH.
Even when being intelligent people know in ‘heart of hearts’ some of things asked to do, not in best interest of patient.
Many ways public mislead.
Is ‘unhealthy circle’ every time media ask public, what worried about?
Waiting lists, then big focus on waiting lists.
Comes up political agenda.
Waiting times not waiting lists.
[Multiple complaints no actions] Identified situations like that.
Staff talked to us about how raised concerns individuals senior to them.
Apparent impossibility of anything changing.
Sadly, often appears to rebound on those who raise concerns.
Because of hierarchical controlling structure much more difficult.
Than being more open organisation, to deal with problems that particular managers management style, stacks up.
Presentation, rise of clinical governance.
Difficult to genuinely ascertain what patients experience, want.
Went through what currently happened, flaws.
Practically torn apart by CE and chairman.
Although done very academic, calm, unemotional way.
Very moderate, toned it down.
Made transparent some of flaws in what people currently doing.
Because flagged up, just drawing out some problems.
Made clear, is national policy, you will not show up any short comings.
Thought; problem with NHS.
Nonsense to insist clinical things evidenced based, but management can be any old rubbish.
Depending on what current most powerful person thinks, regardless of what know about anything.
[Lack of concern for patients?] Experience being told off, few years ago.
Experience of hospitals last 10 years riddled throughout.
Clear not all clinical staff goodies.
Some, at root of some problems.
By and large, management did not want to listen to clinical concerns.
For all the rhetoric, primary concern was not patients.
Am on my soap box.
View, every CE, senior manager stands in front of television cameras says patient safety first concern should be put in stocks, pauleted with rotten eggs [L].
It is a lie.
It is a lie [L].
Do not have much respect for managers in health service.
Whatever came into service with, most of them either give up, get out because can’t cope, or perhaps try and move sideways where less exposed to worst of it.
If want to prosper, just join corporate line.
Repeat endlessly, patients being first priority.
Rhetoric not reality
Huge swathes of what do, quite apparent is not right.
[How live with themselves?] Like lot of people sometimes begin to believe own rhetoric.
Often found in CE’s of trusts where appalling things happened.
Say extraordinary thing about what done.
In, out of trust for 6 months, loads of analysis.
Flatly contradict what they would say.
Stare at us in horror.
Used to not being questioned.
Their word is accepted.
Some, maybe lot of them, begin to believe the propaganda.
Think ‘there is no alternative’ (R&J).
Delude themselves.
Some aren’t very clever.
Maybe genuinely don’t understand effects.
Others, know perfectly well, but, carry on regardless.
It’s depressing.
Other stuff done about horrible culture in NHS, the department never wants seen light of day.
Sometimes commissioned work.
[What action?] Every bit that exposes [horrible culture].
Some stuff stems from adversarial political system.
Impossible to have circumstances under which people in power can without losing political face, being ridiculed.
Honesty to say ‘got this one wrong’.
Minute start doing that, opposition cheering from benches whichever colour.
Bad as each other; media light on it.
Against openess and transparency.
Deadly combination of candid media and politics.
Both of them more powerful than you and me.
[At bottom patients dying] And down at the bottom got patients dying and unhappy staff.
[Moral vacuum?] Spot on in describing a moral/ethical vacuum at heart of NHS management. From the very top.

Framework Theme 10. Negative behaviour

<table>
<thead>
<tr>
<th>FG</th>
<th>Categories for Framework Theme 10. Negative behaviour (Focus groups)</th>
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<tbody>
<tr>
<td>1</td>
<td>Manager yes person; lots of those, sickness levels rising, caseload huge, restructures, staff at risk.</td>
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<td></td>
<td>Knock on effect, B&amp;H increasing.</td>
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<td></td>
<td>Lack of accountability.</td>
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<td></td>
<td>Bullying management style recognised externally.</td>
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<td></td>
<td>CE: likened himself circus ring master, school of management acceptable within environment.</td>
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<td></td>
<td>Middle layer of very, very grateful managers, not reach that level; no one questions.</td>
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<td></td>
<td>Staff so defeated.</td>
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<td></td>
<td>Lot of expertise, but no confidence to speak up and offer solutions.</td>
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<td></td>
<td>Some doctors very rude; shout at nurse in front of patient; don’t get disciplined.</td>
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<td></td>
<td>Question why doctors no discipline.</td>
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<td></td>
<td>Doctors appear untouchable.</td>
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<td></td>
<td>Some doctors and managers treated differently.</td>
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<td></td>
<td>Some managers 10 a penny, like us; expendable.</td>
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<td></td>
<td>Some believe form of gods, should all bow down to them; know best.</td>
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<td></td>
<td>Lot of managers, their way or the highway.</td>
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<td></td>
<td>Get another job.</td>
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<td></td>
<td>Know there is no work.</td>
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<td></td>
<td>Aware of power position, continue to treat as do.</td>
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<td></td>
<td>Some managers good some bad.</td>
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<tr>
<td></td>
<td>Every person responsible for addressing negative behaviour.</td>
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</tbody>
</table>
Dignity and respect never comes lower than management, despite equality department.
End up defending, because not been passed down.
Dignity and respect taught that, but don’t use it.
Rhetoric not reality.
Many staff sniping at each other because lack of morale, fear of jobs, cuts, freeze to pay/job.
In cycle can’t get out of cause got no power.
If no power frustration builds up.
If not treated properly things explode within workplace.
Pressure.
No power to do anything, anywhere else.
Silly little things come to fore.
Dignity and respect sessions, but ‘talking to this wall’.
Don’t want to hear, because he don’t treat me like this, so not going to listen.
Not ‘walking the talk’.
Unless degree of positivity and respect, rest falls down.
Undervalued because walked past as if don’t exist.
Spotlight awards, ancillary staff still not spoken to.
Meaningless tokens.
Staff treated differently.
Managers frog march staff, doctors, managers don’t go to ‘respect’ sessions.
Lip service.
Manager knows about bad behaviour.
Whacking over head.
Seen as normal behaviour.
Desperation; grievance, police.
No action; compounding negative behaviour.
It’s OK.
Need ‘that’s not right’, sort now attitude.
Respect in team, lack of respect between teams.
Don’t like B&H, tend to turn away from it.
Frightened.
Hard to pin them down.
Oh my God got to go to HR!
If don’t deal with it, it’s not happening.
Very difficult to prove (? R&J), so never proved.
Lots of its hearsay (? R&J).
Individual stands up, says, being bullied; it’s double whammy.
Grievance, only recourse, not best way.
When lose; message, shut up and sit down.
Half time manager the bully.
Can’t find people above, very busy diary!
Constant change, who is the manager?
Cannot keep handle on who is responsible, also HR.
If find, bit busy at the moment!
Avoidance.
Investigate, take forever and a day.
Member more and more despondent.
Delay; another year of damage.
Push manager to investigate.
Go straight to the top.
Manager throws it in the bin; long getting no answer.
Difficult to access senior managers, even harder.
Distance/separation.
HR special digital locks [L] can’t get in.
HR won’t let us take anything anecdotal.
Can’t take information to HR.
Only act if grievance (? R&J).
Refusal to act outside policy.
Ask manager: If manager says didn’t happen, hasn’t happened.
Assumptions: Deduce, staff are liars, managers always tell the truth!
Time to write statement, everybody *backing down*.
Why manager *gets away with it* all time.
Manager bullies staff.
Don’t hear anything, despite manager shouting.
Scared of retribution.
Divisive.
*Frightened* to *stand up be counted*.
Cuts; don’t want *‘putting head above the parapet’, say ‘shoot me’*.
*Look other way*, pretend didn’t happen.
*Don’t want to be tarred with it*.
Worry about job; can’t recruit reps.
Bullying brings insecurity; horrible place.
Cannot, will not follow through.
Hope sort itself; never does.
Turns from bullying to competence issue.
Very strong messages very, very, strong messages.
Good social control *at end of the day*.
No confidence to do anything.
Except reps, no support; more and more damaged.
See damage; choose not to *go down that route*.
Managers never tackled.
Behaviours perpetuated; *green light perfectly acceptable*.
CE well-known bully; bullying *comes down all the lines*.
Comes *further and further down line* to people doing the shop floor work.
Totally *cowed*, demoralised by behaviours.
Communication key block, arranged like that.
Difficult to speak to right people.
If not saving money, not a priority.
Wait until grievance, *blows up*.
Won’t try and tackle before *kicks off*.
1 to 2 years sort it out, everybody *fed up with it*.
Some leave, some *draw out of it*, don’t have problem anymore, so why bother.
Give up.
Results so negative, rarity get good result.
No guarantee OK, despite intention, experience.
*Big blocks ministers in government*.
Pressure senior managers to meet targets, leads into negative behaviours.
If government and senior manager *thinking along those lines* have *hit a block*.
Currently government aren’t listening to us.
General problems some good practice; can say what goes on, no formality, finds out what going on, carries out actions.
Negative behaviour, got to go through process.
Policy/procedures not robust enough.
It’s so evidenciary (sic), based on absolute proof.
If bullied, is perception, very hard to take solid evidence.
Court of law better position.
Everyone *different take* on disciplinary & grievance.
Training not a priority.
Sometimes can use partnership forum to change practice.
*Hard pushed* to quote good practice.
Our NHS managers are bad.
Some very good, sympathetic, show compassion.
Good managers not valued either, by management.
Waste time listening to genuine concerns, trying to do stuff about it.
Not team players.
Don’t do as told.
Ones *heading out of door* won’t overtly ask for help, whisper in corridors.
Require support as much as rank and file members.
Taken away simple processes.
Put 2 people in room, sort it.
What trying to go back to.
As to do that, no, got to go through grievance process.
Has to go in writing.
Waste of time, split team right down middle, all for piece of paper.
Tied up in bureaucracy.
Why negative behaviour? Defensiveness lot of time.
Frustration. Insecurity.
Some people just like that, focused by pressures put under.
Habitual] Million different reasons, home/work life, many contributing factors.
Sometimes bullies aren’t as said they are; situations out of proportion.
Informal, still in writing; no one will use; are nervous.
Whole process, win lose situation.
Court like, fighting your corner, could of been resolved, on the shop floor, in half an hour.
Waste of time, damaging.
Some days, all go to work with face on.
Worked out in protective team relationships.
One bad apple in team and will split down middle.
Habitual bullyer get rid of one person, move onto next.
Gather own little clan; builds.
Easier to be on their side, than get picked on.
Some managers like habitual bullying; supervisor below to bully to corral/control group.
So bad news will never come from manager.
Start pressure from the top and work way straight down.
Resisting action?
Lazy, don’t want to do it, can’t be bothered.
Don’t know how to.
If acknowledge problem got to deal with it, takes it to where don’t have to.
Don’t acknowledge.
If give it a name it exists.
If hasn’t got a name can’t exist.
Prefer little niggly problems than major component needs addressing.
Something in team, can’t talk about it out loud.
Reflect badly on them, so let’s pretend it’s not happening! Lot of that.
Going to ‘reflect me in a bad light’.
Answer up, don’t want to look bad.
Looking for job, fighting for role, want this one.
Don’t want any mud, sticking to me.
Self-interest.
Don’t ‘people manage’ anymore.
Skills anticipated normal within NHS don’t exist in way did.
Pretending?] Disattending of highest order; from all levels.
Just don’t want to know.
If hasn’t got name doesn’t exist.
Culture, if don’t give it a name, if don’t say X happening then it’s not happening.

In mental health tolerance of ‘unacceptable’ behaviour towards others.
Behaviour as response to challenge, publically very much slapped down.
How dare you challenge attitude; almost bullying.
Almost bullying.
Still very difficult to address negative behaviour senior clinicians.
Easier specific, direct action around nurse behaving inappropriately.
Doctor/consultant, much harder.
Possibly around structure in nursing, established.
Medical profession, far less defined.
It’s about who manages person.
Some responses from senior clinicians re incidents; amazing stuff.
Very supportive HR team if issues raised.
Big push on respect behaviours.
Covered in induction.
Do raise things formally, followed through.
Very fine line difference between being managed if not performing and harassed, bullied or abused.
Very formal challenging process.  
Response often; bullying.  
Move towards formality, perhaps not very good at it.  
Also, lower threshold to automatically say, ‘bullying’.  
Very fine line, to not trip over into...if under pressure, more harassing [L] than managing.  
Lot like that go on.  
Performance managing, lot of time, effort, mental effort.  
Very difficult when, somebody say bullying me.  
People been allowed to get away with negative behaviours wanted to in past, even if bullied themselves.  
Outside NHS would sack them; not in NHS.  
Little performance management.  
Sacked; been overturned.  
Don’t manage lower level.  
All knew going on, just live with it, so much of that.  
Good manager, that manages.  
When managed; Oh my God, everybody suddenly under pressure.  
Been allowed to do what want; now not.  
Some consultants, if won’t conform; follow rules; destructive way.  
Other professions, not so much.  
Not involved; don’t have to justify.  
Left; just ‘left in a little corner’, so don’t ‘rock the boat’ too much.  
Avoidance of problems.  
Everybody’s hoping nothing will go too drastically wrong.  
Got job for life.  
Can challenge and challenge and challenge them, until become lone little voice in corner somewhere.  
They just continue, continue and continue; hasn’t changed.  
Everyone gives up.  
Ill treatment is still about knowing about it and managing it.  
Need to manage performance of person being nasty up, or nasty down.  
Sometimes don’t realise being bullied.  
It’s about behaviours expect and anticipate yourself.  
Wouldn’t bully someone, so wouldn’t expect to be bullied.  
Lot of bullies don’t know are bullying.  
Lot of bullies do know are bullying.  
Culture; is it acceptable or not, who go to?  
Well established understood formal process.  
But, only when something changes is there recognition.  
We think ‘it’s me’, not what’s going on.  
Shift patterns, very easy to miss it.  
Oh it’s me!  
Only when somebody says ‘I wouldn’t have put up with that’.  
Hadn’t noticed going on so long, it’s ‘normal’.  
Toleration of awful behaviour.  
Used to tolerating consultants, then tolerate bad behaviour [L] from others.  
One level know it’s wrong, shouldn’t happen.  
Other level still happening; just tolerated.  
Not tolerating it from my member of staff [tapping desk! - L].  
Manager using performance process to get people out of department.  
Process used as a tool to achieve outcome.  
Person being bullied.  
People are performing, but maybe viewed as challenge.  
Knowledge within trust but remain in post; no action.  
Repeat behaviour with different individuals.  
Using performance route to get people out.  
[Why nothing done?] Weak management.  
Lack of training.  
Have to speak to people, this is culture, this is behaviour expect in team.  
Very difficult, not taught how to do it.
HR fully aware of individuals, but nothing happening. Just move them, somewhere else.
No, managers still in post, other people moved. Still in post doing exactly same thing. [Hitting table]
[HR?] Complaint, retracted everything; so stressful.
Not letting two bullies push me out of here. [hitting table] Resistance to manager behaviour. Repeated behaviour.
To HR, how many times going to allow individuals get away with this [hitting table]; still remain in post.
Not good answer; still there. Every time seen it, HR turn round say, well that’s the way it is (R&J).
Can’t really do anything about it (R&J). That’s the way it is [R&J].
Whistle blowing policy, hasn’t been much benefit; risk assessment tool has.
Have to put together evidence, details, action plan what tried to do to stop prevent; take to HR.
HR: Not taking responsibility, not proactive. Difficulty: people performing, delivering results organisation wants.
But not respected above or below, but still in post.
Culture; some organisations might address it, others won’t.
NHS no different to other organisations.
Have difficult managers, can’t get out, and don’t manage people.
Want different people, don’t want everybody same. Always going to cause friction.
Suddenly clicked wasn’t interviewing for best friend.
Very difficult to appoint somebody wouldn’t be friends outside.
‘Get on my pip’, but going to do the job [L]. Want people to fill gaps, do the job.
Need different personality colours in team.
Difficult to see that.
Those two [managers] same colours; different to me. A lot of yellows [L]. Disappointed with director.
Don’t want any more reds and yellows, want greens and blues, that actually do stuff.
But should respect others of different colour.
Lack of tolerance for difference.
Why nothings done, though blatantly obvious happening to lots of people, but still not accepted, because how it looks.
Big stigma attached, if senior manager, executive accused of bullying.
Don’t want it. Just reject it.
Even if know happening, won’t accept it. Goes back to de-escalation, how it looks, lot of time.
Managers don’t get enough support from HR; different pictures around room on that.
Threats of employment law etc. don’t help.
Non NHS HR different vibe, advice. Sometimes HR have ‘NHS think’.
Isn’t how done outside.
People bullied to extent can’t raise formally; will deny the bullying.
HR view always unless complains cannot do anything, so forget it.
Nobodies agreed threshold of follow up; in limbo.
Nothings agreed, so nothing’s happening. Inaction, sense of paralysis.
No HR suddenly felt free.
Managers did what needed instead of having to pussyfoot around.
Pander too much to rules.
People in wrong jobs.
Poor behaviour comes from fear not coping, can’t manage, or hate coming to work. Fearful to admit; need job.
Difficult to say is there something else?
Put **good face on.**
Recognition people in wrong jobs.
Others just **toddled along,** bullied because challenged things.
Didn't get on with peer, person employed me.
Witness to behaviour refused to supply statement/support despite high level role and responsibility.
Failure of responsibility
So disappointed.
**Tried to get me through performance.**
Could prove everything against them, tried to **charge me with.**
6 – 9 months ‘I’m not letting you…’ never took day off work.
Stuck it out. [hitting table].
Determined not to be beaten.
They're still there, still doing it to people, did it to people before came.
When **scared** display aggressive and unpleasant behaviours.
They're **scared.**
Need help, knowledge.
More senior harder to ask.
Difficult to challenge bad behaviour.
Like outside work; anything for easy life.
Managing someone a **massive headache.**
Get to point can’t go on like this.
‘to nip it in the bud’, say behaviour not appropriate if don’t deal with this, this will be next stage.
But, life so frenetic now; don’t have time.
As long as things **tick over** will carry on.
Until stops, because *the machine keeps going.*
Goes faster and faster and faster gives less time to enforce, lead by example, how things should be.
Very detailed HR processes about managing performance, bullying and harassment.
Needs more, **deep,** extra explanation to try ‘**nip it in the bud**’, at lower level.
If investigating, don’t have time to do things.
People don’t use **whistle blowing** policy; don’t trust it.
Soon as raise any concerns, it’s straight into disciplinary process.
Should be more advocacy process, before that.
Straight into formal process, puts people off.
Depends on communication channels.
CEs proud to say ‘not shy to deal with something if see happening, address things, but don’t.’
Rhetoric not reality.
Just ignored, ‘**shy away**’.
Lot of things shouldn’t get to that point; should have been **stamped down on.**
Just ‘**look the other way**’.
Everyone knew it, but nobody willing to **put their head above the parapet,** do anything about it.
‘Everyone else’s problem’.
Maybe lot of people in NHS just don’t have general management skills.
 Unsure how far to go.
Need to be given freedom.
Anti-bullying policy; few go through formal process.
Got to have audit trail to get to formal process.
Shows, behaviour happened, how managing it.
Some of it’s not managed properly, some, its accepted behaviour.
Or dealt with another route.
[Scenario] Lot of that around, people get away with it.
Isn’t unusual scenario, **played out** daily basis.
Witness on daily basis.
E.g. CE coming to Risk Committee.
Sits whole time, on blackberry, why **pitch up?**
No interest clearly; needed his input.
Just as **loud a message.**
See it so often, groups senior managers don’t have time to attend or you’re left waiting outside.
Put off, not told meeting re-scheduled.
Summoned without pre warning.
The same behaviours.
It’s about making a point, your credibility, control and power.
Cultural at the top.
Systemic disrespect/disregard for subordinates.
Rudeness.
Putting people down; display of power.
To humiliate presenter.
Presentation about negative behaviour created negative behaviour.

Organisational level very poor due to working, personal relationship issues. Personal issues with each other, anything goes wrong, it’s a major drama.

**Historically NHS always rather blaming.**
Not provided adequate support to staff.
Bullying is a problem.
*Stand in mind ‘blaming’ and ‘bullying’.*
Positive moves to get away from that, but don’t think particularly successful.
Lack of management skills, competencies.
Some rise to challenge, fight own way through.
Because lacking confidence/competence, be bullies, or bullied.
Particularly middle management, lack confidence and competence.
HRs hands tied slightly because changes, caught up with reactive stuff.
People not performing, bullying and harassment allegations.
Haven’t been managed in past now saying bullied, harassed by managers when asked to do job.
Lots of cases managers behaving badly; nothing done.
Come through appraisal.
Nursing cases strong personalities.
Lack skills/confidence to manage it effectively.
In NHS moved from place to place to place to see if behaviour will improve; it doesn’t, continues.
Don’t act timely way to protect other staff being affected.
Why not dismissed?
If go to tribunal, win or not win.
Whatever pay out, got to look at the bigger picture.
Fear.
Worth paying out £50-000 to get rid somebody going to be trouble many more years?
But that’s long term picture against short term picture.
50 grand now, or 4 years of under-productivity and disruption.
Longer in post, longer go from place to place to place to place.
Strengthens case if goes to tribunal.
Worked with so and so, didn’t tell me this.
Needs strong manager to confront, have difficult conversations.
Culture of organisation set by the ‘top table’.
Senior managers, execs responsible for setting the culture.
Leadership needs to show what isn’t/is acceptable.
Senior managers should be managing.
Things don’t go on in isolation, lots of people will have known.
Comes down to poor management, nothing more, nothing less, nothing more nothing less.
Training, experience of managers; fear factor.
Fearful if manage, staff may go off sick.
Better someone disruptive or below par performance, is 50%, but in job, than off sick.
About the system, comes back to training and confidence.
Fear accused of bullying and harassment, investigated themselves.
Performance review immediately bring in bullying and harassment.
Under pressure and stress.
[Responsible?] Managers, everyone, have to set standard.
How treat/speak to, each other as individuals, if don’t have very basic respect just escalates.
Expectations should be laid down by management teams.
Culture should be established very early on.
Individual responsibility.
Management set culture within which individuals operate.
Way managers deal with or not, negative behaviour, further setting culture.
2 individuals at each other’s throats.
If ignored, would have been a cancer, have simply ate its way through team/organisation. Responsibility to step in, sort it out, so could move on. Manager has to take initiative, set the culture where everyone else operating. Managers decide what is acceptable, because people’s threshold different. Needs to be some arbiter what is acceptable. Again, poor people, communication skills. Message from organisation where just shunted people around, haven’t dealt with issue. Allowed such a culture, so long, very difficult to change. Takes long period of time if swimming against that culture; seen as abnormal. In NHS very gentle in how speak to people; could be about management style. [Why resisting?] Strong underlying culture, of bullying of managers, where over strong, not necessarily, staff side. Some teams, strong individuals effectively leading team, undermining management. Not got strong enough management, so rather than confront, allow it to go on. [Not allowing, resisting] Helps creativity of workplace, or teases out those people going to survive in organisation, weeds out those people who won’t? It’s no good being a shrinking violet? Survival of the fittest. Can’t think of active hostility to change, only inertia. Rather than do something, won’t do something. Too much hassle to try and make changes; but not really active resistance. If positive behaviour not coming from the top; individuals on Board don’t have people skills to communicate personal level other than dictates come out. Not behaving positively, taking interest in people, valuing what people do in organisation. Are not ‘out and about’, are remote. People aren’t seen as individuals in a positive light Difficult to see how things can be put in place. All ever hear is negative; got to save more money this year.

Adversarial – Clinicians v managers. Team issues; weren’t addressing issues. Wanted way getting hands on some systemic organisational issues, to work more effectively. Problematic complicated/complex situations trust thrown up. Stimulating, interesting work Very committed, currently under threat of annihilation. One to one counselling fine, but limitations. Symptoms in context of working relationships broken down. Individual and context; might work within entire team Mediation, 2/3/4 individuals. Critical incident stress debriefing. One to one manager support. Training. Clear managers not always equipped, able, knew how to resolve/ deal with problems, difficulties. Negative behaviour, poor working relationships, need for support. Lot of work teams that struggle, not getting on. Disagreemnts, can’t work together. Can restore feeling personal power to teams. Current climate and changes; very disempowered. Enables teams; take things forward themselves, restores that. Ownership; ability to change environment working in. Lot of teams changed, put together, restructured, getting opportunity, allowed to grieve about process going through; have recognition. Pain of constant change/restructure. Recognition of humanity in a system/machine. Struck how powerful organisational support is, hopefully powerful therapeutic way. Guess, very good value for money. Conflict, difficulties, tremendous financial cost. Off sick, productivity, performance may deteriorate, patients may be at risk; quality of care. In absence of informal interventions may rely on formal processes. Team designed to help; reducing costs.
Develop processes of recognition, find meaning in work doing together. Not just HRM discourse. Not interested in instrumentalist way doing things; aligning values or visions. Interested in quality of conversations. Main methodology; getting people to talk to each other, explore what going on between them; effective. Underlying causes, issues, things like power, very interested. How power gets expressed. Want people to feel good about being at work; have sense of meaning. Not just to prop up performance indicators. Difficult, complicated important jobs, want to support them. Conflict/negativity arises inevitably. There to help, come alongside. Conflict inevitable part being in organisation. Patterns, repeated difficulties arise, particular tensions with management. Also repeat attenders; different problem different person. OST always informal. Compliments, often expensive, difficult formal processes. Encourage informal, cost effective resolution, rather 6, 12, 18 months investigation, pain, possible lawyers etc. Same themes arise, not sure same problems. Organisational process iterative, repeats itself. Conflict is one of themes. Over focus on outcomes, targets ways unintended effects, like way people relate to each other. Can mask, what's actually going on, people engaged in ongoing way, how to get along, relate. Transformational outcomes always looking for are emergent in those relationships. Influence/intervene in complicated difficult situations where people hating each other or things are going down the pan. Get in there and sit with people. Collaborative way, try and influence outcome. [Repeated neg beh why nothing done?] Common enough; never want to make it formal. Got to make formal complaint. Frightened, scared of own position, employment, position within team, seen as one raising their hand. Saying problem in team, want something done. It's like whistle blowing, won't do it; risk. Talk of change, restructuring; more afraid. Try to protect position. By stepping outside of that, putting themselves at risk. Not happy, redeploy, something different. Some perceived more power than others. Perceived power of person complaining about affects likelihood of action. Some situations get changed others, wouldn't dare go there. Positioning is around person being complained about. Some difficult conversations possible; confront and effective change. Open conversations, mediation, calling to account. But can create crisis, for person, and group around person. Commonly very senior managers, group has to re position itself. French sociologist Robert Michaels: Tendency for apex organisation, at first, espoused interest protect whole workforce, organisation. After while look after own interests, own particular group interests. Apex, senior management group, start to protect each other, look after what's good for them. Challenge senior person, challenging whole group that sustains their position. Much more tricky, complicated. A counter, always another side to story. Very different perspectives same situation. Formal investigatory route often fail, too scary. More formalised approach, investigation more polarised views. Split into good and evil, side taking. If resolve informal level might, have more chance to get what really going on.
Bad manager why nothing done?
Can exist, but usually more complex.
Manager asked to do very difficult things.
_Agendas smashing together_, get very personalised.
Through trying to _talk it all out_, get the complexity.
Sometimes staff don’t need to see manager all evil.
Sometimes manager can learn how staff experiencing them.
Behind negative behaviour and conflict are _clashing ideologies_.
_Clashing ways_ of seeing the world.
_Clashing of what makes sense_ organisation supposed to be doing.
Conflicts between, market and operational values.
People forget their roles together, forget seeing world in different ways, becomes deeply personalised.
Conflict is to do with where are, what role, how seeing the world.
Lot of work trying to de-personalise that.
[B&H, so low] ’Didn’t have to think about it’ giveaway phrase.
Painful to think about things.
Peer group help to collude.
_Some live in kind of bubbles._
Will only tell them what think want to hear.
Difficulty, middle management, very reliant on jobs.
Constant reorganisation, have to reposition themselves.
Not highly invested in _telling boss things are shit, everyone’s going down the pan_, morale is low.
More likely say everything’s great, going really well, performance on target, statistics prove it. [Big grins]
Look at screen, see how well doing.
_Rhetoric not reality._
Departments winning awards, know; disastrous shape.
Senior management convey _very rosy award winning picture_; reality can be very different.
Got to.
Can pull it off, can do it.

6 Performance manage then comes to bullying.
Plenty examples senior people known to be very difficult people.
Can victimise people, silence and destroy partnership arrangements, working relationships.
People on sick leave, result of behaviour, [culprit] often protected by organisation.
Not strong enough to tackle, or organisations still feels more value out of person.
Don’t get rid.
Scotland don’t have redundancies, another situation would be sacked, but much more difficult.
Can be sacked, but performance takes longer; long time.
_Bang on about_ appraisals, PDRs, don’t always get done, get done properly, and reviewed properly.
Then only place to go down performance review.
Formal, union rep always brought into room, come up to contracting legalese nonsense.
Has to be informal way able to say need to solve problem.
Not many brave enough to say that.
Can still lead to...is this informal, formal?
Bring a friend, rep.
[Complaints nothing done] ’Because know where the bodies are buried’. [L]
Histories between people, people know people.
Medical school, university, together, same church. [L]
A history with people; they know stuff.
Sometimes know bad behaviours by other people in system.
Know, got off with someone else’s wife.
Or be stuff going on, the _unofficial culture_ of organisation.
People don’t have to go, protected, tolerated, until perhaps do something so outrageous, no going back.
But, still better organisation to have person.
Lots very opportune marriages between people, keeps them in quite well positioned, places [L].
Deals are done.
Deals are done, don’t mean quite like royal families, but deals sort of done [L].
People can, do stay in positions.
Early retirement, or might go at some point. But not made example because view will be have served ‘the system’; overall good. Doesn’t get challenged enough. Commissioned 4 investigations. Entrenched. Entrenched, bullying and harassment behaviours years and years, nothing done. Previous managers bullied by staff, I’m thicker skinned, no way can watch, tolerate it. Can completely understand why not done it before. Not bullied, element of harassment from unions who supporting staff and from staff; have to stay really strong. Get barrage of every single thing do, scrutinised because waiting to get you. Big onus on staff supported. Fine, but has to come point where clearly bad, unprofessional behaviour, shouldn’t be supported. Entrenched behaviour. Really hard to prove, hearsay evidence; seen or heard this. Harassment and bullying sometimes very subtle. Sadly, part of organisational culture. Bullied by director, held my own but was bad, to extent people cuddling me after meeting. Behaviour at more senior meetings, so ricocheting down organisation. Same director torn apart, realised where his anxiety came from. Like going home and kicking the dog. Not a bully, lovely man, but was pressure. Everybody in disagreement, but frightened to speak out. Saying should said something, but too frightened’. Horrible; comes at all levels, but starts at the top, permeates down. If there isn’t caring for staff, involving them. Goes with ‘command and control’, bullying part of it. Every level feel got to perform. Commission investigations because know director/HR manager supporting. Last job, line manager disgusting bully. Behaviour accepted by everybody in SHA. Felt only one to challenge and complain. Directors; have you never worked with someone like her before? Hang on a minute why is this my fault she behaves like that? This is her disgusting behaviour, yelling at people across room.

Int | Categories for Framework Theme 10. Negative behaviour (Interviews)
---|---
1 | Staff not treated well. It’s if your face fits. Don’t want to know it goes on; very awkward. Could snowball. Management not forthright. Bad example of area. Not always senior bullying lower person. Some people, their nature, causes atmosphere. Senior managers not dealing with it. Don’t want to be one raises it. Told doesn’t happen. HR said no H&B in trust. Will listen, don’t always know what to do. People don’t know what doing; massive family problems. Not a nice subject; will be lot more in future. It’s just so different.
Not interested.
If don't do anything is 'swept under the carpet', forgotten.
Not always proactive, no.
[Good practice?] Not for long time.
If behaviour not right gently properly, have a word.
[Why neg beh?] No idea, maybe *makeup*.
Not right person in job.
Doesn't reflect well on organisation.
Don't want to know anything untoward happening.
If tackled, *snowball*.
If do it on one, another *perks up, pulls out the pile*.
Like to 'let sleeping dogs lie'.
[Why resisting action?] Can see that.
Just got to admit happens.
Nobody is infallible.
NHS has got problem.
[Why don't admit?] Won't! [L], haven't got the guts.
If admitted - maybe *called over the coals*.
HR stand up for managers.
Is bullying, 2/3 managers, HR around table.
Bullying at *top level*; HR in middle of it.
Scared of H&S and B&H.
Don't want to admit.
Don't know how to deal with it.

**2**
Focus on policies/discussions with managers.
Avoid discussing individual concerns.
Don't want to spend time, money supporting staff; tight budgets, constantly saving money.
Lack of good practice.
[Why negative behaviour?] Upset in past.
Staff needing to be seen proactive to *move up* in organisation; unsupportive to other staff.
Self-interest affects behaviour.
Require negative behaviour to *move up*.
[Key blocks?] Money, time, belief policies in place.
[Why?] Constant organisational changes; emphasis on budgets, not dealing correctly staffing issues.
[Why resisting action?] Focus on budgets, costs.
Lack of realising unhappy workforce worst effect on productivity.
Homophobic, colour prejudiced.
Tired staff.
Constantly justifying existence, leads to stress.
[National staff survey figures?] Constant org change, money/time cannot be spent on staff issues.
Staff constantly harassed about work/jobs; great deal stress.
Staff bullying others (intentionally/unintentionally).
Policies in place, but staff not aware.
Do not realise can do something about B&H.
Managers bullied by bosses to achieve/save money, becomes way of working.

**3**

**4**
Significant cultural shift.
Non punitive to punitive.

**5**
Developed from originally *benign dictatorship run by clinicians into malign organisation controlled by professional managers*.
[Responsible?] Personnel, taken over by "human resources"; own negative behaviour.
Resort to disciplinary procedures, politically correct action soon as any dispute.
Try to prevent involvement of reps.
[Why?] Want to be in control.
[Key blocks?] Clinical staff and managers, key block attitude of managers, prefer to get rid any staff who disagree with them.
[Why?] Matter of who is in control.
*Fight between managerial dictatorship and professionalism*.
[Why resisting action?] Managers in denial to own role in creating bad practice.
No good practice.
### Why negative behaviour?

Medical staff behave badly when tired, hungry, stressed. Long working hours, poor dining facilities; workload increased. Setting of line managers above medical staff; often stressed.

**[Why malign? Supposed to be caring?]**

Clinical teams, caring professions, managers not. Activity around reducing costs created by caring professions. Condemn patients to poor care, neglected.

**[Managers] stress staff who wish to help patients.**

Clinical staff appointed as managers, management courses, told to forget are clinicians. Loyalty must be to management. Taught to manipulate, delegate. If don’t relieved of post. If join in with management lies, rewarded, more pay etc. Effect of management is malign, damaging to both patients and staff, reputation of public services. Finance before patient. Conflicting drivers/motivations.

### Responsible?

**[Responsibility] Line managers.**

All individuals responsible for behaviour at work. Once escalated to HR long standing issues much more difficult to resolve. Hope informally resolved without intervention, or counter claims against individual e.g. performance issues, other complaints. Counter claims most often when manager complained about. 

**[Why?] No resources.**

Most refuse to buy in mediation expertise. More important things to do. HR do not have skills/understanding. Complaints difficult to resolve, take long time. Complainants don't get much sympathy, despite policies.

**[Key blocks?] Time, resources, understanding.**

**[Why?] Significant pressure on public sector organisations.**

Problems worsening. HR departments reduced. Managers preoccupied with cost savings/targets. Atmosphere more tense, less tolerance of staffing/personnel issues. Not priority. Most take view, if employees unhappy should leave.

**[Good practice] Yes, in past mediation from ACAS, other organisations; doesn’t work.**

Most satisfactory outcome one person moving work locations. Relationships broken down, formal complaint made, too late; never seen relationships rebuilt. **All doom and gloom** by time members contact us. Outcome reluctantly accepted, not issue resolved. Once member made complaint not uncommon complaints in future. Hypersensitive from experiences or adopt ‘victim’ at work persona? **[Why negative behaviour?] Personality clash, power/control, insecurity and insensitivity.**

Policies: actions subtle, build up over time, only obvious to person etc. Reality once complaint lodged, too often declared lack of evidence, issues not sufficiently serious (? R&J).

Rhetoric (policy), not reality. Look for tangible evidence, witnesses, how other grievance/complaints work. Often cannot be applied same way for bullying.

### Bullying

Trust awful, **staff are bitches.** Derogatory remarks to others. One day 3 staff saying “I am being bullied”.

### Difficult to raise re negative behavior

Treated inappropriately by managers. Negatively impact on jobs, prospects. Give their all, go above, beyond job descriptions to give best care possible. Often clinicians **DIRECTED BY RESOURCES INSTEAD OF CLINICAL NEED, CAN CAUSE CONFLICT.**

**[Responsible?]** Management, for setting clear guidelines expected behaviour. Ensuring adhered to by ALL staff even managers.
| Page 9 | Experience mostly positive, unless relationships between TU’s, management already strained.  
| Key blocks? | Need clearly defined policies about expectations, ensuring adherence all staff, including managers.  
| Good practice, where commitment to providing good leadership, managers well trained, truly respect staff.  
| Staff need to feel valued, listened to.  
| Why resisting action? | Vested interest, poor leadership.  
| Why negative behaviour? | Whole array reasons, ill health to feeling vulnerable to outright bullying cultures in workplaces.  
| Principle, | managers communicate non tolerance most negative behaviours; is often frustrated.  
| Want to close issue down quickly to reduce negative impact.  
| Page 10 | Culture of uncertainty leading to rise in negative behaviours.  
| Impact on wellbeing/mental health.  
| Unprecedented level work related stress, workplace bullying.  
| Discussed, 2011 Conference.  
| Very poor management of bullying.  
| Racism; not well managed.  
| Management of bullying in NHS long term problem; lack of expertise.  
| Increasingly training own mediators.  
| Non-professional mediation frequently makes matters worse.  
| No redress for perpetrator, expects target continue in challenging environment.  
| Responsible? | Rarely well-structured management of negative behaviour.  
| Line manager/department manager responsibility.  
| Normally totally untrained, unable to bring satisfactory resolve.  
| In the light disproportionate level negative behaviour from more senior positions than target, higher authority looked to assist, or HR.  
| Skills woefully lacking.  
| Personal politics frequently make it harder for target to raise issues.  
| Mixed experience raising issues.  
| Some employers totally engage, others not know what to do, poorly manage.  
| TU rep present, member more confident, advocate supporting, try ensure proper management.  
| Cases reps need further training to ensure management manage appropriately, expediently.  
| Growing desire organisation use ‘non-professional’ mediators, volunteers, to assist dispute resolution.  
| Makes matters worse.  
| Perpetrator not made to confront issues, training needs.  
| Target expected to continue working with perpetrator.  
| Mass training need, how to manage dignity at work issues, every level.  
| Tightening of resources and redundancy programmes targeting administrative grades, expertise diluted.  
| Difficult to raise re negative behaviour? | Reluctant to bring bullying to management until target not able to cope.  
| Many targets personally resolved to resign if process fails.  
| Uncomfortable raising issues, afraid perceived ‘unable to cope’/’weak’, not have serious case.  
| Concerned about politics of case, how line/department manager/peers view.  
| Issues of confidentiality, own mental health, ability to cope with process.  
| Why neg beh? | Range of issues; pressure, stress, politics, fear, other external factors.  
| Mobbing, is about fitting in, peer pressure.  
| ‘Serial bullies’, as defined by Tim Field.  
| Power and control, especially where people competing.  
| Key blocks? | Do not have skill sets for identifying issues.  
| Lack of knowledge how to manage.  
| Organisational-wide training needs in positive and negative behaviours.  
| Need all employees to understand all have responsibility to raise issues of negative behaviour.  
| Patient, member of staff; no one should be a silent witness.  
| Questionable whether new whistle blowing procedures will assist.  
| Why? | Training issues, loss of skill, poor understanding.  
| Not seen good practice.  
| Cases not brought where good practice.  
| Previously worked, good training/management process, still issues, but one of best. |
[Why resisting action?] Unwilling to address issues raised, mass ignorance, intent in not managing situation.
Main reason organisations uneducated, don’t know what to do. Poor procedures, practices. Cases don’t fit into grievance procedures. Re [Situation] Hard to comprehend why not want to reach negotiated settlement. Poorly advised by lawyers or could not see discriminatory practices, therefore believed would win ET. Suspect reluctance to settle matter, believed would be admission was a problem. Trust not expecting level of award granted by ET. Real issues about stewardship of public resources. Hard to read minds those who defend the indefensible! Some organisations clearly incompetent or ignorant how should effectively manage cases. Some are wilful, way manage cases. Witnessed mismanagement way to see someone break or leave. Sometimes methods used to protect perpetrator. Absence of sufficient legislation, employer less concern of consequences, particularly when not discrimination case. -- sector, witnessed there.

11 Most aware of negative behaviour, dealing with it daily. Occasional raising with managers. [Responsible?] Everyone. Wherever possible dealt with immediately when witnessed. If problems escalate, bring to attention higher management. Raised concern formally once. Staff member bullied. Not addressed fully, left. Behaviours could have been addressed earlier; delay. Become much more serious before dealt with. Disciplinaries, dismissal occurred. Support/training option if dealt with earlier. Don’t know why happens. Reluctance of manager to acknowledge, deal with situation. [Good practice?] No. [Key blocks?] Difficult to deal with; encompasses whole ethos work environment. Workplace supposedly recognises diversity/rights of individual. Rhetoric not reality. Needs to work all ways. Staff need to feel valued/appreciated. Employment Law/organisational policy complex. Clear processes, very daunting for inexperienced managers. [Why happening?] Easier not to acknowledge. [Why neg beh?] Great deal intolerance for differences of others. Only excuses work is very hard. If someone perceived not pulling their weight can be unfairly criticised. Small town, many staff ‘locals’; insular. Workforce demography changed; different nationalities. Opportunity for display negative behaviours. [Why resisting action?] Easier to ignore.

12 Lot of negative behaviour all levels. Happens low levels. Whole groups affected. Opposed more senior level, just one individual. Number of incidents, negative behaviour, spread to rest of group. Effect on whole team. People leave, become stressed, sick with stress. If happened to individual once, repeatedly raise concerns. Frequently lose confidence, feel responsible, for negative behaviour. Almost the victim, opposed to issue addressed. Very difficult to raise issue of behaviour, think, nothing’s going to happen.
‘It’s me’, happened before.
‘Very delayed’, go on forever.
Sit and listen, but perception don’t often give feedback.
Not always apparent action.
Group of 10, 5+ to HR, and manager to complain about behaviour.
Nothing appeared done considerable time.
Individuals off sick, some left.
Eventually, restructure, moved into job, no line management responsibility.
Complete havoc caused.
2-3 years hell for individuals and department.
[Why no action?] Line manager didn’t feel was problem.
Individual producing ‘the goods’, delivering what needed.
Line manager felt were doing ok; despite evidence.
[Key blocks?] Lack of awareness.
Lack of training, what constitutes negative behaviour.
Perception with public service, job for life.
Private sector, have to work more diligently.
In private sector often gasp what happens in NHS, how staff treated.
Private sector, much clearer objectives.
Often NHS lack of regular meaningful appraisals, clear objectives.
Lack of clarity what meant to be doing.
[Good practice?] Team of nurses, lot negative behaviour.
Asking staff to do things often didn’t want to do, should have been doing.
Lot of negative behaviours from members of public.
Stressful.
Raised with D of N, contacted Tavistock Institute.
Counsellor to work with team, really, really, helpful.
Open confidential environment with counsellor, could talk.
Positive feedback, really helpful.
Acknowledgement was alright to feel.
Alright how we felt about what was happening.
[Why negative behaviour?] Stressed.
Often don’t know how to deal with it.
No support themselves, no role models.
Those that shout loudest get the most.
The organisation, people, let it happen.
Individuals, managers, ‘turn a blind eye’.
[Why turn blind eye?] Too much hassle, unless formally raised, not a priority.
Outburst dealt with, if really aggressive.
Often more harmful, covert, snides, comments, nobody else in conversation, around to witness.
[Don’t they see impact?] Often too black and white.
Don’t see overarching, if happy group staff, morale is high.
Issue with wards, almost, always, [stressed] down to leadership.
Not just ward sister, but group senior long term serving staff, behave certain way, in a clique.
Often clique, just go out running together, others excluded.
Not always professional.
Group stay there years.
People come and go, get experience want, move on.
Impact on patient care?
It does.
Go on ward, nurses sitting by station ignoring people.
If nurse in charge every shift, ward sister picked up every time somebody ignored somebody coming onto ward, patient asking a question.
Behaviour would change.
[Why resisting action?] Only reason, suits organisation, let behaviour continue.
Organisations resisting, it’s the profile raised in organisations.
Often worried if ‘open a can’ [L], ‘the worms will come out’....[L]
There are lots of worms.
Volunteer role, when started, definitely anxiety at the top going to open something, unleash something, going to be unpleasant, but didn’t.
[Why worried?] Knew was bullying, obviously an issue. Staff surveys, [bullying] something the NHS does. Organisations last 10 years fought back; staff survey (R&J). Justified bullying and harassing behaviour not big problem, only percentage sent staff survey (R&J). Only percentage of that responded, not capturing whole organisation (R&J).

[Experience] A 'witch hunt'. No synergy within, between organisations, Insular. Scapegoat, 'witch hunt'. Continually changing executive team easy to make scapegoats of those low down the pecking order. Last boss started, told not performing, given remit to get rid of me whatever way could. Same grade as him, always problem. Witch hunt word wasn’t my word, union rep. She has just resigned, taken another job lower grade, because had enough of behaviour in trust. Meetings with boss and HR, set on taking me down capability route. Never in 32 years near going down capability route. Every time set objectives, achieved them. Changing goal posts. If something happened, my fault, not project sponsors fault. Blame/responsibility shifting down. Wanted to get rid of me, wanted me out. Voluntary severance. Witch hunt, wanted me out. Support/encouragement of CE.

[How justify?] Not performing in manager role (R&J). Ultimately case ‘face not fitting’. [TU] felt very strong case for tribunal. Director lied number of times. [Why?] Easier, wasn’t going to take blame for any failure. Each executive number of projects. Main deliverable, finance. As clinician, clinical side much more important. Understand importance of money; comes down to cost. [Real motivation?] Driving them, her remit, objectives from CE, things have to deliver this year. If not delivered not achieving in job. When project doesn’t deliver finances, blame project manager. Didn’t have strength to fight in coherent way. 95% certain told to get rid of me when started. Never in all years worked come across anything like that. No fairness/justice, but don’t get so upset. Long service, shouldn’t mean anything but always good appraisals, good feedback. Suddenly no good. Made to feel no good. When put your hand up, having problems, expected support. No support. Suddenly taken down capability route. Nothing worse than not being able to, not having voice heard. Not able to give voice; in position can’t. No voice last 6 months until got out. Takes a while to deal with that.

13 Responsible?] Ultimately CE, day to day sits with managers. HR responsibility strategic, organisational level. Managers want details/names, often reluctant to act without specifics. Managers know staff, may pre-judge issues. Views affected by role, value placed on what do. Unwelcome behaviour in valued member of staff excused, dismissed. [Difficult to raise?] Don’t get involved until formal. Deal with specifics. When raise, organisations want matters raised in accordance with procedures e.g. B&H policies. Formal complaints, generally ineffective interventions. Mediation sometimes offered.
More effective if offered early, before complaints formalised.  
Often rejected by complainant and person(s) complained about.  
Often want “justice” not “resolution”.  
Managers often little time to devote addressing informal problems.  
Lot of time trying to improve relationships to little obvious benefit.  
Even highly skilled managers may lack skills, training, support to intervene successfully.  
Primary focus patient services, not staff relationships.  
[Key blocks?] Lack time, large workloads.  
Lack of information, training for managers on effective interventions.  
Lack of effective management skills generally.  
Do problems in relationships develop/get out of hand because not well managed?  
[Why resisting action?] Not aware of this.  
Organisations deal with take issue seriously.  
Keen to address it.  
Limitations of resources, time, personnel.  
Power plays a role.  
Sometimes doctors difficult to manage.  
[Good practice?] No, only involved when things go wrong.  
Seen managers/HR occasionally trying to resolve matters early/informally, to no effect.  
Members still resorted for formal procedures, refused mediation.  
[Why negative behaviour?] Wide variety reasons.  
Some people very confident, assertive in way conduct themselves.  
Lack insight into effect on other staff, particularly those depressed, vulnerable.  
Others unhappy in work, feel ignored, criticised, powerless.  
Unable to get what want, little control over work.  
Factors outside work, experience stress, make them aggressive.  
Lacking insight into own behaviour.

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14

**Top down culture.**

Every unit NHS, microcosm.  
Why want to do Whitehall’s, DOHs bidding; afraid not to.  
Translates into bullying problems.  
Way of life, way some units in NHS operate.  
Part of daily life.  
All organisations very bullying.  
Endemic in humans.  
Humans are competitive.  
Need strong leaders, counter cultural, to keep set of values, value each other.  
Needs to be understood high performance comes with conflict.  
[Non NHS organisations] Bullying, but, superb results produced. -- dreadful, bully, but superb results.  
Those around him, who did want to do good.  
In work place all about caring, hopeless.  
End up way NHS is now.  
Don’t know percentage interactions that nature, common place.  
Report discussed bullying.  
Bullying organisations, _shadows of each other._  
Cannot get _purity one part of system, if another part impure._  
Doesn’t work that way.  
Other aspect, in public services disciplining people enormous problem.  
Flip into, not disciplining me.  
Though deserve it, call union rep, report harassment by management; big problem.  
Why probably sickness, absence big problem in NHS.  
[X trust] Dysfunctional place.  
Core of staff, nurses, doctors, do not want to serve hospital as institution.  
Do not want to serve patients.  
Think it’s for them.  
In [X Trust] bullying played enormous part.  
[Bullying] Enormous part in failure to uncover [problems].  
SHA tried to bully HCC into not investigating.
Tried to bully Dr Foster by using other academics to rubbish mortality statistics. Playing massive part in CQC as well. If regulator bullying, what chance do you stand? [Example of situation] Sorry tale. Again goes right to top of NHS. Grim. Current people running NHS not able to change it. Are people who shaped it. Organisations are institutions, don’t care very much. Priorities set for them elsewhere, bullied into executives. Organisations don’t see bullying, as bullying. Is way do things round here. Once whole organisation polluted with awful set of values, how change it? People don’t realise what they’re doing. Organisation, in Whitehall, say, whistle blower, how dreadful. Set up help line knowing absolutely nothing is going to happen. [Nobody wants to face it?] No, too difficult, it’s uncomfortable. [Report dignity of care] More of same, leaders must do this, need to do that, have to. Keeps off really uncomfortable subjects. Avoidance. NHS Confederation body, members NHS hospitals, other trusts; shouldn’t exist. Conference June, talking to themselves. Could fix it, at a stroke; why don’t they? Where leadership failure is. [What’s stopping facing up to mess?] Part of the game? Who going to be first one? If someone starts to face up to it, not in position of ultimate power, the system will eliminate them. Nobody to go to senior level. Utter, absolute mess. Can we do something? Even MPs won’t help. Won’t know detail of game, but know is game won’t be able to play. Powerlessness of politicians. Respected MP saw complaints building up, did nothing. Nobody cared. End 2005 NHS 2 billion pound deficit. Tidied up very quickly; by bullying, forcing to meet financial targets. You will do this. Brutal reality of top down culture. Most workplaces lot of nastiness. In NHS nasty culture definitely enforced from Whitehall. Overriding failure to deliver no harm health service, technical reasons not behavioural. No agreed overriding, overarching objective, explicit, every entrance understands. Recruiting wrong people. Signal sent to youngsters Lancelot Spratt lives OK. Get rewarded for appalling behaviour, clinical excellence awards. When young impressions from people meet, is way it goes. Interviews, university, shrug of shoulders. You kill people, is way it goes. Even before get to appalling treatment of elderly, people with dementia. Deniability; few people in healthcare willing to admit to that. In UK NHS some attitudes [contempt for people] may always been there. ‘golden age’ or no ‘golden age’, but got worse. Big divide between professions, public and patients. Clinicians, working day one long rampage [LoL]. Gods aren’t they? Just stuff their mouths with more gold. Give biggy clinical excellence award. Bullying rife lots [sectors] but can have good cultures, safe, supportive of new people, excellent bosses.
[In SMD/ego-defences - NHS train, going over complicated sets of points rattling, shaking, wobbling a little bit, but expect to get back on track, because will just deny everything.
What say when report comes out?
Done all of that, did it, done it, fixed it, did this look.
Truth of matter nothing been done.
Not sure -- knows what he needs to do.
It's humans, large extent.]

16
Lots of bullying.
Staff scared to speak out in fright of retribution.
B&H similar to anger issues.
Primitive response, are not very clever!
Bullying.
Some managers don't have skills/ability to effectively manage conflicts.
Probably exacerbate conflicts.
Starts conflicts through favouritism, unfair distribution of resources and/or incompetence.
Difficult to approach manager.
Staff behave negatively as don't understand human behaviours, id, ego, super ego.
It's about power or superficial issues.
[Responsible?] Junior and senior managers.
CE and directors too detached from front line.
Organisational responses 1) denial 2) dismissive.
Push things under the carpet.
Senior managers don't want to deal with junior managers, reflects poorly on organisation!
As Union Rep, never seen appropriate, proportionate response to disciplinary issues.
Key blocks, time, leadership, arrogance, power.
Inadequate selection processes.
Appointed managers 'yes' written on forehead.
If supposed leaders not able to address negative behaviours their level, as role models, no hope for junior managers to tackle problem.
Issue never be resolved, endemic.
Got to start with leaders, doing right thing!
Disciplinary process bias way resolving staffing issues!
Too much weight on punishment, don't take balance view!
When make mistakes, HR or management, it's ok or plausible! (R&J).
You make mistake, will be targeted!
Different treatment for different groups.
Bullying pure and simple!
Individual staff easy target (united stand divided fall).

17
Bullying intolerance of failure to meet irrelevant targets, consequences don't matter.
Bullying management culture.
SHAs bullying to enforce what comes from politically driven centre.
CEOs, other managers bully and suppress staff.
Inadequate managers adopt bullying, autocratic/repressive management style.
Dominant and pervasive bullying culture conflicts with need to protect whistle blowers.
Oppressive.
Bullying can occur anywhere.
In Scotland, emerged into public sphere! [re Lothian Board].
Suppression of bullying, "negative behaviour" (by managers and clinicians) widespread.

18
[First theme]
Culture of fear pervades NHS management.
Fear.
Culture of fear pervades NHS.
Problem of centralisation.
Use centralised bullying tactics via very strict management system, dominated from centre, to regulate system.
[B&H?] [Centralised political control] That being wrong, inevitably leads to DOH wanting good stories.
Anyone trying to do well, do good things, may come across problems if shows up results politicians/No 10 don’t like.
Very little attention paid to patients, although *lot of noises* made about that. Rhetoric not reality.
NHS managers *look up, not out*.

19 Bullying.
Passive aggression.
Pretend to go along with it, but don’t do anything.
Different parts NHS very disrespectful of each other.
Each *institutional building blocks ‘slags off’ the other building blocks*.
It’s been ‘*divide and conquer*’.
Hospitals ‘*slag off*’ GPs, vica versa.
Most people *slag off* managers.
Discipline* always been in a corner*.
Lack of respect between different professional groups, different institutions
Worse?
Senior manager, get moved, often promoted.
Why promoted?
Look after each other.
CEs look after each other; may be them next.
Argument use, are the accounting officer (*R&J*).
Have to account for money, *buck stops with them*.
Use that, *modus operandi* where treated differently from anybody else (*R&J*).
Look after themselves.
Still getting massive payoffs.
Other people not getting payoffs.
Not going into it, libellous situation.
Could list individuals, *screwed up*, moved out, put somewhere else, often more responsible bigger job, more money.
Corruption.
Movement CEO to charity?
Wouldn’t want to comment.
Sometimes offered to another organisation, *free good*, salary being paid.

20 National staff surveys, bullying in NHS.
Organisation as whole far too tolerant such behaviours.
More difficult to challenge if most senior positions do not lead by example.
Paradoxically often very good, local level, high commitment tackling dignity at work issues especially within/between work teams.
Often good HR support.
Some individual Trusts/PCT’s cultural issues, organisational responses not as robust.
Often clinical areas greater tolerance of negative behaviours.
Organisation under political control for many years.
‘*norms*’ of performance etc., may get in large business, what NHS is, do not apply.
SoS concerned with reputation and *suppression of bad news*.
Inevitable culture *spill over* into Civil Service.
Even where SoS may put patient care at top, SoS’s do not last long enough to counter cumulative effect culture over years.
Do not win votes for NHS but could lose them.
**Bury bad news**, claim all one off incidents etc. becomes norm (*R&J*).
Manager persistent neg beh nothing done] Not unusual in NHS because of culture.

21 Negative behaviour not norm, but not uncommon.
Some individuals particularly lacking in interpersonal skills, some personality traits lead them this direction.
Aspects work environments make behaviour increasingly more likely.
Poor management development, performance targets, diminishing resources, job insecurity create atmosphere lends itself to negative behaviour.
Organisation beginning to understand significant negative impact of negative behaviour; but long way to go.
Two high profile dignity at work cases.
Alleged perpetrator identified, left organisation.
Colleagues known to exhibit this type of behaviour, no one addresses it.
Organisationally policies in place.
Additional staff support.
[---] Service and confidential contacts for workplace bullying.
No matter how good policies come down to one brave individual prepared to talk about it; extraordinarily difficult.

[---] service safe neutral space to think things through, whether bullied, witnessing bullying or accused of bullying.

[Why not dealt with?] Sometimes behaviour serves organisational need. Perceived as people can make things happen. Behaviour is ignored so long as continue to 'perform' e.g. bringing things in on budget, making difficult cuts in services.

One person serves ‘attack dog function’.

If challenge her, probably need to leave; is quite powerful.

Staff too frightened to raise allegation against such people, make life very difficult.

Almost need ‘class action’ group of people acting together.

These people can have favourites singled out for special projects, promotions.

Divide and rule going on.

Sometimes senior people don’t know what to do, so unaddressed.

If addressed, sending on training course rather than ongoing tricky conversations about behaviour change.

Busy managers often put in too difficult box (R&J).

Another approach, move people on where do less damage; don’t involve managing staff.

Evidence can be patchy easy to dismiss (? R&J).

Series of incidents over time, takes some focus to keep accurate records to tell story.

Where behaviour addressed, negative stories range of places, hard to ignore.

Prompts action is high turnover and/or sickness, financial implications, so hurts organisation.

[Get rewarded] Some very good ‘managing up’.

Good impression to those above whilst very unpleasant to those work for them.

Seen several occasions.

Complicated; conflict is fascinating. Working in NHS, not all bad.

[Neg beh] It’s horrible, vile, but is not everywhere, not everybody.

Very often, high performers some behaviour in repertoire.

Divide and rule going on.

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Difficult for organisation to say produce the goods, not always sure about methods.

| Negative behaviour, three forms. |
| Conflict between peers. |
| E.g. Rival consultants conducting feuds may last years. |
| Conflict between hierarchies. |
| Strong perception of B&H from management to staff. |
| Often result of weak, inexperienced management. |
| Maybe linked to suppression bad news, persecution of whistle blowers. |
| Conflict between professions. |
| Professional groups, conflict because different approach/ethos. |
| Simple conflict strong personalities, different visions of service model e.g. midwives/obstetricians. |
| Time to time, all three own organisation. |
| In bottom 20% of organisations in NHS for staff reporting B&H. |
| [Why nothing done?] 3 reasons. Organisations adapt to, learn to accept bad behaviour. |
| Becomes norm people work around. |
| Often take someone new to come onto scene to challenge status quo. |
| 1970s bad practice in long stay psychiatric hospitals often revealed by student nurses coming on to wards with idealism, shocked. |
| Organisational and managerial inertia. |
| Belief “nothing can be done” (? R&J). |
| Tackling “bad behaviour” involves difficult conversations. |
| Subjective discussions about perceptions of behaviour. |
| Sometimes people behaving badly in positions of power. |
| Those beneath them fear reprisals if speak out, especially if think most senior managers won’t tackle issue. |

[Transferred to Actions - Personal experience number of different interventions. Signing up to set of approved behaviours/values, derived from staff focus groups. Formally adopted, promulgated, role modelled through organisation. Very effective if handled correctly. Wider organisational development programme attempts to define vision of organisation.]
Sets out what is to be achieved, how achieved.
Aim to get broad sign up to vision, get alignment with personal objectives.
Development of “dignity champions” or “whistle blowing facilitators”.
Outside management line, source of advice, support to individual.
Focus groups on departmental level, examine concerns, attempt to address.
Formal policies, procedures staff can invoke.
Any can be effective, depending how well applied.

23 [NHS as whole] Negative behaviour tolerated and managed different ways between different staff groups, within each of groups.
Medical staff behaviours tolerated greater extent than administrative, nursing behaviours.
Inter-staff group behaviours tolerated greater extent than intra-staff behaviours.
Aggressive behaviours come more from patients, visitors against staff, than between staff.
Bullying behaviours between different levels seniority within teams due to differing appreciation, understanding of priorities.
Individuals simply not getting on.
Broader question, capacity of NHS structures to place pressure on other organisations.
Does DOH bully NHS Trusts, via SHAs to deliver certain targets?
Does Treasury “bully” DOH to achieve financial targets?
[Own organisation] Mirrors much of above.
Occasional negative behaviours between individuals in teams, similar status, tends to manifest in lack of respect, appreciation of another’s skills, ability or contribution.
Individuals in teams of different status.
Bullying if senior individual uses hierarchical power to reflect poorly on more junior staff.
More junior staff look to undermine authority of more senior staff, reliant upon specialist ability/capability as opposed to capacity to use hierarchical power.
Organisations, individuals tend to try to avoid conflict.
Clinical setting, active management of individuals sometimes seen as bringing about conflict.
Consequence of conflict avoidance
a) Individuals, groups try to resolve negative behaviours informally.
Can work but often needs degree of mediation to get to nub of issue.
If isn’t wholly resolved likely to resurface.
b) Individuals, more formal route, Trusts policies applied.
Significant amount of time, multiple issues, often unsatisfactory, inconclusive outcome.
Often compromise, does not necessarily resolve underlying issue.
c) Generically organisations demonstrate through form of punishment poor behaviours not tolerated.
Needs to be carefully, consistently managed.

24 NHS as whole, often negative behaviour results from staff feeling undervalued, under pressure.
Change creates fear if not handled sensitively.
Need to work harder at this.

25 [NHS as whole] Staff complaining unnecessarily.
Low staff morale.
Not taking responsibility when things go wrong, always someone else’s fault.
[Own organisation] Senior managers not taking enough responsibility.
Lack of communication to all levels of organisation.

26 Still harassing.
When Labour Government into power, NHS target driven.
Bullying culture began to permeate through NHS.
CEO’s, significant pressure on them from the top down; DOH.
More pressure staff in clinical care settings experience from top-management more likely cycle of negativity.
[−−] [role of NHS, now [organisation], general attitude bullying.
Will read what saying, watch what does.
Will be setting tone, agenda. Important to see how relates to new SofS [−−].
Knows very little about new job, not seen much yet.

27 [NHS as whole] Attitudes still pervade some medical staff, inappropriate treatment of patients/staff other professional backgrounds.
Despite public pressure, remain whilst BMA stance refusing to acknowledge medical profession needs to move same way other professions.
Medical profession unique. Exceptionally well paid, extraordinary access to life or death decisions. Yet most protected personal employment contracts in country. Much is canonistic. Still far too slow in addressing faults within own membership. On receiving end most difficult behaviours are middle ranking admin/managerial staff. Often sit between ongoing remorseless contradictorily requirements of senior managers and clinicians. Behaviours worst in larger teaching hospitals. [Own organisation] Tensions greater within small Acute DGH, more exposed to risk. Category of NHS organisations currently failing most in country. Despite this behaviours not necessarily worse than elsewhere. [Response to scenario not related to questions] Worst examples i.e. negative behaviour between staff in two different NHS Trusts, between most senior staff. Strong clinical networks around cancer networks, clinicians closer together. Orthopaedics, other specialties, private practice market, clinicians less likely to share good practice, audit across different organisations. Senior managers by far worst in respect this type behaviour. Egos of Directors/CE feel cannot be seen to be “backing down” by reaching intelligent compromise agreements. Months/years stalemate; often patients' detriment. Common fault Executive Director level externalise problems of their organisations. Blaming other organisations. Occasions, behaviour if not supported certainly stimulated by ways key regulators measure understanding of risk/governance effectiveness. Negative behaviour, issue of Medical Consultants. Often consultants remain at Trust far far longer than any manager. Teaching Hospitals not uncommon consultants with peers as consultants and whole medical training. Creates very strong bonds (significant stronger than between managers). Strong bonds can be strong positively and negatively. Collective charge against senior managers in Trusts. Lack of challenge/appropriate challenge to Medical Consultants who consistently visibly display inappropriate behaviour to one another.

28 [NHS as whole] Professional disrespect. Hierarchical domination. [Own organisation] Less so, has existed but... Strong focus on values, common purpose, personal responsibilities, reinforced from top. Sanctions and intervention on evident poor behaviour.

29 [Repeated negative behaviour] Seen it own organisation [Soc Services], getting worse. Didn’t used to be so. Pressure people under to save money. Pressure affected peoples stress. Not saying right, but continuous pressure over years; lot of stress. Answerable to other people. Want to know why something costing so much. Become a bit nasty, short, with people. Can say you told me come in on budget, or can’t have this staff. When constantly in the middle, between a rock and a hard place, just have to tell them straight. Personalities come into it. Some manage communication, interaction, more professional, personable way. Others haven’t got professionalism, personality. Resort to sounding, being aggressive. Not everybody has personality, people skills. Sometimes, especially younger days management, could sound bit nasty, autocratic. Years go on, always aware of behaviour. Some aren’t aware of behaviour. Latter days say, agree with you but that’s what it is, I’ve been told to do that (R&J). Can’t do anything about it so that’s what we have to do (R&J).
Will accept that, might not accept, but wouldn’t see it as bullying.  
Answer is the same.

30 Bullying.
Lies and bullying.
Attempts to cover up with more lies.
Often passive bullying, exclusion from meetings, staff appointed without consultation.
Money often talks.
Money guiding principle rather than excellence in patient care.
Hacking of [persons] computer.
Searching office while [person] away considered acceptable behaviour by managers.
Lack of transparency; often.
[actions] deliberately concealed.
Subtle form of aggression, stress was freezing posts, delays in filling posts, to put pressure on [person] to leave.
To cover things up.
Defend those in power, put more pressure on [person].
Attempts to see [person] as problem, refer to OH, etc.
CE - ‘It is good to sack a few consultants now and again, it makes sure the others toe the line’ (R&J).
Number reasons for poor culture.
In goal-driven culture, end (goal) often considered to justify means.
As long as goal achieved, lies, bullying fine (R&J).
Where very senior people, get lots of power, like using it, if bring in lots of money, smooth talkers, contribute to culture.
Often rogue doctors do managers favour, vice versa; form of nepotism.
‘CE’, [other titles] does not help, remind is hierarchy.
Some cases, private practice, related jealousies is factor.
Some consultants ganging up against another consultant.
Managers no proper accountability, professional regulation.
Mistakes by managers ignored, downplayed.
Clinical mistakes, major inquiry.
If problems with managers; police investigating police.
Managers, some doctors, support each other.
Reluctance to have independent external input, if input happens is ignored.
In case, ignored input, ignored professional guidelines.
No leadership from DOH, Trusts, especially FTs, so much independence, do what want.
DOH does not intervene.
Regulatory authorities, CQC, Monitor, mainly clinical issues, ignore management culture.
Limit what see on site visit.
Trusts can easily hide dirty linen.
Bullied and told lies afterwards to cover up.
Manager then told lies to cover up bullying.
Consultant who bullied “have to show people who’s in charge” (R&J).
If can get away with it, show people, am in charge, they don’t do anything; power is even more.
Bullied, got away with it.
Show people who’s in charge; authority gets more.
Can get away with it, nobody bothers.
Jimmy Saville, wasn’t powerful; powerful image.
Lots of money generating.
Can’t criticise JS, raised 40 million pounds.
Have this system, organisation 100% behind him.
Top personality, can’t say anything.
How dare you even raise issue; BBC protected him.
Somebody powerful, brings in lots of money, organisation decides going to defend person, no matter what.
How dare you criticise.
Manager said ‘How dare you, won’t allow you to say anything negative about person’.
When three things operating, person allowed to get away for years and years and years, until somebody stands up.
Very difficult to break that down.
JS only after died, courage to stand up, say was wrong.
System, covers up for person/people who do wrong.
Lot of top people BBC protected, sheltered JS.
Same thing in [hospital].
Enough top people supporting managers, doctors misbehaving.
As long as get enough key people in system to support, it’s all hushed up, suppressed.

Defensive, bullying, blame.
Negative behaviour; aggressive email totally unnecessary.
Mostly negative behaviour behind closed doors.
Subtle, insidious.
Relates to divisive culture.
Very poor investigating allegations bullying.
Wonder if HR know what bullying is, don’t know how to investigate?
HR encourage, facilitate bullying many occasions.
Where organisations want to silence, get rid of whistle blower process can be driven from the top.
CE’s driving attempts to dismiss staff.
Bullying arises through insecurity, fear.
Many managers poorly trained, supported.
Immediately fearful when issues patients safety raised.
Middle managers particular under pressure to meet targets.
Not met held as failed.
Constant pressure of squeezed budgets.
Most patient safety issues relate to low staffing, resources; time and time again.
If no money to recruit managers feel powerless.
Something goes wrong blame person least power to resist.
Doctor [hospital] perfect example.
[Repeated complaints no action?] Yes, a manager, hopeless.
With managerial role comes responsibility.
Many managers poorly equipped for role.
Maybe unsupported by seniors.
Seeing pattern, real genuine concerns brushed aside.
Why? Too difficult?
Furore over Jimmy Saville same; easier to let things go than try sort out.
Things get buried and gagging clauses.
Gagging clauses, make sure buried.
If something scandalous, force doctor out, bully doctor/nurse, force gagging clause.
Not illegal, legal; not what should be happening.
Bullying organisation some very favoured, some victimised.
Favoured think CE amazing, support to hilt; get rewarded.
Stand up, say CE amazing, supports, prioritises patient safety, blah, blah, blah; waffle.
Reality different.
People trying to challenge that, victimised.
All in power, we are ones at the bottom; power imbalance.
Bullying linked to power differentials.
Why so much bullying?
Bullying is awful.
Bullying I experienced absolutely dreadful.
SHA said ‘wasn’t bullied’; absolutely ridiculous.
‘wasn’t bullied’, just incompetence (R&J).
Bullying malicious, done on purpose (R&J).
HR director changed outcome of grievance.
Not incompetence, on purpose.
SHA denying evidence.
Indicator comes from higher level.
SHA implicated in Mid Staffs?
[Post recording]
‘Emperor’s clothes’.
Lost our humanity.
But people, now talking about compassion.
If don’t respect staff, don’t respect patients.

[Top person] referred to GMC for alleged unprofessional bullying conduct.
Mixed [experience]
Full spectrum, lack of support to outright bullying, mis-briefing to seniors.
Also good ethical behaviour.
Often non-executive board useful source mediation, support.
Starts from the very top.
NHS not being led, being driven, very big difference.
Leads to cascade of maladaptive behaviour all the way down.
[Added to Actions - If NHS led, visionary leader, our purpose, mission, vision.
Everyone, great, can do that, sign up, willing to follow.
Motivated, content with lot, though struggles with money, patients.
Difficult, harrowing work sometimes, but know what for.
Following a leader, want to follow.]
More driven, business model imposed, purchaser/provider split.
1990 ish alien to culture, value system people in NHS.
Not trained in it, not very good at it.
Led to all other things go with business mentality, performance targets.
Targets sent down from above.
Rather do things because intrinsically good, just following targets.
Driven by what have to do, start cheating, do silly things.
Sub optimal care.
Wrong model, driven by targets don’t accept, believe in.
Pushes into inappropriate behaviours.
Feel under stress, snap at people, try get people to deliver target given.
Pass it on down, pass on the pain down, on down the line.
Compounding, intermediate tier, SHA ought to be sorting, showing more leadership; don’t.
Don’t sufficiently.
SHAs don’t care how make financial balance, meet targets, just want to know met.
Didn’t want any ‘bad news’.
If send ‘bad news’ means not performing, are out.
Many, many, many managers lost jobs.
Usually financial, target purposes.
Don’t know single manager lost job because failed to improve health of population.
SHAs job simply to tell NHS Board, ministers ‘all is well’.
There to make ‘good news’.
Seen some appalling behaviour of SHAs on PCTs.
[Trust] in financial mess, monthly meetings with SHA, shouting matches.
No secret of fact going to make very unpleasant meetings.
Unpleasantness would go on and go on, and on, until got [organisation turned around].
SHA CE point fingers, at CE or FD.
What are YOU going to do about it.
It’s YOUR responsibility.
Why haven’t you fixed it YET.
Unreasonable, unrealistic expectation of delivery.
Culture have got.
Don’t enjoy culture, cannot thrive, or break down in that sort of culture, move out.
Selective pressure, only ones who enjoy or thrive in environment, stay, become managers, move on up hierarchy.
Self perpetuating dysfunctional system.
Survival of un-fittest.
Only those who like that culture.
Last four managers, career individuals.
Sometimes admit career came first.
Not there to decide, genuinely run things, just there to deliver.
Look up to tier above, not out to population serve, staff work for.
Maybe NHS wide phenomenon.
People in post, learnt to behave, adapted for own survival purposes, to that culture.
Dysfunctional behaviours.
Seen bullying, impoliteness, cowardliness, pride, arrogance.
Outright dishonesty, corruption, you name it.
People are people; all sorts in NHS.
Symptomatic of wider, deeply engrained malaise, culture of bullying and dishonesty. Prevailing culture is bullying, command and control leading to fear, insecurity and cover up. Constructive challenge, inquiry seen as disloyal, frowned upon. Dissenters not welcome as agents of change, marginalised as trouble makers.

33 [Negative behaviour] Goes on a lot. Lot of B&H. Staff, feel harassed because manager saying deliver it on time, want it tomorrow.
Have you dug deeper into harassment element?
Is harassment around disability, learning disability, race.
Nobody tackling in NHS, hardly.
HR said ‘look into it get back to you’.
Nobody said anything, nobodies done anything.
Rhetoric not reality.
[Why?] Perhaps don’t know how to.
Reputational risk.
Lack skills, frightened?
Don’t know why.
Unless tackle issues head on not sure can deliver fair system.

34 [Added to Actions - Often say perceive colleagues behaviour, in negative ways.
Colleagues deserve chance to take ownership of behaviours, explain how intended behaviours; not often tolerated.
Some insist on formal grievance, blame, to uphold own belief in own perception.
Not allow full understanding to be attempted.
‘I’m right about you – you’re wrong about yourself’.
‘Just trying to make excuses to get out of trouble’ etc.
[Organisational responses] Depends on political leadership.
If political comment on particular organisation, will be blame orientated response.
Slowly enabling organisations to see another way; PIN Guideline on Dignity at Work. Encourages, try resolve issues first with mediation.]

35 Degree acceptance of aggressive behaviour, medical consultant staff to junior staff.
Erosion of culture of deference in society, showing in NHS.
More likely highlighted now.
Is view colleagues have to earn one’s respect.
Applies to patients?
Rhetorical question; ridiculous notion.
Colleagues equally entitled to respect, former view still prevalent.
Some areas tolerate foul, abusive language between colleagues, routine basis.
Don’t think great deal actual systematic bullying.
Manipulative behaviour occurs.
Boundaries between legitimate self-interest and working the system for own benefit is not uncommon.
[Organisational responses] Up to point respond reasonably well.
Threshold when perceived too disruptive to service, other negative reputational consequences.
Not dealt with robustly.
Times, reports get three wise monkeys treatment.
[15% B&H too low to think about?]
Always apply large pinch of salt to self-reported success stories from organisations.
Aware views from nearer shop floor.
%age figures, staff surveys, around 16% report witnessing bullying and/or harassment.
Is high, include conflict situations.
Challenging behaviours, may be inappropriate but not bullying behaviours (? R&J).
Evidence is frequency investigations into allegations of B&H conclude, clearly difficulties in communication, genuine distress, not due to bullying (? R&J).
HR Director might be justified confident if figures less than 5.
Still high if genuine level of bullying/harassment.
Survey figures mostly non-bullying related conflict, might explain being relaxed. [? R&J]
Complacent better description.

36

37 Member of staff tries to raise concern, criticised or ignored.
Those involved in whistle blowing experienced all aspects negative behaviour.
<table>
<thead>
<tr>
<th>38</th>
<th><strong>Managers stick together</strong></th>
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<tbody>
<tr>
<td></td>
<td>Loathe to criticise another manager.</td>
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<td>Upholding bullying claim would be.</td>
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<td>Imply management class riddled with pettiness, incompetence.</td>
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<td>So many barriers to crappy behaviour being challenged.</td>
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<td>High cost to manager 'calling out' another manager.</td>
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<td>Same level suspicion accuser trying to damage rivals career prospects.</td>
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<td>If accusing <em>higher up food chain</em>, there go career hopes; labelled troublemaker.</td>
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<td>If subordinates, implies person over promoted (possibly by yourself), poorly managed/supported (by yourself).</td>
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<td>Telling someone a bully, good way making enemy.</td>
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<td>Counter allegations/<em>drag up skeletons in closets</em>/keep tally of mistakes etc.</td>
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<td><em>Better not to rock the boat.</em></td>
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<td>Costs to junior staff/clinician calling out manager high.</td>
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<td>Only do if leaving, foolhardy or absolute <em>rock solid evidence</em>.</td>
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<td>Evidence rarely <em>rock solid</em>.</td>
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<td>By nature bullying insidious, done in private.</td>
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<td>&quot;Everybody knows&quot; but nobody does anything.</td>
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<td><em>Don't want stick head above parapet.</em> OR other cases bullying taken to disciplinary, NOT upheld.</td>
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<td>Good demotivator.</td>
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<td>If management not going to listen only go down route if desperate.</td>
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<td>Desperate, don't make good witness, more reason claim dismissed.</td>
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<td>Most people hearing bullying claims appeals <em>so far up food chain</em>, never clinicians or haven't been loooong time.</td>
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<td>Cases, jealousy of manager, no (deserved no) approbation for what did versus clinician (also female), patient testimonials to die for, list as long as arm.</td>
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<td><em>Unspoken war</em> between managers, mostly <em>pen pushers</em>, could be replaced by robots or works councils.</td>
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<td>Insanely jealous of validation clinicians get, making difference to individuals.</td>
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<td>Two clinicians in dispute need to look at class, gender.</td>
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<td>Suspect female manager hearing case between female and male clinicians predisposed to females viewpoint.</td>
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<td>Same true of male managers, but most HR managers/managers hear bullying cases tend to be women.</td>
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<td>More senior clinician, more &quot;like&quot; (disposition, class) person hearing case.</td>
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<td>Evidence viewed (unconsciously) more plausible etc.</td>
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<td>HR people either <em>on way up greasy pole</em> or plateaued (Peter Principle).</td>
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<td>Tend not to have (or recent) clinical experience.</td>
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<td>Jealousy thing applies, and <em>rocking the boat thing</em>.</td>
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<td>If find in favour of junior member.</td>
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<td>Never know what friends senior - who is <em>now enemy for life</em> - may have.</td>
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<td>Flag to bosses are <em>(dangerously) principled</em> &amp; independent.</td>
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<td>TU rep for 6 years, excellently supported by FTO.</td>
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<td>TU reps, overworked volunteers.</td>
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<td>Can be reluctant to pursue bullying cases unless 100% clear cut.</td>
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<td></td>
<td>Very very rarely clear cut.</td>
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<td>Tone things down, do half arsed job.</td>
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</table>
Signals to members won’t be supported if bring things up.  
Senior managers could make a difference.  
Either/both don’t notice it, so used to it/think it’s normal.  
*Never ask a goldfish for its opinion on water!*  
Actively benefit from that culture!  
Autocratic decision making not challenged.  
Egos never deflated having to acknowledge stupid ideas unworkable.  
Once start noticing subordinates bullying, colleagues, superiors doing it, where end?!  
A *nasty can of worms to open.*  
Concrete drivers for organisational change.  
Darwinian terms, what are selective pressures?  
Trusts don’t go under because of bullying, go under for financial reasons, or high death rates.  
If KNOW bullying grievances won’t be upheld, *vote with their feet,* find another job, rather go through soul destroying, futile process.  
Lots of fine words, bullying won’t be tolerated blah, blah, blah.  
Rhetoric not reality  
In real behavioural drivers/selection pressures, not even in top ten.

| 39 | [NHS as whole] Made up individuals who work for it; NHS no different irrespective of size.  
Set professional boundaries in place revert to, in difficult times.  
Spend lot of time training to be exemplary individual clinicians, less time on team-working, support good individual behaviour.  
Very strong hierarchies in place through/across organisation.  
Often create inappropriate environment more junior staff, unless target broader culture.  
Need to be pragmatic, more time with colleagues than own close family.  
No need to be best friends.  
Argue, perhaps old-fashioned?  
Courtesy should still be apparent.  
Distinctive feature NHS should be caring approach to individuals.  
More attuned to understanding what care means for colleagues.  
Often other dynamics, create “them and us” mind-set between management, staff.  
Culture often attacked by nature of relationship between staff side representatives and managers all levels.  
[Own organisation] New management team, new organisation.  
Thought lot about shared values, show “the way we do things around here.”  
Finding new, different ways communicating with staff, formally, informally, personally, organisationally.  
Access to confidential support, services for those need to raise concern; unable through line management.  
Add more personal dimension, although agreed policies.  
Launched dignity at work policy personally.  
Own reflections, experiences.  
Open intranet forum to CE, bullying come up.  
Spoken with, met individuals reporting.  
Personal blog to highlight.  
Lack of tolerance for negative behaviour.  
Need process in place to support both perspectives.  
Not all concerns clear cut.  
Confidence to report/address will be based on believing organisation will respond fairly.  
Hope got balance most of time, but needed some visible personal instruction.  
Essential to demonstrate basics in place, through agreement, use of clear policies.  
Mechanism to allow concerns raised up through structures, via staff reps or confidential counselling services.  
Application of any process needs to be discharged fairly, professionally.  
Always two sides, difficult to balance expectations both parties fairly.  
Attitude and tone.  
Has to become engrained as unacceptable behaviour.  
Show organisation does what said it would.  
Need reality matching rhetoric  
CE, help with all of these, support rather than just heroic interventions.  
Try to demonstrate tone, attitude from very top. |
At top of organisation culture of corporate bullying.
Corporate Thuggery at highest level.
Corporate Thuggery at highest level.
Competitive environment NHS management breeds negative behaviours.
Many top level managers do not have social skills to understand impact behaviour on others.
NHS arrogant, elitist at the top.
Middle managers very frustrated group.
Forced to carry out actions do not always believe correct.
Put downs at meetings regular occurrences for anyone not in agreement.
Middle managers try to resolve negative behaviours in amicable way.
Top level managers little understanding of front line pressures; create bullying organisation.
Culture of bullying starts at the top.
Director/executive levels not held accountable to government employers for mis-treatment of staff.
No recourse other than expense of tribunals.
Organisations gleefully spend public money on top QCs to defend wrong-doings.
Generally don’t understand professional issues.
Ignorant about qualitative aspects care delivery.
Don’t want to hear what say.
Do not value clinicians; contradictory to them.
Believe general management superior, all powerful (regards to power, sadly the case).
Not held accountable for anti-social behaviours to any higher bodies.
Lack of accountability how treat staff, key to behaviours.
Organisational culture driven from the top.
Are arrogant, display narcissistic behaviours.
Good people do not speak up, publically humiliated if disagree.
Personalities senior managers part of problem.
Hubristic tendencies.
Should be screened out interview stage.
Regrettably, actually screened in.

Plenty nightmare behaviour.
Bigger concern, culture.
Very centralised, controlling, hierarchical.
Closed, intolerant of criticism.
Not open, transparent, although claim are.
Rhetoric not reality.
Frequently, bullying.
Lot organisations overall very unhealthy culture.
Seen serious service failures, slightly distorted, particularly negative view.
Just more extreme examples than what saw as director.
Prevailing culture.
Failing organisations, culture more evident, more extreme.
Very few organisations, where isn’t widespread, endemic.
Leadership too centrally controlled. Lot of bullying.
Horrible descriptions.
CE of NHS, phoning up individual CEs effectively threatening them with the sack if don’t deliver.
Wrong sort of people leading NHS.
‘Corporate bullies’ end up leading it.
Negative behaviour sometimes entirely centred around dysfunctional individual.
Upbringing, life experiences, genetics, just very difficult dysfunctional damaged people.
Sometimes negative behaviour comes from that.
Sometimes, circumstances, culture find themselves.
Isn’t always easy to distinguish.
People very clever, cunning.
Sometimes allegations bullying malevolent.
Just as much, horrific bullying.
Often if one person says they’re bullied, person bullying them, counter, been bullied by person;
very, very, tricky.
Particular situation, tragic.
Professional life ruined by malevolent group of staff.
Didn’t like fact person high standards. 
Some things heard, absolutely shocking. 
Example of bullying, shouldn’t come into work, clinical role, long dangly earrings.  
*Frontline* clinical practitioner; extremely difficult. 
*Other side of line* horrible tales staff *on their knees* in A & E, threatened by site manager. 
Stop raising concerns or *be in deep trouble*, just get on, manage. 
Clearly unsafe. 
Not straightforward. 
Problem, behaviour, over all, set in context of unhealthy general culture, environment in NHS. 
Makes it worse. 
Lessens chance of, ‘*lancing the boil*’. 
[Centralised and corporate stuff?] Yes 
Not dealt with, or deal with them badly.

43 [NHS as whole] Negative behaviour discouraged through policy, process implementation. 
Where effective individual performance management, skilled management, dealt with timely way. 
Where missing behaviour can remain unchecked. 
Corrosive effect on team behaviour and performance. 
[Own organisation] Pockets extremely good practice, negative behaviour addressed appropriately. 
Examples behaviour not challenged. 
Encouraged to move on through recruitment, promotion, many years. 
Now talking about culture, how tackle poor performance. 
Some managers have to address poor negative performance in individuals left unchallenged long periods time. 
Organisation asked to support managers in team development where failure to deal with one member of team displaying negative behaviour. 
Can rely on policies/processes and fall to engage in organisation wide discussion about culture. 
Behaviour change and supporting of positive behaviour. 
Positive culture can only be driven from *the top*. 
Must be role modelled by senior leaders. 
Whilst individual negative behaviours must be challenged where occur, only happen consistently where such a culture.

**Framework Theme 11. Self-interest/relationships**

<table>
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<tr>
<th>FG</th>
<th>Categories for Framework Theme 11. Self-interest/relationships (Focus groups)</th>
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| 1  | Not going to do anything to make me look bad, *in bad light*.  
I’m looking for my job. *Fighting for my role*.  
Want this one.  
So don’t want any mud, *sticking to me*. |
| 2  | Manager does not want to be seen to be performing poorly.  
Avoidance.  
Fear of being overlooked in restructured career progression.  
GPs not in NHS, independent businesses. In it to make money; commissioning for themselves.  
Conflicts of interests.  
*Eyes really opened* naively assumed greater plan *at the top*. [L]  
Talking about right time, right place.  
Just empty words and meaningless.  
Rhetoric not reality.  
About *creating names* for themselves.  
Politically, regionally, own organisation, was the focus.  
*Opened my eyes*, behaviours at regional level and own organisation. Just, mayhem, absolutely mayhem.  
Cultural shock, working off own agendas. Just about what they wanted.  
Incredibly ambitious people in NHS; *NHS is political pawn*. |
Looking for certain avenue in life NHS can be place to ‘make your name’. Agenda is their own, probably not for best of organisation. Achieve something, goes with them, doesn’t help organisation long term. Then move on; top people only stay few years. Disappear before anything ‘goes funny’. No bad name with that. Replicate, might not fit, force to fit in new organisation. Empire building, build directorates up, which build individual reputation up. Need top team can read between lines see what going on; point scoring. Some people very good, happy not to take lime light, do their work, don’t want to play the game. Sidelined and forgotten, person with loud voice, playing the game, is one to get on. If top tier not around long, time to understand players. People shout loudest always get heard. Personal agendas and power bases. ‘Very tempting to join club, be part of ‘good news factory’. Only interested in themselves, next job. Very short term that level, looking for next job’. Constant movement turnover at senior level. Head of HR body guard for Senior Director. Lack of care & concern. Lack of humanity. [Supposed to be caring for patients] Clearly don’t, got their own agendas. Whatever level, far too many have their own agendas. [Push back?] Only interested in themselves, next job. Very short term that level; looking for next job. Head of HR protects Directors; ‘a body guard.’

3 Clique. Detached, arrogant, paternalistic. ‘Know best’. Work characterised by failure to engage with staff all levels. Drive personal agenda through operation of their trust.

4 Professional politicians only out to make gains for themselves, not for good of country. Tony Blair is classic, built up his profile so much during government, earning a fortune. All point scoring. Avoiding difficult decisions, back tracking. PFI, issues, concerns raised at time, but things still railroaded through. Question what relationship is, was of government ministers with people who organised/in charge of, PFIs.

5 Apex of organisation, espoused interest is protect whole workforce, organisation. After a while look after own interests, own particular group interests. Senior management group, start to protect each other, look after what’s good for them. Challenging senior person with difficult behaviour, inadvertently challenging whole group that sustains their position. Seriously could lose jobs, occasionally get nicked. Set up to try to fiddle everything, cover everything up because didn’t want to lose jobs. Real anxieties can be replaced, rid of easily. Taken over.

6 Lot of self-interest. Self-interest, under the surface, though presented differently publically. Representing own interests. Factions, silos, defending position; strengthen. Haven’t looked at, make better delivery service? Changes to make the best? It’s will I have job? Is human nature, but don’t think many people are open; doing it with self-interest. Dressing it up in, quite bad really. Need support but it’s fact not brought to surface. Different groups, where work, relationships impact on culture; in crisis coalesces in good and bad. ‘Defensive’ Being defensive about current position. People hanging onto the power have got.
**Categories of Framework Theme 11. Self-interest/relationships (Interviews)**

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<tr>
<th>Int</th>
<th>Text</th>
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<tr>
<td>1</td>
<td>It’s <em>if your face fits.</em>&lt;br&gt;Always higher grade come off better.&lt;br&gt;<em>The ‘little people’ don’t count</em> sometimes.&lt;br&gt;[HR?] Not a lot.&lt;br&gt;<strong>HR will stand up for managers.</strong>&lt;br&gt;Bullying on its own; 2 or 3 managers and HR around table.&lt;br&gt;Bullying <strong>top level; HR in middle of it.</strong>&lt;br&gt;Don’t go on HR.&lt;br&gt;<em>Not on same planet as us.</em>&lt;br&gt;All the same.&lt;br&gt;On holiday, met one, didn’t like her.&lt;br&gt;Really weird, human beings are strange.&lt;br&gt;[Who really controls?] Don’t know; HR [L] and the cronies.</td>
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<td>4</td>
<td>Person responsible for HR; needs challenging.&lt;br&gt;No-one in organisation/unions prepared to challenge.&lt;br&gt;Conflict of interest.&lt;br&gt;Nobody dares challenge.&lt;br&gt;Any &quot;open &amp; frank&quot; discussions reported back.&lt;br&gt;Culture of openness lost.&lt;br&gt;Each out for their own/jobs for the boys.</td>
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<td>5</td>
<td>Managers refuse to accept any blame for wrong doings.&lt;br&gt;Expect large payment when sacked for failings.&lt;br&gt;Managers do not get &quot;struck off&quot; like clinical staff.&lt;br&gt;Usually reappear another hospital higher salary.&lt;br&gt;Only ‘managers’ get severely punished, originally doctors.&lt;br&gt;May lose jobs, struck off by GMC. Even if acting purely managerial way.&lt;br&gt;GMC view &quot;once a doctor always a doctor&quot;.&lt;br&gt;People/different groups treated differently.</td>
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<td>Out for themselves.&lt;br&gt;[Person] got to where wants to be.&lt;br&gt;Self-promotion/ambition.</td>
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<td>Personal politics; harder to raise issues re negative behaviour.&lt;br&gt;People uncomfortable raising issues.&lt;br&gt;<strong>Afraid perceived ‘unable to cope’/‘weak’, be found not have serious case.</strong>&lt;br&gt;Concerned about politics taking case.&lt;br&gt;Sensitive to views of line/dept manager/peers.&lt;br&gt;Issues of confidentiality, state of mental health, ability to cope with process.&lt;br&gt;[Why neg beh?] Range of issues.&lt;br&gt;Pressure, stress, politics, <strong>fear</strong>, external factors.&lt;br&gt;Where mobbing, is about fitting in, peer pressure.&lt;br&gt;Others ‘serial bullies’.&lt;br&gt;<strong>is about power and control, especially where people having to compete</strong></td>
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<td>11</td>
<td>Everyone has own agenda.&lt;br&gt;Small town, many staff ‘locals’; insular.&lt;br&gt;Workforce demography changed to include different nationalities.&lt;br&gt;Opportunity for display negative behaviours.&lt;br&gt;Lack of tolerance to incomers to group.</td>
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<td>12</td>
<td>Not just ward sister, group senior long term staff; in a clique.&lt;br&gt;Clique, e.g. running together.</td>
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Exclusion of others.
Not always professional as should.
Group stay there years.
[Real motivation?] Personal remit, objectives from CE, deliverables.
If not delivered not achieving in job.
Personal objectives/goals come first.
When project doesn’t deliver finances, blame project manager.

Managers know their staff, may pre-judge issues.
Views affected by individuals’ role, value placed on them.
Unwelcome behaviour in valued person may be excused/dismissed.
People treated differently.
Protection of certain people.

[Trust] dysfunctional place.
Core of staff, nurses, doctors, do not want to serve hospital as institution.
Do not want to serve patients. Think it’s for them.
Trade unions/leaders, not explicit; attitudes.
Fool people into thinking NHS there for them.
Big, big problem.
[Nobody wants to face it?] No, too difficult, uncomfortable.
Avoidance.
Report dignity of care, more of same.
Leaders must do this, need to do that, have to.
Keeps off really uncomfortable subjects because NHS Confederation body members NHS hospitals, other trusts.
Self/mutual protection.
Civil service culture many ways.
Universal now, civil service stay for life.
Civil servants at DOH, covering backside of minister, prime minister’s backside.
Began to realise how bad [situation] was in Dec, Jan/Feb 2009.
Yes Minister doesn’t tell half of it. That’s how it is.
Complaint, consultants as body/cohort.
Must outnumber management.
Why don’t go, do gentle bullying with them, be assertive.
Mmm [prevarication].
Don’t like to do that, might lose clinical excellence award; big factor.
One consultant mid staffs inquiry, why didn’t do anything?
Mortgage to pay.
Brutal reality of people.
Ignore professional commitment shrug shoulders, carry on..
Nobody in NHS goes.
Lot who failed, promoted.
[Why?] 2 fingers to public; but don’t think they notice.
People get increased roles.
Get knighthoods.
Nobody resigns.
Nobody say’s sorry.
Personal loyalties.
Personal dynamics build up so gangs of nurses, sisters, modern matrons.
Thought new CE wonderful; was rubbish destroying the place.
Allowed themselves to fool themselves.
Stalin syndrome.
All great leaders, bullying figures should say; coterie around them.
People who won’t question.
They blame the patients, other people.
It’s their fault.
We are doing a great job.
People not held to account.
Just want to move people.
Society massively complex network.
Interrelating networks people with loyalties.
Want to protect some other entity, reason may not understand.
People who raise concerns victimised.
Clinical Excellence Awards buy silence; doctors getting them despite appalling performance.
Pay mortgage!
Appalling attitude for professional.
Gods in the NHS.
Stuff their mouths with gold.
Give biggy clinical excellence award.
"Coin operated cops", same syndrome.
Society suffused with it.
Society run by elites who look after their members.
CE’s - "kiss up kick down".
CE promoted for 'doing the dirty' on --.
On behalf of --, CE SHA, looking to impress --. It worked!
Rotten from top to bottom.
Boss at [Trust] didn't like stories exposing big problems, removed [person].
[Newspapers] producing spin for hospitals.
Why? Self-interest! That's all.
It's cross party.
Labour MPs defended [Trust] now it's a Tory; can never resist telling world how [hospital] improved.
Challenge for clinical evidence, never comes.
Way with MPs; big struggle.
MP prefers to go along with spin and nonsense from hospital management.
Redditch doesn't surprise.

16
Managers have own agendas, not entirely patient focused!
Sometime have own career of interest! Selfish.
Do not upset your manager otherwise life will be hell.
If work for nhs! Have good relationship with manager, colleagues.
Kiss there (sic) arises from time to time so in good books in case need support!
Exercise concept 'one rule for you, different rule for organisation'.
Managers there to line pockets; get away with it!
How many patients do they see?
Strong view middle management should go!
Corruption comes to mind!
Lack of transparency and accountably with public monies.

17
Self-serving complicity of elite circle.
Complicity of regulators.
Patronage rather than open competition for management posts.
Senior SHA staff limited operational experience.
Opportunities for careerists.
Career non execs, financial and career interest.
Can use role, stepping stone.
Fail to promote quality.
Have to 'toe party line', is 'ethical fading'.
Personal interest in serving political objectives.
Most people work in it believe fundamental principles.
Try hard to do high quality job.
Feel obliged to compromise to meet political objectives, retain positions.
Main overriding priority protect politicians any cost.
Personal interest in serving political objectives.
Elite closed circle of career driven managers.

18
People responsible monitoring Mid Staffs several promoted.
Managers have a duty, a pressure from above.
Managers large pressure on doctors. Junior level pressure, lack of places for young doctors.
Managers can influence, get next job, as can consultant.
Very large influence on consultants Managers involved in committees recommend clinical excellence awards.
Very top level can almost double salary; pensionable.
Very large sum of money.
Pressure on senior doctors.
At very top, power of patronage; knighthoods, honours.
Political tension.
Pressures on Universities, influence of money, dependence on funding.
If didn't affect people's lives, if English hospital care not so poor by international comparisons wouldn't be so concerned.
If things suggested true, some might suggest misuse of entrusted power for personal (i.e. intended political advantage) gain.

19
[Why promoted?] Look after each other.
CEs look after each other.
May be them next.
Argument use, are the accounting officer **(R&J)**.
Account for the money, **buck stops with them**.
Use that, to come to modus operandi, treated differently from anybody else **(R&J)**.
Differently from any other grade, type, look after themselves.
Still getting massive payoffs.
Other people not getting payoffs.
Not going to go into it; libellous situation.
Could list numbers individuals, screwed up, moved out, put in somewhere else.
Often more responsible bigger job, more money.
It's corrupt.
[CEO to charity] Wouldn’t want to comment.
Sometimes offered to another organisation as *a free good*, salary paid.
[Part of the deal?] Mm mm [Agreement].
Entrenched defence of weak services.
Totaally intransigent opposition to doing something about it.
Opposition of consultants not wanting to change working practices.
Orchestrated opposition of public/media to maintain status quo; not in public interest.
Managers go along with that, jobs likely to go or change.
Trade unions have to accept responsibility as well.
Complex picture
People lost sight what mission was.
Protection of image organisation more important than patient, welfare of staff
[Why?] Democratic deficiry, deficit, lack of accountability.
Fascist situation, technocrats running show without, democratic accountability.
Own personal interest, dominate agenda.
Very understandable; democratic deficit.
*Grafted* onto that, boards, non executive directors.
Often supplement to pension.
Interested making sure get another 4 year term.

20
NHS effectively one employer.
If *fall out* in a Trust *blackballed* nationally.
Career in NHS *blackballing* devastating.

21
Operational managers moved around a lot.
Need to perform quickly, to be safe in next promotion.
New managers introduce changes to *make their mark* in short time; consolidation more useful.
One person *serves 'attack dog' function*.
Generally acknowledged if challenge need to leave; quite powerful.
Staff *too frightened* to raise dignity at work allegation against such people.
Make life very difficult.
Need 'class action' group of people acting together.
These people can have favourites, singled out for special projects, promotions.
Divide and rule going on.
Massive financial pressure, so achieving target really important.
Careers completely dependent on financial targets.
Below them, careers dependent on last 'gig'.
Need to perform in parlance of the times, bring bosses good news.
Need to demonstrate can perform.
Next time is *cull*, 3 times last 6 years, won’t be them gets displaced, removed.
Dynamic gets played out.
If clinical person, some extent ‘have got a ticket’, job anywhere. 
If manager, middle, higher middle manager, not same. 
Not going to do career any good if go along with ‘bad news’, problems, difficulties. 
Hilarious. 
People, don’t have any currency, qualifications, certainly not professional qualifications. 
 Totally dependent on being groomed by ones above, looked after. 
Young woman, not graduate, may have A levels, if that. 
Somebody obviously advising. 
Came in, we joke about it. 
Cocktail dress, heels, jacket. 
Next thing, promoted. 
Sort of person prepared to shed previous life, vested interest for her. 
Got nothing else. 
Never heard senior level/execs talking about justifying actions not best interest of patients/staff (R&J). 
Never admit, never admit that. 
Not possible hold onto jobs, if articulating that. 
So it is all good. 
[Nothing wrong?] Can’t afford, to be thinking like that. It’s, a road to nowhere for them. 
[Denial?] Don’t know what happening in heads; focusing on behaviour. 
Not in their best interest, talking that way. 

22
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27 Private practice market, clinicians less likely to share good practice, audit. 
Consultants remain Trust far, far longer any manager. 
Teaching Hospitals not uncommon consultants with peers, as consultants, and whole medical training. 
Creates very strong bonds between consultants (significant stronger than between managers). Strong bonds, positively and negatively. 
Collective charge against senior managers, lack of challenge, appropriate challenge to Medical Consultants. Consistently, visibly display inappropriate behaviour to one another. 

28
29

30 Private practice, related jealousies. 
Some consultants ganging up against another consultant. 
Where very senior people, lots of power, like using it. 
If bring in lots of money, if smooth talkers, contribute to culture. 
Often rogue doctors do managers favour, vice versa. 
Nepotism. ‘CE’ [other titles] does not help, remind is hierarchy. 
Managers, no proper accountability, professional regulation. 
Mistakes by managers ignored, downplayed. 
Clinical mistakes, major inquiry. 
Problems with managers; police investigating police. 
Managers, some doctors all support each other. 
Reluctance to have independent external input. 
External input is ignored. 
[Why?] There’s power, arrogance, financial things. 
Academic games, were playing. 
Links between different people, e.g. Marriage, close associates/academic colleagues influencing where money goes. 
Nepotism. 
People dependent on flowing of money, lots of money in form of grants. 
Couldn’t say anything against this person. 
Manager didn’t want to upset because person bringing in lots of money to hospital.
Regarded as God, very powerful.
Surgeons often regarded as Gods, bringing in money.
*Money speaks.*
Ignore all flaws, limitations.
Bullied, told lies afterwards to cover up.
Manager told lies to cover up his bullying.
One person protecting another person.
If you support me I will support you.
Give me *pat on back* will give you *pat on back*.
Lot of that going on.
In middle of that.
People twist things round in terms own agenda.
Question of fairness wouldn’t come into it.
Played political games.
Not a power struggle, but situation power mattered.
Very important people mattered.
Bringing in money grants, publications, research mattered.
Clear conflicts of interest.
Never declared conflicts of interest.
[People] never consulted.
Decided behind closed doors.
Allocated [space] to themselves; gross unfairness.
Reasons, power, money, nepotism some extent.
Manager said ‘won’t allow you to say anything about doctor.
As if could suppress right to free speech.
Manager tried to say not allowed to freely express opinions, views on someone.
It’s all related, power in situation.
Decide because they are together.
One is supporting the other.
Manager access to space, things, knows where spare money; doctor gets it.
Manager wants promotion, reference; doctor gives reference.
Lot of that goes on.
Pretty awful.
Unless want to be part, *play their games.*
If don’t do that, end up in trouble.
Manager doing wrong things again, again, again.
Get away with it; the unfairness.
One law for them, one law for others.
If [person] does tiniest thing wrong, *jump on it.*
These people, so many things wrong.
Good things some people do, totally ignored.
When doctor bullied screamed, yelled.
People twist the truth, just to make sure person not penalised.
Ignore what do because on management side, no matter what do.
This wrong, that wrong, just ignore it.
Usual thing person in trouble, things always magnified out of proportion.
Things do, can keep on doing them.
No matter how serious, nobody bothers.
One law for them one law for us.
Way it works, *part and parcel* of overall scheme of things.
Third thing have system, organisation 100% behind him.
Jimmy Saville top personality, can’t say anything.
How dare you even raise issue, BBC protected him.
Get somebody powerful, brings in lots of money, until organisation decides going to defend person,
no matter what anybody says.
How dare you criticise them.
Manager said ‘How dare you, won’t allow you say anything negative about this person’.
When three things operating, person allowed to get away for years, years and years.
Until somebody *stands up.*
Very difficult to break that down.
| 31 | Representative; may have got cosy relationship. |
|    | Compromise agreements often unions, HR people coming to agreement. |
|    | Behind the scenes. |
|    | Not listening to member. |
|    | Goes against public interest, sorting something out, between themselves. |
|    | [person] made the stand ends up aggrieved; getting paid off. |
|    | Doesn't do anything for safety. |
|    | In bullying organisation get some people very favoured. |
|    | Some people victimised. |
|    | People favoured think CE amazing, support to hilt. |
|    | Get rewarded. |
|    | Stand up, say CE amazing, supports, prioritises patient safety, blah, blah, blah. |
|    | Come out all this waffle. |
|    | Reality might be something different. |
|    | People trying to challenge, get victimised. |
|    | Very, very difficult. |
|    | People who support senior managers get promoted, then have more power [sad L] |
|    | [Rat & just's?] Justify it in loyalty to organisation (R&J). |
|    | If manager known to have failed, CE where service failed under, your watch, you’re protecting yourself, by taking this action. |
|    | Might rationalise to themselves, protecting organisation (R&J). |
|    | Actually protecting themselves. |
|    | Potentially could be sacked for what did. |
|    | All know each other. |
|    | People get promoted from hospital to SHA, vica versa. |
|    | [CEO Mid Staffs to charity] Another CE of [hospital] now CE of [charity]. |
|    | Clearly links, connections, dynamics. |
|    | Maybe is little club? |
|    | People meet regularly, get to know each other, can transfer. |
|    | –, Chair of CQC. |
|    | Used to be CE [Charity]. |
|    | Maybe little club at the top, between charities, senior members health service. |
|    | Not all charities obviously, but definite, people moving between. |
|    | Area of concern, charities ought to be independent. |
|    | Wonder whether funding from DOH. |
|    | [charity] one point getting funding for helpline from DOH. |
|    | [charity] now receiving funding from DOH. |
|    | Are links, might well be funding stream what does it. |
|    | Fact ex CE of [hospital] now CE [charity]. |
|    | Suggests people haven’t realised, understood what CE involved in, how behaves. |
|    | All interlinked. |
|    | With [organisation] something strange goes on. |
|    | Some people get hammered. |
|    | Others get let off really quickly. |
|    | Have to question. |
|    | People treated differently. |

| 32 | Vested personal and organisational interest. |
|    | Person who oversaw faulty system promoted to director of - to [organisation]. |
|    | Impossible to get to admit fault; would risk career. |
|    | Same goes for others, won't give account, gone onto good jobs. |
|    | Rule by mediocre people. |
|    | Only those who like that sort of culture. |
|    | Last four managers all career individuals. |
Sometimes admit career came first. Not there to decide, genuinely run things, just there to deliver. Look up to tier above, rather out to population serve, staff work for. Maybe NHS wide phenomenon. People, directors of trusts in post learnt to behave, adapted for own survival purposes, to culture. What’s driving it? It’s self-preservation. Protection for people senior positions. Want to cling onto power, privilege, earn a lot of money. New ideas not welcomed. People expected to conform. Cronyism and word of mouth bypasses proper checks and balances. Cronyism is rife senior levels. Failure dealt with by redeployment or redundancy. Seldom by acknowledgement, discipline or dismissal. Leads to cynicism lower down ranks. Reinforcing culture of not raising concerns. [Added from theme SMD/ego-defences] [What’s driving it [spin and not learning]? Underneath this?] Self-preservation, protection for people in senior positions, want to cling onto power, privilege, earn lot of money. Are well paid. -- 250-000 a year as does wife, runs one of -- hospitals. Half a million pound a year household. Want to protect lifestyle, privilege, power. Who wouldn’t? That’s human nature.

33 Morale is so down. Everybody’s a stranger. Everybody doing own thing. Nobody smiles at you, each other, says good morning, hello. It’s horrendous. Although -- talks about humanity, caring, lost out on that. No one particularly cares for me. Colleagues feel nobody really cares about them. Everybody fighting own battles. It’s incestuous [Why incestuous?] Seen people haven’t performed well. Put aside Agenda for Change. Because done little piece of work, management, given titles like associate directors, higher wages. People who are friends of friends at higher levels, will do everything. Never challenge, never bold, never courageous, just go along with it. Despite know in heart, perhaps not right. People who do speak up, bold enough to speak up, just left on the sides. Get into labelling (R&J). Marginalises opinions don’t suit management, no matter how well opinions were, are. Really incestuous in NHS. Promote people you like. Tell HR Director, need to look at workforce profiles see who’s not getting up the ladders. Focus on help people access education, training, develop skills. Said, not into all that, into talent spotting. Said [L] what does that mean, what criteria, how make sure fair? Who are people talent spotting? Are there identified people in HR go round talent spotting? Said, that’s where we are, that’s what we are doing (R&J). Not single thing answered. Seen managers like their secretary. Secretary suddenly becomes something else. Might be commissioning manager. Why? Somebody really liked them. Incestuous. Against grain of equality. How address equalities if what goes on?
People who raise concerns, don’t get a look in.  
Been in [-] game less than year, said, lead on [-].  
Was much higher grade with -- years’ experience.  
Because liked him.  
Woman liked him, immediate manager, director liked him.  
All from particular organisation taking over part others.  
When spoke up about this, just told, that’s how it is (R&J).

Traditional medical hierarchies overlay power struggles, alliances (strategic and tactical) that result from competition between groups.  
Cultures within groups tend to be insular, anti-diversity.  
Overall consequence organisational culture is homogeneous.  
Re-creates itself in terms of power bases.  
Works against learning and change.  
Boundaries between legitimate self-interest, and working the system for own benefit, not uncommon.  
Another strong cultural norm, don’t land colleague in trouble.  
Don’t point the finger.  
Fear that Incident reports will be used to do that.

Multi factorial.  
One problem clinicians invariably become managers.  
One of reasons, don’t want to be clinicians anymore, don’t want to do shifts.  
Want to move on be manager, so ain’t going to do all the ‘getting your hands dirty’, ordered around by everybody else.  
Crap shifts like Christmas day, night shifts.  
Not trained.  
Don’t take ownership of service.  
Just want to move on.  
Want innovative change on CV, for when move on.  
Competitive element.  
Innovative change, for them, not the service.  
It’s to look good on CV.  
Or look at us, save loads of money, doing this.  
But left behind ‘a crock’.  
Seen it so many times over years.

Continual ‘re-organisations’.  
Problem beset NHS particularly past 25 year, revolving door managers.  
Career managers move posts every couple of years without ever seeing through changes put in motion.  
Not conducive to working as collective team, common understanding, goals.  
 Doesn’t create effective managers committed to organisations, staff or patients.  
Committed to career progression/personal ambition.

Managers stick together.  
Loathe to criticise another manager.  
What upholding bullying claim would be.  
Imply management class riddled with pettiness, incompetence.  
So many barriers to crappy behaviour being challenged.  
High cost to manager ‘calling out’ another managers behaviour.  
Same level suspicion accuser trying to damage rivals career prospects.  
Accusing higher up food chain, there go career hopes; labelled as troublemaker.  
Subordinates, implies person over promoted (possibly by yourself).  
Poorly managed/supported (by yourself).  
Telling someone a bully good way making enemy.  
Counter allegations/drag up skeletons in closets/keep tally of mistakes etc.  
Better not to rock the boat.  
Costs to junior staff/clinician calling out manager high.  
Only do if leaving, foolhardy or absolute rock solid evidence.  
 Evidence rarely rock solid.  
By nature bullying insidious, done in private.  
“ Everybody knows “.
Nobody does anything. 
Don’t want stick head above parapet. 
Bullying taken to disciplinary, NOT upheld; good demotivator. 
If management aren't going to listen only go down that route if desperate. 
Desperate, don't make good witness. 
More reason for claim to be dismissed. 
Most people hearing bullying claims appeals so far up food chain, never clinicians or haven't been loooong time. 
Cases jealousy of manager. 
Got no (deserved no) approbation for what did versus clinician (also female). 
Patient testimonials to die for, list as long as arm. 
Unspoken war between managers, mostly pen pushers, could be replaced by robots, works councils, 
insanely jealous of validation clinicians, making a difference to individuals every day, get. 
If two clinicians in dispute need to look at class, gender. 
Suspect female manager hearing case between female/male clinicians, predisposed to female’s viewpoint. 
Same true male managers. 
Most HR managers/managers hear bullying cases tend to be women. 
More senior clinician probably one accused. 
More "like" (disposition, class) person hearing case. 
Evidence be viewed (unconsciously) more plausible etc. 
HR people either on way up greasy pole or plateaued (Peter Principle). 
Tend not to have (or any recent) clinical experience. 
Jealousy thing applies, as does rocking the boat. 
If find in favour junior member, never know what friends senior, now enemy for life may have. 
Flag to bosses are (dangerously) principled, independent. 
[Good news factory?] Nature of bureaucracy. 
Rewarded for taking good news to boss. 
Take bad news to boss seen as “negative”, “not a go-getter” etc. 
Way bureaucracies work, hierarchies work. 

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42 [What is commitment?] Graduates, quickly learn careers enhanced by ‘being corporate. 
Careers suffer if not ‘corporate’. Some, very clever people manage to influence positive direction, 
with lot of guile at local level. 
Sadly many take ‘Queens shilling’ follow directorates of DOH. 
Even when know ‘heart of hearts’ some things, not in best interest of patient. 
Have to rethink it. 
Why troubles me NHS managers if ever had principles, lose them. 
Sacrifice on altar of maintaining, developing their careers. 
Whatever came into service with, most either give up, get out. 
Can’t cope, try move sideways, less exposed to worst of it. 
If want to prosper, just join corporate line. 
Repeat endlessly patients first priority. 
Huge swathes what do, quite apparent not right. 
[Added from scenario - Why troubles me NHS managers if ever had principles, lose them. 
Sacrifice them on altar maintaining or developing careers. 
Classic example.]

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Framework Theme 12. Scenario

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<tr>
<th>FG</th>
<th>Categories for Framework Theme 12. Scenario (Focus groups)</th>
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373
Responding to an ‘Elephant in the room’.
Non-spoken about issue.
Once it’s out of the bag, is evidence.
Not spoken about, no evidence; not there.
Negative behaviour is an NHS ‘elephant in the room’.
Staying puts spotlight on them.
Resistance to hearing.
Avoidance.
If don’t hear, don’t have to take action.
Need force to attend.
Not interested.
Needs money to put right.
If listen/listen are acknowledging problem needs investigation.
Don’t want it public.
If public then is issue of bullying.
Will say no bullying.
It’s got a name, then it exists.
Defensive.
Letter, rubbishing it, are defending something not acknowledging is there.
Deflection.
Have ‘looked in the mirror’.
Frightened ‘finger is actually pointing at them’.
Attack is best form of defence.
Don’t want evidence.
Prefer hearsay.
If acknowledged then fear of opening flood gate for litigation
Damage limitation.
Old power thing, just to prove point.
Going to just because can.
Act as group.
Power, or presentation of power.
Everybody thinks they’re all powerful.
Didn’t say what they wanted it to say.
Done it so can say tick box.
Not transparency.
‘Hear no, see no, speak no’.
Hear nothing, see nothing, say nothing.
Don’t tell us what is going on, don’t listen to what we are saying and choose to ignore it if in e-mail.
So cannot see it.
The amount of people who don’t get that e-mail! [Irony]
Resistance to knowledge.
Choose not to see.

Seen similar scenarios.
Arrogance.
Not interested.
Don’t want to know; then have to do something.
Fear; expected to know what to do.
Pointing at me.
Group behaviour.
Easier to put ‘heads in the sand’.
All maintain ranks, can get away with it.
One breaks ranks, says need to know, may get ‘outside of the club’.
‘Ostrich effect’.
‘Heads in the ground it may go away’/forgotten.
Will raise itself if important enough, again and again and again.
Disengagement.
Nothing to do with them.
Distancing.
Don’t want to know, not interested, don’t want to make changes or acknowledge results.
Feel got at.
Always blaming senior managers.

Worried.

Senior managers don’t like dirty linen being aired; being surprised. CQC, HSE debrief with senior managers; have to deal with fall out.

Need to not be put on the spot.

Do not want our dirty laundry aired, in public.

Public bad news outside impact on funding streams. Publically being noticed.

Don’t care about inappropriate behaviour.

Directors; untouchable. Indestructible, cannot be challenged.

Think so what! Carry on.

Information won’t get out.

Aware; don’t feel need to change.

Personal agendas and power bases.

Arrogance.

Where in hierarchy; if getting results why change?

Group behaviour; agreement.

Agreed researcher had agenda?

Why bother? Great way to make a point!

Much better, turn up, walk out, than just not go.

Actively had chance to tell people too busy for this nonsense.

Staff uncomfortable with managers?

Last 5 years ‘outrageous’ in vocabulary.

Had choices; been dealt with differently.

Lot of it around, get away with it.

Not unusual scenario, played out daily basis.

In meeting on blackberry, why pitch up?

No interest.

Input needed.

Just as loud a message.

So often; groups senior managers don’t have time to attend, left waiting outside.

Put off, not told meeting re-scheduled.

Summoned without pre warning.

Same behaviours.

It’s about credibility, control and power.

Cultural at the top.

Led by culture at the top.

Clearly felt wasn’t ok way to behave or do it.

Not outrageous is normal culture, acceptable; busy people (R&J).

Not acceptable lower level.

Disciplinary.

Just implement.

Outrageous because was executives and senior management.

Culture comes from the top.

How filtered down behaviours senior managers allowed to do.

Discomfort.

Lack of training.

The ‘t word’.

Fear of being found lacking.

Being responsible for action.

Create work.

Don’t want to be responsible.

‘If I stick my fingers in my ears and hum loudly, then it’s not happening.

Got to do something, so just pretend doesn’t exist.

If don’t formally hear findings or findings say something about me personally; can’t hear them.

To discredit the work.

Humiliate, to humiliate.

Presentation about negative behaviour created negative behaviour.

Walking out, very clear message don’t support this.
Removes credibility.
Lack of endorsement.
SHA, CQC, behind closed doors; nobody would know.
Open v behind closed doors.
Says it all; no credibility, no interest, disengaged; it’s not happening.
If happening going to make sure don’t have to do anything about it.
[Caring about patients?] Clearly don’t care, got own agendas whatever level, far too many own agendas.
Higher up go, forget what here for.
Meetings; word patient not mentioned.
Correlation between research and patient care divorced, cannot see how impacts, cause getting results.
Not realising everything do affects patient care.
Always NHS managers to blame, always H&S spoiling everybody’s fun.
Culture, acceptable to kick researchers.
No power, authority to impact, influence on trust; SHA, CQC do, penalise, withdraw funding.
Clinical research fine, even if load of old tosh, great, thank you.
Related to staff everyone rips it to pieces.
Or just wait for staff survey results shall we? [L]
Delay, deflection, avoidance.
‘If I stick my fingers in my ears and hum loudly then it’s not happening.
Arrogance.
Fearful.
Easier to put heads in the sand.
Show bad image of their organisation.
Fear of findings.
Easier to ignore than accept.
Discomfort; didn’t want association with research.
Not prepared.
Bad publicity.
If trust ‘under notice’ more publicity not reflect good on organisation/funding streams/themselves.
Disengagement.
Nothing to do with them.
[Why?] ‘Uninterested.
Scared.
Feel accused/backed into a corner.
Lack of trust;
Viewed personally.
Guilt.
Learnt behaviour to protect themselves.
Fearful being found lacking.
Don’t understand role, accountability.
Wanted to prevent ‘bad press’, flood of complaints, assurance seeking from commissioners.
Denial.
Don’t want it in black and white behaviour is poor, not being addressed.
Difficult to take criticism; truth hurts.
Don’t believe in negative behaviour.
Don’t know how to take forward.
Concerned how perceived; specifically by top management.
No actions in place.
Ostrich effect – put their heads in the ground it may go away, forgotten – but raises itself later.
Didn’t want to know.
Not interested.
Didn’t want to make change, or acknowledge.
Anticipated results wouldn’t be complimentary’.

3 Wanting to block any bad publicity.
Worried negative behaviour in trust, don’t want acknowledgement.
Senior managers not wanting to acknowledge concerns raised by staff/issues not dealt with
Directors, senior managers felt outside pressures more important.
Trying to deny any problems/didn’t want ‘bad press’

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Avoidance.
If findings negative make trust look bad, them in particular.
Fear would look bad.
Fear of public embarrassment.
Desire to avoid problem didn’t wish to face.
Insecurity, of senior managers.
Didn’t want to hear negative things about themselves/trust.
Denial, disbelief.
Blocking to decrease chance of bad publicity.
‘Head in sand’.
Lack of empathy.
Don’t know how to address.
Embarrassed.
Blocking info; detriment to trust.
Blocking publicity.
Promote relationship of management.
Prevent negative reputation; needs in conjunction with sorting problem.
Hide the truth.
Worried.
Ignoring situation.
If don’t deal with face to face, don’t have to manage ‘fall out’.
Avoidance.
Staff are open; being ignored.
Concern how trust show against other
[Why?] Criticised if findings not good.
Lack of support from senior management.
Obviously blocking, publicising information potentially put trust, managers in a ‘bad light’.
Hide the truth.
Obviously want to hide.
Doesn’t mean bad thing trying to hide it.
If publicised immediately get negative reputation.
Expectation of negative relationships.
Misunderstandings, wrong ideas.
Should be taking it on board to find way to address it, improve.
Should be published, but lot of negative ramifications.
Need to rectify.
[Why didn’t do that?] Don’t know why.
In denial; not believe is what staff feeling.
Think everything’s fine at top level; running OK.
To hear home truths, staff undervalued, over worked, likely to hear within NHS.
Think running OK then ‘head goes in the sand’.
Don’t care or know how to address it.
Lack skills to address; such a large scale.
Managers human beings, have feelings.
A lot of success in life, position got to.
Strength of feeling when something negative comes against them could be considerable.
To protect their egos, self-confidence, want to avoid.
Big problem need to deal with.
Need to be able to accept criticism, do something about it.
Lot of them, don’t have skills to deal with it.
Don’t want to acknowledge are concerns.
Trying to hide it away.
Don’t want to acknowledge.
Don’t want to hear it.
Didn’t want to hear it, don’t want to hear it.
Difficult to know exactly what motivated them to get up and walk out.
Disturbing could behave in such a way.
Need to be prepared for the bad news.
‘Bad news being buried’, in denial.
Senior managers have responsibility to understand things about their organisation, less than proud
Ready for unwelcome news, be prepared to ‘take it on the chin’, with proper response. Thank you very much for this bad news. Suggest dealing with it, rather than, walking away from it, pretending it wasn’t there. Pusillanimous; cowardly, utterly cowardly, it’s spineless [L].

3 scenarios:
- Welcome news, everything rosy, wonderful, nothing to worry about.
- Few issues need to think about, generally ok.
- Absolutely awful, real problems to deal with.

Walking away weren’t going to know.

Not a public meeting.

Could have been shared to allow acknowledgement, to challenge and learn.

What are the lessons?
What need to do next?
To ignore it, pretend wasn’t happening; cowardly and bit daft.
By walking away from it, pretending wasn’t there, still was; just hadn’t heard it.

Either:
Don’t care about negative behaviour.
Regard negative behaviour being beneficial to organisation from their perspective.
Keeps people under control.
Weren’t prepared to do difficult things required.
CE paid level do, to handle difficult stuff, difficult decisions follow on from that.
Not up to the job.

4 To bury “Bad News”.
The ‘head in the sand’.
Don’t want to believe is happening.
Rather than bring it out into the open, rather bury it.
Bit of collusion?
Typical, don’t want to show any part of organisation in a poor light, publicised.
Not unusual, it’s ‘burying the head in the sand’.
Behaviour not going to go away.
Demonstrated very much did not care about negative behaviour, behaved very badly themselves.
 Comes right from the top.
Opportunity to say don’t want this.
Demonstrate to all and sundry behaved very badly.
Very disrespectful.
Demonstrating behaviour is acceptable, we want to bury things.
Don’t want to deal with difficult, difficult questions.
Fear of failure.
Fear of failing, admitting are problems, issues.
Dismiss it, just bury it, dismiss it.
Don’t want to learn.
Don’t want to identify issues where need to change; can be improved.
Want to think everything fine, don’t want to hear anything going wrong; setting culture of organisation.
If that senior exec team what chance rest of organisation?
Not listening, not engaged, never going to turn that around.
All singing from the same hymn sheet.
Everybody prepared to walk out of room, having walked in.
Utter nonsense; very strange.
Seems artificial scenario.
Individuals amazed, shocked, cause, just wouldn’t do that.
Viewpoint, highlights need to see it as opportunity.
Need to recognise bad points before can move forward.
Let’s see what can afford.
Organisation not going to change because not receptive to listening to views and addressing them.
Never aware of situation like that.
Corporate appraisal process:
What set out to do, what achieved, gone well, can be improved, do to move forward?
Is missing critical steps, about evaluation, evidence around what doing, what actually achieving?
What need to learn in order to set new directions? Completely missing it. No surprise if [Hospital] involved, their management railroad things through. Style. Not facing up to things. Ticking boxes need to tick, until something crumbles nothing done. Have to fail before gets better. Funding is an issue. [System under stress?] Something has got to give. 5 Didn’t like findings. Didn’t feel need to change. Felt threatened, power challenged. Influenced by one senior member staff. Avoidance. Fear of naming/shaming. Avoid negative consequences. Power. Defence, avoidance. To silence/block. Fascinating; recognise this sort of thing happening. ‘The problem coming into the room’. Organisations fondness for board members sit down in sequestered room, dream up values, how everyone behaving. Values functionalised very different ways. Seeing here, what occurs with tense difficult situations, need to think about together. Opportunity to look at how values functionalised, operationalised, but avoiding it; obviously scary. Doubtless rationalising, constructing some story about lots of other really important things to do. Indicates real problem, difficulty being able to sit down together, discuss issues need to be talked about. (R&J) Highly avoidant, make me furious. Fascinating and infuriating. Don’t want to hear results. Symptomatic of problem trying to get at. Adverse influence on other members; group behaviour. Didn’t like it, so nobody else should. Depressing; absence of willingness to engage in dialogue. Depressing, pathetic. Previous situations, say banal statements like should ‘just focus on the positive’. Why focus on all negative? Whole appreciative thing out of States. Be smiling all of time, up for it, positive. Crack at positive psychology movement. Problem is things complex, feelings complex, negativity complex. Can’t have just positive, can’t split positivity from negativity. Like to say, this is the good, that is the bad. Good feelings, those are bad feelings. All interdependent, interrelated. Amusement when read monthly news bulletin. Very glossy, looks wonderful, just cheery positive, wonderful. Good news, amazing stuff, all achievements, rah, rah, rah, rah. Ok, but see underside, is a fantasy. If only think about positive aspects, incapacity to think what troubling or difficult, things worsen. Need different approach; think constructively about both. Have to acknowledge the negative. Shows up powerful role take by completely avoiding. Suppression. Silence. Done for effect, making a statement. Too busy, so this little importance (? R&J). Let down entire staff, whole organisation; behaved appallingly. Mummy and daddy disapproving, walk off, rest of you will do as you’re told.
Caught up in something very powerful.
Need help to think.

*Behind closed doors* somewhere, why get caught up like that.

Avoidance very natural reaction to fear.

Fear.

*If I’m frightened of snakes then I don’t walk in tall grass.*

Personally or staff responsible for, going to be blamed, something shameful.

Felt/Feeling threatened.

Control definition of what talked about.

Nothing talked about, nothing thought about.

Nothing needs to be done.

Orwell ‘1984’ acronyms stop thinking; NHS full of acronyms.

Closes down, makes it impossible to think.

Don’t know what acronyms mean half the time.

Don’t know how to think.

Closes down thinking, probably not conscious strategy, but way close down conversation.

Boils down to, who defines what talked about, what truth is, how something understood.

Who’s got power to do that?

Using their power in absolutely obnoxious way.

One aspect of power, top editor, whoever, final approval to what into newsletter.

Blocked by HR Director, person led exodus.

Culture: tendency in large centralised organisational structures towards totalitarianism, way of getting things done.

Group rationalisation, to convince of rightness of action *(R&J).*

<table>
<thead>
<tr>
<th>Int</th>
<th>Categories for Framework Theme 12. Scenario (Interviews)</th>
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<tbody>
<tr>
<td>1</td>
<td>Didn’t want to know.</td>
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<tr>
<td></td>
<td>Rude, very, very, rude.</td>
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<td></td>
<td>Scared of H&amp;S and B&amp;H.</td>
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<td></td>
<td>Don’t want to admit.</td>
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<td></td>
<td>Don’t know how to deal with it.</td>
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<td></td>
<td>[Why scared?] Very bad name if goes about.</td>
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<td></td>
<td>Whole trust very bad name.</td>
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<td></td>
<td>Not on same level, don’t know how to deal with it.</td>
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<td></td>
<td>[Offering to Board?] Cascades down all layers of people.</td>
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<td></td>
<td>Managers think got wonderful job because secure; not secure.</td>
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<td>2</td>
<td>Directors managers felt knew, understood what was happening.</td>
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<td></td>
<td>Wanted to show not priority.</td>
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<td></td>
<td>Too busy to give time.</td>
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<td></td>
<td>One walked out, others felt should leave.</td>
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<td></td>
<td>Discussed beforehand, did not think demonstrated what was taking place.</td>
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<td></td>
<td>Didn’t want published/shared with staff.</td>
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<td></td>
<td>[Why?] If listened had to acknowledge negative behaviour was/could be happening.</td>
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<td></td>
<td>Not prepared to spend time/money, effort on subject.</td>
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<td></td>
<td>Very rude.</td>
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<td></td>
<td>Did not want to acknowledge piece of research showed management skills in poor light.</td>
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<td>Management exhibiting very “negative behaviour” by belittling presentation research.</td>
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<td></td>
<td>Did not understand behaviour a bullying tactic.</td>
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<td>Chances of implementing any changes minimal.</td>
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<td>Starting point must be with management.</td>
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<td>3</td>
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<tr>
<td>4</td>
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<tr>
<td>5</td>
<td>Similar responses managers, Post Graduate Deanery, Royal Colleges.</td>
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</tbody>
</table>
Many people believe themselves position of power just want "yes" response from everybody. Not interested in well-informed dissent. 1970s research; consultant didn’t want to know results. Refused to let it be published. "publicising our errors will just bring us into disrepute".


7

8

9 Pattern of behaviour; suggest planned walk out. First turned up, walked out, deliberate point. Clearly not priority. Behaviour continued, suggest walk out targeted at presentation. Rationale for behaviours harder to assess from outline. Pattern of non-engagement.

Whether legal advice on current case taken against Trust, fear of embarrassment, denial, fear raising awareness increase workloads, demands on tight resources, not 100% clear. Employers determined no further communications around negative behaviours to employees. Denying employees appropriate information necessary for managing behaviours, or confidence bring personal, collective cases. Own behaviours negative. No opportunity for promoting positive behaviours, addressing negative behaviours.

10 Didn't want to acknowledge. Unprepared, fearful, unsure how could respond. [Why?] Fear.

11 ‘gob smacked’. Making a point. Decided not to wait for it. Don’t think an issue. Not important, or would have stayed. Fact wouldn’t let research shared with board. Would have thought any board would have wanted. Assume aware of findings? [Yes] Embarrassed by it. Want to ‘shut it down’, not acknowledge. [Why doing that?] Haven’t done anything. If issues raised, expect exec team OK got problems, what going to do about it? To board, present research this is plan, monitor. Expect any sensible, reasonable, organisation to do. ‘sweeping it under the carpet’. How can staff feel valued? Senior executives won’t acknowledge. Don’t appear interested. Choice strong words; will refrain. [L]. Would be ashamed as director, as CE, if went to press. [The scenario?] Yes; appalling. Culture of NHS; ‘enclosed’, ‘head in sand’. If ‘don’t talk about it’, don’t acknowledge; not happening. Seriously worry about exec, senior team behaves like that. God, need a gin. Get very cross.

12 Want to say why, why, why? What’s your motive? Social science evidence, research. High morale/happier staff patient care going to be much better. Don’t know what to do. Don’t know how to deal with it. Didn’t want to deal with it. Big organisations, employers, NHS trusts. What happens at the top affects so many lives, staff/patients. Organisation cannot learn/move on.
HR director, Director of organisational development?
Bit of a joke.
If can’t, get staff to behave in a, won’t address.

13 Scenario isn’t plausible.
Response difficult to understand.
Only assume felt threatened. Threatened individually.
More likely, perceived research outcomes unhelpful.
Negative impact on organisation.
Very important, sensitive issues get management buy in stage research designed.
Researcher sensitive to way work perceived.
Ensure research targeted at achieving positive outcomes/recommendations useful to research subjects
Ensure anonymity.

14 Absolutely typical of NHS.
Situation similar kind. Manifestation of everything at [Trust].
Say had problems, went into denial.
Rubbished [information & reports].
[Similar things happened] Commissioned [Organisation] to do spoiling exercise, say things good really.
Scenario, absolutely the NHS, way NHS is.
Does not pay attention.
Tries to rubbish things will tell the truth.
Piece of work done; disappeared down black hole.
Same thing.
Evidence, uncomfortable, need to do something; ‘Airbrushed out of history’.
[forum] Reports, place isn’t clean etcetera; disappeared.
Taken out of the record.
Breaking rules; being critical.
Local councillors, hospital governors, non-executives or nodding NEDs.
All conspire, don’t want to know.
DOH’s response to crisis.
NHS treats 99.9% of patients very well, on time, etcetera (R&J).
Of course problems going to arise time to time (R&J).
Always switch it round.
Part of same effect.
Going to get increasingly difficult to raise issues.
No surprise if close Board meetings.
Don’t want anything to leak out.
Couple of paragraphs to hospital governors, know won’t ask questions.
Accurate of what going on; that’s your NHS.
If got into newspaper, research journals.
Whitehall ringing up, politely, perhaps not politely.
What the hell doing, let this get out?
Hospitals PR/communications manager; wanted nothing, even slightest thing.
Didn’t want PPI forum to say anything.
Didn’t uncover any great scandals, but was petrified about anything.
That’s the way do things.

16 Denial happening.
CE, directors responsible for cleaning up organisation.
Highlights organisation failures as public body should be addressed.
Always going to be negative behaviours, thinking, unwise decisions made in NHS.
Learning from these, way forward.
HR/managers needs to facilitate, way forward.
Do as I say, don’t do as I do culture must be addressed.
Seniors managers have to influence others with positive attitude and behaviours.

17 If start presenting things not acceptable to management use various mechanisms blocking being made more public, certainly not published.
Imagine do go on at times, don’t hear about them.
Whistleblower, refused to be gagged.
Great Ormond Street trust, smaller hospitals.
Doctor refused to be gagged payment £100,000.
Many accept, almost have to accept if want career in NHS.
Totally unacceptable; how things are.
Cannot get better health service when situation.
Prevention of learning and improvement
Will continue while problems mentioned, there.
If report discuss, criticism, report poor quality, poor service provided by NHS.
Managers taking action make sure report, various levels, did not reach light of day, not get publication.
Response of DOH to data.
People told to ignore it.
Assisted getting into public domain.
Did try to suppress.
Made life very difficult.

It’s extreme.
Being unwilling to collaborate with this kind of findings, work, recognise.
Commission stuff tell what want to hear.

Another [trust] echo type of behaviour.
CE, England, management trainee?
People worked for, with part of deep culture cover up bad news, maximum gloss etc.
Part of training, within ‘norms’ of behaviour.
Do not get on by making mistakes.
Paradoxically do not get sacked either.
Worst get moved round system!
Do get sacked for exposing them hence concerns about whistle blowers.
Not wishing to be implicated in bad news story led to leaving meeting.
Negative behaviour may been coming from the top.
Suppression from Board because Non Exec Directors there.
Would not wish to expose issues in forum where cannot control outcome.
Same happened in [Trust].
Do not get on by being open and transparent.
Significant factor, people not standing up to this conduct.
NHS effectively one employer.
Fall out in Trust blackballed nationally.
Career in NHS blackballing devastating.

Either do not think concerns them, not good use of their time.
Know reflects on them.
Do not want to have to answer questions.
Very peculiar behaviour.
So many negative messages to staff.
Senior staff nothing to learn.
Research findings not important.
Senior staff not be involved in behaving badly so why stay.
Refusal to allow article again unacceptable.
Denies all can learn from all research findings; negative & positive.
Stop it going to Board decision CEO/Chairman.
Indicates organisation in trouble.
Not come across such behaviour in long experience.

In denial.
Know research presented correct.
Don’t know what to do about it. Maybe feel threatened. Have no answer. Don’t want seeming to be, not knowing what to do. Lack of knowledge. Idiots in not able to put it right, or responsible in first place. Behaviour very short sighted, to point stupidity; compounds situation. If *paid lip service* in doing the time, sitting, listening. Just ‘rubber stamps’ what’s attitude. Why things are, as are. Politically no favours. Should have, done the time, sitting listening, being available. Says, now we know why [L]. End of story. Utterly stupid. Utterly stupid. Haven’t got the skill. Felt very threatened. Took very personal. Just pulled rank. Usually pull rank when can’t cope. More than one way dealing with something. Still same results, outcome. Some ways, more skill, more time, investing in people approach. If haven’t got internal resources, skill, personality, time, pulling rank quicker, easier [Acting big boss?] Yeh, *stonewalling*. Haven’t got time for this. More important things to do than listen to/see this. Very short sighted, stupid. All about attitudes. Nothing more important than coping with something like this. Result of research. Could be at *deaths door* but they won’t be seeing to them. Be some poor *hands on* nurse/doctor; at the *coal face*. They’ll probably gone, cup of tea think oh shit [L]. Idiots. Made situation 10 times worse [L].

### 30

Senior management trying to suppress information. Particular suppress any exposure, embarrassing information re negative behaviour. Fear managers, Trust, seen *in a bad light*. Walk-out probably planned. Refusal by Trust Board share findings suggests suppression. ‘paranoid’ stance, right up, most senior levels. ‘passive bullying’. Exclude people, information from normal discussion relevant to health care. [Why] Root cause fear. Fear by some directors/senior managers own positions, reputation compromised. May been more ‘genuine’ reasons, around ‘bringing Trust into disrepute’. View may have been any actions prevent this happening, regardless of how unfair, is acceptable *(R&J)*. Unsatisfactory behaviour consistent across various levels. Culture fear and arrogance in Trust.

### 31

Culture, trying to speak to the truth makes group feel nervous. Retreat into old comfortable ways of being. What happening so bad, hard to *take it on board*; may become unmanageable. Much of response; unconscious drivers. Study at [organisation], group relations courses. Responses in groups, sometimes takes all by surprise. Act differently in different groups. When something strange happens now, someone gets very upset/angry, stop, reflect why. See regularly when try to speak truth, everyone becomes very anxious.
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<table>
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<tr>
<td>32</td>
<td>Relatively familiar scenario.</td>
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</table>
|33 | Desire to avoid negative criticism/feedback about themselves.  
Unbelievable arrogance exempt from feedback and issue.  
Difficult to second guess intentions/perceptions/actions.  
Didn't make follow up  
Avoidance or arrogance.  
Information not worth their time, undermining relevance, credibility.  
If accountable could avoid, as hadn’t associated with presentation.  
Could deny knowledge of issues should be active in resolving.  
Justifications would relate to denial of situation (R&J).  
If avoid presentation, reality of situation still hidden.  
Can deny anything needs to be done.  
Investment of resources, introspection into own actions, points to develop.  
Denying credibility of report, situation existing in first place.  
Enable: denial of truth, lack of credibility.  
Reputational damage to presenters by denying credibility.  
Preserving own reputation, avoidance by peer group.  
Results in no change, no resources invested in change, no credibility to presenters, and report.  
Peer group who left retain control!! |
|34 | Action orchestrated in advance.  
Directors prior warning research, indicate negative behaviours.  
Why allowed to happen on their watch, what going to do about it.  
First question criticism personally, collectively deep psychological level.  
Uncomfortable any context.  
More so when ‘junior’ managers, TU reps etc. present.  
Second question, too messy, possibly reveal not capable making real change.  
Usual way deal with that, sub-group chaired someone no authority to change anything.  
Let any proposals wither on the vine.  
First question really difficult, probably what drove behaviour.  
Board presentation, executives very wary of washing dirty linen in front of non-execs.  
Board meeting public, create more caution.  
Self-defence, psychological level.  
Want to prevent being blamed.  
Can do both by denying anything wrong.  
May even believe own self-deception everything OK, no bad behaviours.  
Therefore research can’t be valid.  
If asked would say didn’t publicise outcomes of research, would undermined staff, possibly public confidence (R&J).  
Very powerful narrative in society, NHS staff caring, selfless, dedicated.  
Bad apple exceptions proving the rule. (R&J)  
Embodied in Olympics opening ceremony, suggesting narrative part national identity.  
Never going to be easy to present alternative perspective.  
Was HR Director doesn’t surprise me. |
|35 | Managers view research invalid, biased, motivated for reasons deliberately damaging to organisations.  
Didn’t want give it validity.  
Self-rationalisation for own behaviour (R&J), but by walking out, sending out message research, 
subject of research does not justify presence.  
Certain irrationality.  
Even if believed research completely invalid, important subject matter.  
Should publicly challenge, redress balance.  
Walked out in unison suggest dictated from higher level.  
May simply been deliberate move to close off, ignore research.  
To allow ‘business to carry on as normal’.  
Indicate aware problem, not one gave priority, prepared to have exposed, wanted to address.  
Strongly suggests organisations not functioning healthy, safe way.  
Culture of suppressing problems not acknowledging, addressing.  
Organisations not listening, wanting to listen. |
Only way issues addressed in organisations functioning this way, *whistle blowing* to outside agencies.
This type scenario seen in [hospital]
Lacked insight, reinforcing position by *closing its ears to any criticism*.
Persisted throughout inquiry.
Filtered out much negative data before reached Board.
[Why?] Very similar behaviour patterns apparent when patients challenge poor care.
Form of collective stupidity, self-preservation.
Poor quality of management, long standing issue within NHS.
Lack good quality leadership.
Reflects prevailing culture of organisation and/or management.
*‘sick’ culture* at top ultimately tends filter down throughout organisation.
If bullying culture within management, unlikely to challenge bullying culture within staff, perhaps recognise it.
Wrong people becoming managers, not producing right kind of managers.
People often think, behave very differently when part of group. Adopt cultural norms, lack insight.
No longer comply with external standards.
Those challenge, break with organisation’s cultural norms tend to be isolated or victimised.
‘it’s not our problem, it’s yours’.
If group managers *out of depth*, insecure in position, last thing, someone from outside *shining a light on a problem*.
Challenge prevailing belief system of organisation.
[Hospitals] inquiry report level of denial maintained throughout inquiry.
Perhaps too difficult to face.
Unusual in scenario two organisations.
Not clear negative behaviour restricted amongst staff individual organisations or crossing between.
Good management, dealt with research very differently even if considered research faulty/approach at fault.
Walking out *sends out* completely wrong message, albeit possibly accurate message.

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<tbody>
<tr>
<td>Directors/senior managers feel threatened by findings, potential outcomes.</td>
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<tr>
<td>Senior manager critical without reading it.</td>
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<td>Legally termed “Wilful Blindness”.</td>
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<tr>
<td>Prior knowledge how damaging might be.</td>
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<td>Ongoing disciplinary/grievance issue might be scuppered by event.</td>
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<td>Very dysfunctional organisation.</td>
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<td>Management had to be seen not to be involved.</td>
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<td>Genuinely busy.</td>
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<td>Views research not legitimate/carried out appropriately.</td>
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<tr>
<td>Suspect organisation going through difficult stuff. Implications research had legitimacy, should be seen as helpful.</td>
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<td>Many examples research, evaluations, do not come out as want; often quietly dropped.</td>
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<td>Not seen such full on inability to engage.</td>
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<td>Part much more complicated situation.</td>
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<th>41</th>
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<tbody>
<tr>
<td>Typical cameo, central problem in NHS.</td>
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<td>Problems face if raise concerns.</td>
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<tr>
<td>Even if local manager reasonably sympathetic, concerns legitimate or not, would have to continue, be introduced.</td>
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<tr>
<td>Is this ‘we haven’t got a choice’, ‘we have to do it’, ‘there is no option’ <em>(R&amp;J)</em>.</td>
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<tr>
<td>Senior NHS manager, director on board say to CE ‘I have no idea why we are doing this?’</td>
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<tr>
<td>Say, ‘we have got no choice in this’, ‘we have to do it’.</td>
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<tr>
<td>Say naive way don’t understand.</td>
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<td>If all CEs said counterproductive, not in interests of patients.</td>
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<tr>
<td>If all stuck to your guns.</td>
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<tr>
<td>Have to rethink it.</td>
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<tr>
<td>Why troubles me NHS managers if ever had principles, lose them.</td>
</tr>
<tr>
<td><em>Sacrifice them on altar maintaining or developing careers</em>.</td>
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<tr>
<td>Classic example.</td>
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</table>
Don’t want clear analysis, critical research, well evidenced work, *flags up* problem. Causes panic, indicates what doing not correct, feel ‘there is no alternative’ (R&J).

Centralising thing can’t possibly admit things aren’t working. Actual scenario?

Doesn’t surprise me if is.

This ‘there is no alternative’, ‘we must do it this way’ (R&J).

*Very closed culture, very unhealthy closed culture.*

As long as people like -- get knighthoods, continue in positions of extraordinary power, can say things like, [specific details]

Interest, concern was for management of trust/SHA.

No concern for patients.

That is the **nightmare**; quite extraordinary.

[Why?] System of government doesn’t allow for *shades of grey.*

Don’t like challenge to authority, no matter how well intentioned.

**Scary** to them, because it’s exposing a problem.

Don’t know how to deal with.

Dealing with it mean having to admit flaws in *system.*

Having to abandon things feel can’t abandon.

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**Framework Theme 13. Selective moral disengagement (SMD)/ego-defences**

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<tr>
<th><strong>FG</strong></th>
<th><strong>Categories for Framework Theme 13: SMD/ego-defences (Focus groups)</strong></th>
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<tbody>
<tr>
<td>1</td>
<td><strong>What we say doesn’t fit business plan.</strong></td>
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<tr>
<td></td>
<td>If isn’t what want to hear, don’t hear it.</td>
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<td></td>
<td>Paperwork, duplicating work don’t seem to hear.</td>
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<td></td>
<td>Targets to achieve; don’t want to hear not good service.</td>
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<td></td>
<td>Not interested in what problem is; it’s your responsibility</td>
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<td></td>
<td>Shifting responsibility downwards.</td>
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<td>Directors responsibility; <em>faced with brick wall.</em></td>
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<td>Very hard to raise issues, if <em>facing that brick wall.</em></td>
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<td>Resistance &amp; deflection.</td>
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<td>Don’t like B&amp;H; <em>turn away from it.</em></td>
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<td></td>
<td><strong>Frightened; Hard to pin them down.</strong></td>
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<td>If don’t deal with it, it’s not happening.</td>
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<td></td>
<td>Very difficult to prove, so it never is proved (R&amp;J).</td>
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<td></td>
<td>Lots of its hearsay. <em>Hearsay indeed</em> (R&amp;J).</td>
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<td></td>
<td>Rationalisations &amp; avoidance.</td>
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<td>Message is very, very positive.</td>
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<td>Shut up and <em>sit down.</em></td>
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<td></td>
<td>Silencing.</td>
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<td>Try finding person above. Got very busy diary (R&amp;J).</td>
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<td></td>
<td>Busy at the moment! (R&amp;J).</td>
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<td></td>
<td>Investigate <em>forever and a day.</em></td>
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<td></td>
<td>Delay.</td>
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<td>Deflection.</td>
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<td></td>
<td>Despondency of member.</td>
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<td>Justification/rationalisation of lack of action</td>
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<td>Got to go through process, grievance process (R&amp;J).</td>
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<td></td>
<td>Has to go in writing (R&amp;J).</td>
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<td>Well, that’s the way it is (R&amp;J).</td>
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<td>You can’t do anything about it (R&amp;J).</td>
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<td></td>
<td>That’s the way it is (R&amp;J).</td>
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<td>Unless person complains cannot do anything, so forget it (R&amp;J)</td>
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<td>Policy as blocks to resolution.</td>
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</tbody>
</table>
*Tied up* in bureaucracy.
If acknowledge problem, got to deal with it.
Takes it where don’t have to.
Don’t acknowledge.
If give it a name it exists. If hasn’t got a name can’t exist.
Prefer little niggly problems than major component needs addressing.
Something in team, can’t talk about it *out loud*.
*Reflect badly on them,* so let’s pretend it’s not happening! Lot of that.
*Going to* ‘*reflect me in a bad light’.*
Answer to next up, don’t want to look bad.
*Looking for job, fighting for role,* want this one.
Don’t want *any mud,* *sticking to me.*
Self-interest.
[Preting?] Disattending of highest order; from all levels.
Just don’t want to know.
If hasn’t got name doesn’t exist.
Culture, if don’t give it a name, if don’t say X happening then it’s not happening.
Very ‘*Hear no, see no, speak no*’ word evil missed off.
*Hear nothing,* see nothing, say nothing.
Don’t tell us what is going on, don’t listen to what we are saying, choose to ignore it if do it in *e-mail.*
So cannot see it.
Amount of people who don’t get that *e-mail!* [irony]

2
Avoid reality.
Anything highlight problems with performance, show negativity.
Boards don’t wish to hear reality.
Operating from position of blame.
Division.
Managers don’t want to know negative views, deviate from ‘*the party’ line’.
‘*Blue sky thinking’.*
‘*Supposed to be’.*
Rhetoric v reality.
*Creating names for themselves.*
NHS place to *make your name.*
Can’t have *bad name.*
Build individual reputation up.
Image building.
Image v substance.
‘*blue sky thinkers’* ‘*Blue sky’* and *top level.*
*Could change titles to fit.*
Same things; same rhetoric.
To media, awfully sorry putting X in place.
Nobody says what changes?
No challenge.
Just a response, *spin response.*
Acceptance of spin.
The truth: through NHS, government, don’t want reality.
Want to hear what want to hear.
Am not saying what people want to hear.
Saying what actually happening to patients/staff.
Shock.
Making it look certain way, to *tick boxes,* rather than looking at the reality.
Saying right things instead of looking at real issues.
Have to say it as it is, not really.
Give, not a *rosy picture,* have to give a *positive spin.*
Give poor report; penalised.
Why ever report on ‘never event’, if fined for reporting it?
Learn, never put anything negative, so safe to report.
Why when raise things, don’t want to know?
Implications of how seen on organisation
Wrong incentives, motivations.
Not seen as being open and honest, learning.
Why make that mistake?
Going to come down on you like a ton of bricks.
Punitive.
Key to it; it’s to be seen.
From top, all way through to bottom, it’s all about being seen.
It’s everybody, it’s seen to be doing this.
Everybody’s operating from position of blame.
Fear. Fear. Fear of not being seen to be something that we are not.
[Truth?] Doesn’t necessarily meet own individual, organisational agenda, or that paid to present.
Doesn’t demonstrate result supposed to achieve.
Say it’s about patient safety, but it’s not.
It’s about getting an organisation that appears to run smoothly, has no hiccups, is perfect, and
government will get no flak from in media.
All about image not reality.
Auditors: is way of presenting data is not lying, is truthful (R&J).
But, couple of more questions; different answer.
RM’s asking, pointing out next 2 questions.
Prefer to live with, for external reporting, answer which will, not put head above parapet, make you
look OK.
Nobody else reporting other stuff, so not going to do it. (R&J).
Point out things don’t necessarily want to hear.
Most trusts don’t lie in reporting, but are ways of manipulating figures honestly (R&J).
As long as keep that going, matters little, what next 2 answers to questions.
Don’t want reality.
It’s about how it looks again; presentation of it.
Best agency, NPSA disbanded because too raw, too close to the truth.
Telling people what nobody wanted to hear.
STEIS reporting dictated by media interest/story, not seriousness of incident.
Futile work/actions.
Priorities distorted.
Any notion to do with seriousness of incident, hogwash.
Whatever role, raising different concerns; don’t want to hear it
Get the treatment again; always same behaviours.
If not saying what want to hear.
Takes a lot, unfortunately, element of trust, time to get you, not there as enemy to make life
difficult, but help them get it right.
Raise concerns; seen as enemy.
Need understanding.
[Rat & Just?] That’s the way it is (R&J).
Can’t do anything about it (R&J).
Nothing’s been done, though blatantly obvious happening.
Lots of people, still not get accepted, because of how it looks.
Big stigma attached to senior manager, executive accused of bullying.
Don’t want it, reject it, even if know happening, won’t accept it, goes back to de-escalation and how
it looks.
Aggressive, start displaying unpleasant unacceptable behaviours, because scared.
They’re scared; need help.
Haven’t got knowledge.
More senior harder to ask.
Difficult to admit lack of knowledge, understanding.
CEs proud to say ‘I’m not shy to deal with something’, but don’t.
Rhetoric v reality.
Would just ‘look the other way’.
Everyone knew, nobody willing to put their head above the parapet, do anything about it.
‘Everyone else’s problem’.
Maybe HR like RMs a foot in both camps, difficult, very rarely going to be telling managers good
things.
**Bearers of bad news.**
- Knowledge and information, tell them, don't want to hear.
- Possibly same negative response.
- [HR] want to stay away from the problem.
- RMs stay with the problem.
- Won’t let it go.
- Fear of being found lacking

**[Written notes]** Very tempting to join club, part of ‘good news factory’.

**Dip in and out of that.**
- Trying to protect organisation also trying to protect interests patients/staff as advocate.
- Can accept giving positive picture as long as, cooperate to implement solutions.
- Often let down by that.
- Not managed to do that; fall into the trap.
- Avoid reporting things up.
- Sometimes make decision withhold information to have time to deal with issue.
- They don’t care about anything else as long as not reported; leave it behind.
- Executives and directors a bit of a game.
- How get away with doing least possible when trying to do other things?
  - **Balancing act.**
  - Good news factory like ‘Iced cake syndrome’.
  - Lovely on outside, mouldy on inside.
  - Part of culture led by government.
  - Present pretty picture fed up to voters.
  - [Mid Staffs?] Kidded themselves; we do it a lot.
  - Cannot bear doing any more work putting it right, so much to do, almost go into denial.
  - Like is some power wielding person like a Hitler figure going to do something really nasty to them.
  - Under great threat.
  - Something really, really nasty. Why don’t people say no?
  - [Push back?] Only interested in themselves, next job.
  - Very short term that level; looking for next job.
  - Head of HR protects Directors; *a body guard.*

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<thead>
<tr>
<th>3</th>
<th>Lot of talk.</th>
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<tbody>
<tr>
<td></td>
<td>Rhetoric v reality</td>
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<tr>
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<td>Frequent lip service paid to improving for patient/staff.</td>
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<td>Managers human beings, have feelings.</td>
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<td>Lot of success in life, position got to.</td>
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<td>Strength of feeling when something negative comes against them could be considerable.</td>
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<td>To protect their egos, self-confidence, want to avoid.</td>
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<td>Big problem need to deal with.</td>
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<td>Need to be able to accept criticism, do something about it.</td>
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<tr>
<th>4</th>
<th>“Creating the illusion of progress whilst producing confusion, inefficiency and demoralisation”.</th>
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<tbody>
<tr>
<td></td>
<td>Ignore it, it will get better.</td>
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<td>NHS has negative image.</td>
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<td>Concerned about negative image.</td>
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<td>Scared to make a decision.</td>
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<td>‘Risk adverse’.</td>
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<td>Making mistakes particularly costly ones, aren’t looked at favourably.</td>
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<td>If make a mistake; failed.</td>
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<td>Not given autonomy, second question.</td>
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<td><strong>Anxiety</strong></td>
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<td>Fear of making mistakes incredibly important.</td>
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<td>Typical when don’t want show any part organisation in a poor light, being publicised.</td>
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<td>Not unusual, it’s that ‘burying the head in the sand’.</td>
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<td>Showed didn’t care about negative behaviour.</td>
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<td>Hiding doesn’t improve things.</td>
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<td>From the top, senior management leadership, demonstrating behaviour is acceptable, that we want to bury things.</td>
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<td>Don’t want to deal with difficult questions.</td>
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<td>Fear of failure.</td>
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<td>Bit battle weary as well.</td>
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</table>
| Listening to same messages for 'God knows' many years.  
| No improvement.  
| Same message underpinning everything; no good news.  
| Daily Mail factor, all very negative.  
| Don’t hear *good news stories* about NHS.  
| Daily Mail, whatever newspaper, negative story about NHS in different location, think NHS is rubbish.  
| Hear enough times start to believe it.  
| Wouldn’t surprise me if [Hospital] involved; management style, to *railroad things through*.  
| Not facing up to things.  |

| Depressing, pathetic.  
| Previous situations, say banal statements like should ‘just focus on the positive’.  
| Why focus on all negative?  
| Want to push away negative/distance from.  
| Whole appreciative thing out of States.  
| Be smiling all of time, up for it, positive.  
| Crack at positive psychology movement.  
| Problem is things complex, feelings complex, negativity complex.  
| Can’t have just positive, can’t split positivity from negativity.  
| Like to say, this is the good, that is the bad. Good feelings, those are bad feelings.  
| All interdependent, interrelated.  
| Amusement when read monthly news bulletin.  
| Very glossy, looks wonderful, just cheery positive, wonderful.  
| Good news, amazing stuff, all achievements, rah, rah, rah, rah.  
| Ok, but see *underside*, is a fantasy.  
| If only think about positive aspects, incapacity to think what troubling or difficult, things worsen.  
| Need different approach; think constructively about both.  
| Have to acknowledge the negative.  
| Avoidance very natural reaction to fear.  
| *If I’m frightened of snakes then I don’t walk in tall grass.* Nothing talked about, nothing thought about. Nothing needs to be done.  
| Orwell ‘1984’ acronyms stop thinking; NHS full of acronyms.  
| Have language in talking.  
| Closes down, makes it impossible to think.  
| [B&H, so low] 'Didn't have to think', giveaway phrase.  
| Painful to think about things.  
| Peer group help to collude; some *live in kind of bubbles*.  
| Will only tell them what think want to hear.  
| Difficulty, middle management, very reliant on jobs.  
| Constant reorganisation, have to reposition themselves.  
| Not highly invested in *telling boss things are shit, everyone’s going down the pan*, morale is low.  
| More likely say everything’s great, going really well, performance on target, statistics prove it. [Big grins]  
| Look at screen, see how well doing.  
| Rhetoric v reality.  
| Departments winning awards, know; disastrous shape.  
| Senior management convey *very rosy award winning picture*; reality can be very different. Got to.  
| Can pull it off, can do it. Huge pressure to do it all the time.  
| Inspectorates, CQC, Monitor, rest, checking up.  
| Status as organisation depends on it.  
| Foundation this, that status.  
| *Got to be giving ‘can do’, competent image all time.*  
| Sometimes feel sympathetic. Seriously could lose jobs and occasionally get nicked.  
| Big fraud case, Independent picked it up, it’s a *big cover up*.  
| *Set up to fiddle everything, cover everything up* because didn’t want to lose jobs.  
| Fear.  
| *That’s other side of story.*  
| All probability, Christ, if this comes up won’t get this, or that, our star, foundation status, real anxieties, can be replaced, rid of quite easily, taken over. |
Ethical conflict.
Jobs at risk if don’t comply.
[Rat & Just?] Group rationalisation, to convince of rightness of action (R&J).
Cuts, have to make cuts, cut our costs (R&J).
Don’t have time, to meet, or think about something; common (R&J).
Economic imperative is big one (R&J).
Huge, driving everything.
Got to be competitive, it’s marketisation processes (R&J).
Got to be flexible (R&J).
Got to be flexible, you should accept less pay (R&J). Lots of rebanding (R&J).
All kinds rationalisations (R&J).
Difficult to counter it, or even think.
R&J stops thought.
Overwhelming.
Concepts; ‘well it’s obvious we should be doing this’. (R&J)
‘How could anyone complain we want to do it this way? (R&J).
Sensitivity to press reports.
Retraction of statements; say isn’t true.
Say staff are important.
Repeated behaviour & retractions.
Benefits, but in terms of cost sort of deafness goes on.
What do is threatening.
Not always welcome, changes things.
Change what get out of situation.
Threaten self-interest/benefit.
[Threat?] Talk with CEO, managers; not always comfortable relationship.
Dependent on maturity, ability to listen and their anxiety.
Trying to make sense why under threat.
Don’t understand actions.
Rationale is cost savings (R&J).
Don’t really buy it to be honest.
Think is a red herring.
Money could be found; something else going on.
Motives unclear.
Threatening because hear criticisms about organisation and senior management.
Senior position invested in one-sided rhetoric in trust monthly newsletter.
May see value of OST, but motivated to silence dissent

Defensive.
Staff defensive about current position.
Leadership defensive.
Patients/carers defensive now.
Loss of trust in professionals.
Defensive; making sure.
Really desire to get to bottom of it?
Management, desire to get to bottom of it.
Clerical more distancing, get away from blame.
So more concerned, than blaming?
Lothian.
Culture: particularly senior managers ‘don’t want bad news’.
Meeting: are we like this? All said ‘Oh no.
Go to be kidding!
Million grievances against senior managers there.
If some bad news want to wash own washing.
Don’t want anything unpleasant reported up the line.
Bad news needs to be managed, doesn’t get addressed.
Some awareness.
Clinical leads said, we just don’t learn.
Situation one place, should be lesson everywhere else.
Lack of learning.
Just say, "oh we’re not like that. Couldn’t happen here."
Lack of awareness and denial.
Is Scottish specific, flatness of structure, way of reporting.
Very, very, flat structure, need to manage whole political environment, means lot of things are closed down.
Not known; Closure thing.
Don’t learn from Lothian.
Know whole story of Lothian.
Don’t learn in Scotland in desire to close it down, part of political management health service.
Is desire not for things to blow like Staffs.
Hadn’t considered whether political closeness affects it.
For good and bad.
Probably little local MSP jumping up and down thinking can make.; there will be.
MSPs making political capital from bad news.
[‘Not like that’, how?] Probably believe that.
Mid staffs - Not another English trust thinks are Mid Staffs.
Mid Staffs not the worst.
Assured SHA, Francis report reviews, no trust like Mid Staffs.
Rubbish.
Just saying it enough, hearing it enough, putting in black and white enough, saying to people are all ok jack.
No trust put their hands up said, lot to learn from Staffs.
Not NHS specific thing.
Independent care providers, BBC.
Stuff going on, people know.
Try feed it back up. Hits the ceiling, bang.
CQC, used to self-assess high now go low. End up same mark.
Still same care way reported different.
Don’t go saying are, the ‘bees knees’; will fail.
Ian Patterson breast surgeon.
Haven’t; can everybody else look at all breast surgeons see what’s happening?
Lack of learning, self-assessment.
Trying to say rogue surgeon, now at GMC. (R&J)
Like rogue trader thing.
Bloke got done this week, sure wasn’t only one, banking guy.
Where is the learning?
Other than say, look at us, aren’t we great, rooted it out?
Allowed it to happen long time, then don’t share it.
[‘Good news factory’?] Stopping bad news factory’ rather than ‘good news’. Frantic responses, and covering things.
Lovely NHS nurses dancing around beds; couldn’t watch it.
We dance around; turned it off.
Knew billions spent on opening.
Celebrating NHS, but being destroyed.
The contrast; dreadful.
Extreme discomfort.
That veneer gets painted over.
Look everything’s fine.
Let’s paint veneer over it.
People going hungry, NHS just collapsing.
Bitter taste in mouth cost so much.
Director interviewing sheep, thought Jesus [L of L].
About state of country etc.
Veneer in sense ties in with scapegoating of managers.
In middle between staff and directors.
Whipping boy, least support, get it from below, and above, all the time.
Have to present veneer of everything being fine and ticking along nicely.
Don’t want to create fear.
Losing confidence in NHS.
Constantly back to veneer, and false front. 
['Good news factory']?
Politics, going for FT.
Cover up where work, got to be careful.
Fear of identification.
Fear put into, from director level.
Again this stiff upper lip making sure everything is looking good.
Appears good.
Lack of concern with reality; all image.
Inspections; always have to put forward best, don’t show up flaws.
Concern who talks to inspectors.
Complete lack of honesty.
[Rat & just’s?] It’s good management, not bullying (R&J).
Stressed, got so much work on, that type of thing (R&J).
It’s her personality (R&J).
Acceptance, nobody wanting to challenge.
Too frightened.
If are one to put head above the parapet, and then it gets shot off like yours did (R&J).
Too risky (R&J).
Best way to survive is to keep your head down.
If things go wrong for patients, not my fault, it’s theirs (R&J).
Have their directives, what going to do (R&J).
Push, push, push, don’t want to listen to, creating unsafe structure.
People going to suffer, managers not got competencies.
Don’t want to hear that.
That’s muddying the water, so shut it up, silence it.
Immune to suffering of others.

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<tr>
<th>Int</th>
<th>Categories of Framework Theme 13: SMD/ego-defences (Interviews)</th>
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<tbody>
<tr>
<td>1</td>
<td>Don’t believe any B&amp;H in their area.</td>
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<td>Refuse to believe.</td>
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<td>Doesn’t set good example.</td>
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<td>Don’t want to know goes on.</td>
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<td>It’s very awkward.</td>
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<td>Told doesn’t happen.</td>
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<td>HR said didn’t have H&amp;B in trust.</td>
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<td>If don’t do anything ‘swept under the carpet’, forgotten.</td>
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<td>Doesn’t reflect well on organisation.</td>
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<td>Don’t want to know anything untoward happening.</td>
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<td>Like to ‘let sleeping dogs lie’.</td>
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<td>Got to admit it happens.</td>
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<td>Nobody is infallible.</td>
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<td>NHS got a problem.</td>
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<td>[Why don’t admit?] Won’t! [L].</td>
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<td>Haven’t got the guts.</td>
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<td>If admitted it, maybe called over the coals.</td>
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<td></td>
<td>Scared of H&amp;S and B&amp;H.</td>
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<td></td>
<td>Don’t want to admit.</td>
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<td>Don’t know how to deal with it.</td>
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<td>[Why scared?] Can get very bad name if goes about.</td>
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<td>Whole trust, very bad name.</td>
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<td>2</td>
<td>Constant changes, everyone can say do not have time, changes required, to truly support staff (R&amp;J).</td>
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Historically NHS always been blaming.

High blame culture. Complaints common but lengthy, drawn out, seek to attribute blame. Want to close issue down quickly; reduce negative impact. Suspect reluctance to settle matter; admission was a problem. Avoid admission of problems Level of award ET; real issues about stewardship of public resources. Hard to read minds of those who defend the indefensible! (R&J) [Diff to discuss?] Reality. Duty to Organisation to ‘manage’, finite resources, forever changing objectives. Better just get on with it, pretend everything is OK! Reality, Older person rehab, end of life care, not well resourced. Usually not acknowledged by management. Sometimes seems working to realise unachievable goals. Unit smaller, improved facilities. Few years ago one bath, 32 patients; brought this up. Manager, ‘you are staff nurse, your responsibility to make sure patients bathed.’ (R&J)

Deflection. Shift responsibility down. Documentation, much duplication. Even now reality patients very dependent. If 2 HCAs, 16 patient’s, bells will go unanswered, patients needs unmet. Consequently ‘uncaring’ nurses continue to get pilloried by press. Patients promised ‘intensive physio’; do not provide this. Unrealistic claims made, promises unfulfilled. Pretence. Physio, OT hours not enough to help patients achieve goals within desirable time frame. ‘Pretending everything is OK’; coping mechanism used. To confront problems need to be addressed, too much hassle. Why some problems become very serious before anything gets done. [Neg behaviour] Too easily look for reasons why behaviour occurring, try justify what clearly wrong (R&J).

Make excuses. [Late action re neg beh] Don’t know why. Reluctance of manager to acknowledge, deal with situation. Easier not to acknowledge. [Resisting action?] Easier to ignore it.

Telling manager bullying, hard for individual to be told. Reaction, in acceptance, or complete denial. Individuals, managers, ‘turn a blind eye’.
Profile raised in organisations. Often worried if ‘open a can’ [L], ‘the worms will come out’ [L]. Are lots of worms. Anxiety at the top was going to open something, unleash something going to be unpleasant. Justified bullying, harassing behaviour, not being big problem, only percentage sent survey, only percentage responded (R&J).
Not capturing whole organisation (R&J).  
Culture enclosed, it’s ‘head in sand’.  
If don’t talk about it, don’t acknowledge it, not happening.  
Denial.  
Resistance to knowledge.  
Seriously worry about exec, senior management team behaves like that.  
Continually changing executive team easy to make **scapegoats of those low down pecking order**.  
Déflection of blame.  
Shift blame/responsibility down.  
[Director] Wasn’t going to take blame for failure.  
Project doesn’t deliver finances; blame project manager.  
Bullies at top department, don’t believe any problem, or refuse to listen to it.  
If somebody makes any kind of hassle; ones get watched, pushed out.  

‘focus on good things’.  

Need NHS to **face up** to mess beloved institution in.  
Society not good at facing realities.  
Utter denial.  
‘cover up’, ‘airbrush’.  
Need to break culture of denial, sham.  
CQC designed to **charade**.  
‘covering up’, in complete denial’.  
‘**shooting the messenger**’.  
Secrecy, is default of NHS.  
Blame organisations as opposed to blame free.  
Beings to describe it; pretty unpleasant.  
3 reports hidden away by NHS.  
Practically everybody DOH sneered at reports, dismissed them.  
Proves a point.  
Another element culture, ‘keep the lid on’, ‘don’t expose your dirty linen in public’.  
If people want to do that, attack them professionally, personally, make them go see psychiatrists.  
If beat you at IET, pursue for costs.  
No end to what NHS will do to people who try to break open ‘the citadel’.  
‘**keeping the lid on**’.  
Thou shalt not let public know how many people NHS actually kills.  
Negligence, errors, harm each year, through very basic things.  
Does not want to expose, although gradually coming out, appalling care to elderly people.  
Way culture, our society works.  
Key critique ‘**The Emperor’s New Clothes**’, King’s new clothes.  
A little boy; look what’s going on.  
All that drives culture of NHS, Thou shalt not break the golden rule’.  
[Golden rule is?] **Golden rule is keep stum, don’t let it out**.  
**Try to keep the lid on it**.  
If complain treated as whistle blower.  
Hospitals, managers, or doctors.  
Doctors driven by medical unions.  
Do not ‘**give the game away**’.  
Do not admit liability.  
Prevaricate or procrastinate.  
Something to hide, something being hidden.  
Avoidance.  
Problem got in [--].  
People want to say. Wasn’t really such a big deal (R&J).  
People died unnecessarily, over few years period.  
Were elderly, die anyway (R&J).  
How NHS operates, when concerns raised.  
Idea, complaints such a valuable resource of learning!  
HA, HA...HA one has to say to that [Cynical laughter].  
Rhetoric not reality.  
Campaign from [TU] to blame health care assistants for poor care elderly receive.
This is the reality
[Nobody wants to face it?] No, too difficult, it’s uncomfortable
[Report dignity of care] more of same.
Leaders must do this, need to do that, have to.
Keeps off all uncomfortable subjects.
NHS confederation body, members NHS hospitals, other trusts.
Want it to be all behind [processing of complaints], because don’t want to give the game away.
Part of the game.
Who be first one?
If someone starts to face up to it, not position ultimate power, the system will eliminate them.
If top person recruited to keep the lid on are in deep trouble, unless person of sufficient weight.
[Not facing up to harsh realities] Yes, all part of that, that’s our society.
Society, people in NHS, people who lead it, politicians.
All take cue, from way we all are as society.
Chaos on the move, all the time.
Utter chaos on the move all the time, nobody wants to admit that.
Denial, cover up, air brushed, complete denial.
Saying the right things.
Artefacts of culture.
People who talk that organisational language, culture language.
All artefacts [meaning tools or work of art] of culture.
Denial, charade all part of it.
See in the bullying, failure to take complaint seriously.
Charade of meeting 4 hour target.
Rub it out little bit, put it back at start, won’t say anything.
On board, always way of fiddling it.
[Trust] charade operated grand scale.
All CQC self-assessment stuff, total charade.
Clinical governance system? Tick the box, yes.
Whether did anything, neither here nor there.
Not interested, part of charade.
Everything to look good.
All different organisations; blame each other.
All part same game.
Managerial-ism, bring along ideas, or buy into ‘set of words’, phrases.
Culture of ‘trotting out stuff’.
Detached from reality of world.
Fools people.
‘Leadership’ one of favourite phrases.
Did […] point transformation plan of managerial-ism.
Detached from real world; typical of NHS.
Jogs memory, situation similar kind.
Manifestation of everything at [Trust].
Say had problems, went into denial.
Rubbished [information & reports].
[Similar things happened]
Commissioned, do spoiling exercise, say things good really.
Scenario actions; absolutely the NHS, way NHS is.
Not only not pay attention, tries to rubbish things will tell the truth.
Piece of work done, disappeared down black hole; same thing.
Here’s evidence, it’s uncomfortable, need to do something; ‘Airbrushed out of history’.
Not talked about local councillors, hospital governors non-executives or nodding NEDs.
Same, all conspire, don’t want to know.
DOH’s response to crisis.
NHS treats 99.9% of patients very well, on time, etcetera (R&J).
Of course problems going to arise time to time (R&J).
Always switch it round (R&J).
Part of same effect.
Get increasingly difficult, new executive team, to raise issues.
Not surprised if don’t close Board meetings.
Don’t want anything to leak out.
Just couple paragraphs to hospital governors.
Know won’t ask any questions.
Accurate of what was going on.
That’s your NHS.

[Research] If got into newspaper, research journals.
Somebody from Whitehall ringing up, politely, perhaps not politely.
What the hell doing there, to let this get out.
Hospitals PR/communications manager.
Just wanted nothing, even slightest thing, didn’t want PPI forum to say anything.
Didn’t uncover great scandals, but petrified about anything.
That’s way do things.

[MAND] Told it like it was, truth & reconciliation.
Hospitals don’t do that; not brave enough.
People just defend what done; shown not in reality.
[forum] Reports saying place isn’t clean etcetera.
It disappeared; taken out of the record.
That’s breaking rules, being critical.

[CITADEL?] Citadel is notional home of big secret.
NHS cannot do better than killing lot of people.
Treating tens if [not] thousands, largely elderly, appalling manner.
Metaphor for NHS, AJ Cronin’s title.
Primary purpose is to protect itself.
Public believe there solely to make them better.
When individuals see what’s going on in Citadel try to advertise; be repulsed.
[Organisation] broke down walls of Citadel because suited new ruler to help break them down.
Insiders wondering how to respond to being on display.
First response, pretend nothing happened.
Hope walls can be rebuilt.
[Good news factory?] Spot on!
Two manifestations.
Great when things go well.
Nasty, aggressive, dishonest, vindictive, much more when go wrong.
Rule is don’t embarrass Prime Minister, don’t embarrass Health Secretary.
NHS train, going over complicated sets of points rattling, shaking, wobbling a little bit, expect to get back on track.
Because will deny everything.
Say when report comes out.
Done all of that, did it, done it, fixed it, did this, look.
Truth, nothing done.
Not sure -- knows what he needs to do.
Patient voices at board meetings, often just somebody there to praise hospital.
Which planet on?
Don’t know how it works.
Live in this La, La, Land.

[Trust] problems of covering up, and awful care.
[NHS train?] Metaphor.
Normal mode NHS runs along quite smoothly as it covers up all of chaos.
Gets to complex set of points, slows down swings and sways (Mid staffs disaster), but spins and lies its way past it, then goes smoothly on.
Consultant (worst case of NHS machine bullying) reminded me to read Bristol babies’ report on culture.
Kennedy/team fundamental errors.
Very little changed.
Milburn, Reid, Hewitt, Johnson, Burnham didn’t want change.
Their enforcers, Carruthers, Crisp, Nicholson ensured was none, although looked as though been lots.
Appearances not reality.
Chapter 21. IK making assumption NHS is for patients!!!!
NHS staff are "dedicated", unconditional.
Entire investigation demonstrated opposite. Cultures take a long time to change; they don’t. True leaders can change them overnight. Evidence of it every day. [Trust] in deep, deep crisis again, always was. For last year, board, management tried to deny it. Boss at [Trust] didn’t like stories exposing big problems there, removed [person]. [Newspapers] producing spin for hospitals. [Nursing leaders] involved with cover ups around poor care. People need to acknowledge this and resign.

**16 Organisational responses 1) denial 2) dismissive.**

*Push things under the carpet.*
Respond this way, senior managers don’t want to deal with junior managers, reflects poorly on organisation!
Staff behave negatively, as don’t understand human behaviours, id, ego, super ego.
It’s about power or superficial issues.

**17 Not open disclosure of problems, or culture of honesty.**
'Blame free' culture not encouraged.
Failure to learn from earlier inquiries.
NHS is secretive, self-protecting.
Perverse incentives to focus on input/outputs rather than quality.
Insatiable political demands for good news, burial of bad news.
Manipulation, corruption of data to deliver good news.
Credit is centralised.
Blame is shifted downwards.
Inability or lack of inclination to read warning signs.
Maybe *wilful blindness*.
No focus on quality.
"Ethical fading" term in literature, corporate governance.
Downward spiral in standards of conduct when executives, board members *turn blind eye* to malpractice.
Frequently starts small way, progressively worse as *culture of cover up* progresses.
'Wilful blindness' frequent consequence.
Most people work in it believe in fundamental principles.
Try hard to do high quality job.
Feel obliged to compromise to meet political objectives, retain positions.
Causes many real internal conflict, some find very difficult to handle.
Applies to HR specialists as much as others.
Would not describe situation 'moral vacuum'.
*Ethical fading* significantly present varying degrees.
Study literature on dysfunctional organisations to understand why ordinary people with basically sound moral judgements prepared to *turn blind eye* or perpetrate evil deeds.
Resistance to *bad news*, constant promotion of good.
Tendencies to *turn blind eye* to, or suppress, politically unwelcome news.
Importance of protecting reputation, also encourages dishonesty.
Less transparency, concealment or denial when things go wrong.
*Rat set in* during increased intensity 'spin' introduced by New Labour government, insatiable appetite for good news.
PM only work experience in PR, can see consequences!
Used dishonest to encapsulate difference between 'good news factory' and reality on the ground.
Associated self-delusion/wilful blindness many politicians, some managers.
Mismatch between reality and aspiration re level of quality can be achieved.
Constraints of context.
Corrupt in context to denote deception, manipulation of truth re denial of reality when things go wrong.
Corrupting impact of context (e.g. perverse financial incentives).

**18 Culture of NHS, particularly hospital sector, is not to embarrass the minister.**
Politically difficult to accept have poor hospitals.
Difficult to accept, poor care, for political reasons, publicity reasons.
[Multiple examples given of altering figures/changing coding to make situations, care look better]
Managers responsible for changing, signing off data, CEOs SHAs.
Same time high mortality rates published, trying to put Mid Staffs one of best in country.
Hospitals ignoring data; completely irresponsible.
Tried to discredit mortality figures.
Cost and *good news story* more important than quality/safety of care.
*Spin* more important than providing good service.
Political importance to government to have *good news story*.
If report going to discuss, was criticism or report poor quality/poor service provided.
Managers taking action make sure report, various levels, *did not reach light of day* or not get publication.
Response of DOH to data.
People told to ignore it.
People assisted getting into public domain.
Tried to suppress it.
[Going on for years/different people] Yes
[Good news factory?] Likely to be true.
Function of DOH is to manage *good news stories* for minister, is their job; nothing else.
[Scary isn’t it?] Very scary.
Not many people can be honest, straight forward about things.
DOH communications raison d’etre is to produce *good news story* for minister.
Minister said all did what No 10 wanted.
Does not want, party political reasons, a *bad news story*.

**19**

Very defensive culture.
Not committed to openness.
Not committed to learning from mistakes, or near misses.
Very defensive culture.
Not willing to reflect, look at itself, see how to improve.
Defensive.
Not willing to listen to external criticism or any external efforts to move in different direction.
Passive aggression.
Pretend to go along with it, then don’t do anything.
Defensive, unwillingness *to hold up hands* to admit when got something wrong.
See with serious untoward incidents, reporting of those, how handled.
Desire, normal response is not want to ‘wash dirty linen in public’.
Try, deal with internally, without learning lessons.
‘Organisation with a memory’, based on airline industry; *sunk without trace*.
Staffordshire hospital.
It’s extreme [scenario].
Notion being unwilling to collaborate with this kind of findings, work, recognise.
Commission stuff tell them what want to hear.
[Whistleblowers/protecting image of organisation?] Organisation should be in disrepute.
Somebody, position becomes intolerable, is parting of ways.
Compromise agreements, essentially *gag people*.
Organisation should be being *exposed to light of day*, but it’s avoiding it.
[Protection of image organisation more important than patient, welfare of staff] That’s right
[Why?] Democratic deficy (sic), deficit, lack of accountability.
Fascist situation, technocrats *running the show* without, democratic accountability.
Own personal interest, dominate agenda. What is about.

**20**

Culture at the *top* controlling, not liberating.
Opaque not transparent.
More concerned with reputation than delivering safe care.
Culture created, get on by never making a mistake can be *PINNED ON YOU*.
Creates one worst aspect culture, blame culture.
More senior positions blame others lower down *management chain*.
In turn, to avoid blame, act inappropriate ways e.g. manipulating waiting lists, concealing clinical incidents.
SoS concerned with reputation and suppression of *bad news*.
Inevitable culture spill over into Civil Service.
SoS may put patient care at top.
SoS’s do not last long enough to counter cumulative effect culture over years. Do not win votes for NHS, could lose them.  
*Bury bad news*, claim all one off incidents etc becomes norm *(R&J)*.  
[Good news factory?] *Good news factory* not bad description parts of NHS.  
Are good, enlightened managers.  
Deep culture of *cover up bad news, maximum gloss* etc.  
Part of training, within ‘norms’ of behaviour.  
Do not get on by making mistakes.  
Paradoxically do not get sacked for them either.  
At worst get moved round system!  
Get sacked for exposing them hence concerns about *whistle blowers*.  
Suspect not wishing to be ‘implicated’ in *bad news story* led people to leaving meeting.  
Negative behaviour may well been coming from top.  
Suppression from Board because Non Exec Directors there.  
Would not wish to expose issues in forum where cannot control outcome.  
Same happened in [Trust].  
Do not get on by being open and transparent.  
*Rat/just’s??* Mind-set difficulty understanding.  
If get on by never making a mistake, more to point no mistake ever being *pinned on you*, work in blame culture, perhaps inevitable consequence.  
Worse perhaps many get into positions of power, through adopting that mind-set.  
Becomes over-arching culture.  
Sacking of *whistle blower*, won ET, not NHS.  
Clear documentary evidence very senior manager realised organisation wrong.  
Lead up to appeal against dismissal, appeal chairing, wrote in email (before hearing), come too far to reverse dismissal!!

| 21 | Pattern: managers, highly challenging areas, failing to turn them around, moved on, manager gets blame.  
Another manager brought in as saviour, pattern repeated.  
Many organisations/senior team only want *good news*.  
Very reluctant to engage with anything does not reflect well on them.  
Especially if don’t know how to change it  
[Only want good news?] In [Country] executive team, very close to politicians, government  
CE/executive teams feel pressure.  
Massive financial pressure.  
Achieving target really important, careers completely dependent on financial targets.  
Want *good news* and solutions.  
Don’t want problems to think about.  
Just below them, careers dependent on last ‘gig’.  
Need to perform parlance of times, bring bosses *good news*.  
Need to demonstrate can perform.  
Next time cull, won’t be them displaced, removed.  
Dynamic gets played out.  
If clinical person, extent ‘got a ticket’, job anywhere.  
If manager, middle and higher middle manager, not same.  
Very important seen to perform, coping.  
Not going to do career any good if go along with *bad news*, problems, difficulties.  
Dynamic.  
What see quite a lot, wouldn’t say fabrication, but cliché.  
‘economy with the truth’, in information gets passed up.  
Clear understanding not to take problems, take answers, things positive.  
Occasionally feels like working in two organisations.  
One talked about senior level, one experienced on the ground.  
Cannot hear message because cannot do anything, because of financial position.  
Don’t think anybody evil, just think unfortunate dynamic at moment.  
As long staff keep running faster and faster, will be ignored.  
[‘good news factory’?] Can understand that analysis, but think systemic dynamic going on.  
Have skewed picture of organisation.  
Job is not to hear *good news*, job is to hear *bad news*.  
People bring problems to talk about. |
Some of stories very pervasive; I listen to these stories. Then hear announcement on internal internet. Marvellous news in organisation, how great it all is in ‘so and so’ bit. *Feels like, 1984.*

*No-one has got any bread to eat, it’s all absolutely ghastly, drinking horrible, cheap spirits to keep hopes up, is announcement, fantastic news grain yields up by million percent this year.* Feels bit like that sometimes. Isn’t how feels to me, lots of people listening to everyday. Look at politicians, *played out right across system.* It’s sort of a fabrication. Constant fabrication about how things are because how going to get elected again. Gets played out.

Politician who is honest, if can be honest and survive, done bloody well. People like [---] and [---] e.g. unusual examples, interesting. Encourage people to take care of themselves. To protect them, separate themselves out from organisation. Long history NHS staff feeling organisation will look after them. Wouldn’t call themselves corporate people. Certainly in ‘NHS family’. Would be looked after. Last 10 years definitely changed. Consistently encourage people take care of own careers, themselves. Separate out from organisation. Metaphor, partner, betrayed you some way. Forgive them, take them back, but never the same. To protect yourself disengage emotionally. What people have to do now. Loss to organisation. ‘Good will’, people services, of staff, what makes it all work. Eroded. People won’t be prepared to give extra bit anymore. Because how being treated. Normal behaviour. Costs the organisation. Although trying to save money. Erosion of ‘good will’ means costing them; cannot measure it. If cannot measure it, cannot count it, it doesn’t count. Soft stuff very hard to track actual pathway. Virtually impossible. To track pathway between, outcome, cause of outcome, so complicated. [Senior management view staff?] Cognitive dissonance. To cope in jobs have to resolve dissonance. Each senior manager different way doing that. Some dismiss staff, lose respect for them. Only way can cope. Some people never been clinicians, don’t understand anyway. Almost have to have these layers. If do understand what clinical work like, very hard to do senior management jobs. Know what impact going to be. Have to resolve dissonance somehow. Denying it. Leaving the job [L]. Having a nervous breakdown [L]. Some, very hard to sustain. Some *say put on a mask* in order to cope. Some personalities means doesn’t particularly affect them. Can just move on to next thing. Occasional senior manager/executive understands fully, also able to survive senior level. Are unusual. Complete respect for them. Really get it, yet, survive at senior level. Implement what required, with some integrity. Very hard to do. Some struggle with that dissonance.
Very, very, draining for some people.
[Robots, automaton?] Yes, if view as change of behaviour.
Another extreme metaphor, people who had to do all sorts of things to survive in concentration camps during war.
Incredibly extreme example, but that type of thing.
It is what do I have to do to survive?
Got a mortgage, a family.
How do I do this?
Is about reducing dissonance.
Whether begin to believe what doing, don’t know.
Afterwards people really suffer because recognise what had to do.
Those people are the most dangerous.
Ones most chameleon like, just take on next thing required.
Not bad people, kind to families.
Almost, at work, value free; that is quite hard.
Whereas somebody, my position years of training, values, principles.
Everything comes across my desk viewed through that filter.
Privilege, responsibility to say, won’t be doing that.
Doesn’t fit with professional training, standards.
Lot of people don’t have that.
Hilarious, one minute in cardigan, next day, in cocktail dress [L of L].
‘Oh hello, [L of L] what going on here? 
[Moral vacuum?] One way understanding it.
My discourse, narrative, aren’t by and large bad people.
Sometimes does look like; don’t get it.
Totally focus on people’s behaviour, not personality.
One or two people who are, [L] borderline.
Mostly, how would I be in that position?
Don’t know answer.
Are some decent people.
Know one or two people very senior positions; good values.
Try to do their best in nightmare situation.
[Rat/just’s?] Clinical, making best of bad job sending 90 year old home 11pm.
On trolley all night, no beds. (R&J).
Never heard senior level, execs talking about justifying actions not best interest patients/staff.
Would never admit, never admit that.
Wouldn’t be possible for them to hold onto jobs, if articulating that.
So it is all good, basically.
[Nothing wrong?] Can’t afford, to be thinking like that.
A road to nowhere for them.
[Denial?] Don’t know what happening in heads.
Focusing on behaviour.
Not in their best interest to be talking in that way.
Talking about, old fashioned way of talking about this, ‘working smarter’, ‘sweating the assets’, that kind of stuff (R&J).
What thinking, absolutely no idea.
Think executive team genuinely trying to do their best, genuinely trying to move services.
Hospitals into community, cared at home.
Working very hard reconfiguration of workforce.
Incredibly hard to do, NHS good at is beds, constant draw on resources.
Moving services into community, big ask.
Most part doing their best under very difficult circumstances.
By and large, not in control of their destiny.
Behaviour talking about as consequence gets played out.

22

23

24

25 Culture of blame immediate response when something goes wrong.
Blame.
Not taking responsibility when things go wrong.
| 26 | Staff need to take risks, test whether Boards/managers want to know what is happening.  
   |   | [Why don't Boards/managers want to know what happening?]  
   |   | Not simple, straight-forward answer.  
   |   | Sometimes depends who raises unpopular issues, whom speak to.  
   |   | Maybe someone thinks reflects on them. Will not want to pass it on.  
   |   | No manager, Board will say do not want to hear bad news as well as good news.  
   |   | Truly believe systems in place to facilitate this happening.  
   |   | Seemed slow to accept had computer system failures as well. |
| 27 | Last two years dramatic shift to defensiveness within NHS organisations.  
   |   | Significant difficulty attempting to balance running public service, with requirement to stay within financial limits.  
   |   | Defensive.  
   |   | Reason vast majority costs linked to staff (70% operating costs average DGH).  
   |   | Security of NHS contracts very difficult to release staff quickly [[Euphemism]] without incurring significant redundancies.  
   |   | Senior managers, by far worst, in respect of this type behaviour.  
   |   | Egos of Directors, CEs, cannot be seen to be “backing down” by reaching intelligent compromise agreements with other organisations.  
   |   | Produce months, even years stalemate, often to patients’ detriment.  
   |   | Common fault Executive Director level, externalise problems their organisations, blaming other organisations.  
   |   | Occasions, this behaviour stimulated by ways key regulators measure our understanding of risk, governance effectiveness.  
   |   | [[Rat & just’s?] 95% A&E or Mark Newbold’s “Majors” Internal Cross Charging, anything to do with budgets (R&J).  
   |   | Model using front door to train staff rather than American model. Moving patients creates infection (R&J) [This response statement not fully understood!] |
| 28 |   | ![Image of NHS] Hitler in his bunker.  
   |   | Optimises secrecy, colluding, non-consultation.  
   |   | Image conjures up that.  
   |   | After 35 years working public sector not many things strike you forcibly anymore.  
   |   | Get neutralised, acclimatised to most practices.  
   |   | [[Examples of Rat & just’s] Latter days, say I agree with you, but that’s what it is, I’ve been told to do that (R&J).  
   |   | Can’t do anything about it, so that’s what we have to do (R&J).  
   |   | [[Rat & just’s] Governed by money and resources, will be about money, resources. Meet needs not wants (R&J). |
| 29 |   | Pay lip service to views those working on the ground.  
   |   | CE, ‘Good to sack a few consultants now and again, makes sure others toe the line’(R&J).  
   |   | Number reasons poor culture.  
   |   | In goal-driven culture, end (goal) often considered to justify means (R&J).  
   |   | Long as goal achieved, lies, bullying is fine (R&J).  
   |   | Managers no proper accountability, re professional regulation.  
   |   | Mistakes by managers ignored, downplayed.  
   |   | Clinical mistakes, major inquiry.  
   |   | Problems with managers, police investigating police.  
   |   | Managers, some doctors all support each other.  
   |   | Reluctance to have independent external input, if input happens is ignored.  
   |   | Ignored input, ignored professional guidelines as wished.  
   |   | No leadership from DOH, Trusts.  
   |   | Especially FTs, so much independence, do what want, DOH does not intervene.  
   |   | Regulatory authorities, CQC, Monitor, mainly deal with clinical issues, ignore management culture.  
   |   | Limit to what can see on site visit.  
   |   | Trusts can easily hide dirty linen.  
   |   | [[Good news Factory?] Entirely agree ‘good news factory’ operates many Trusts.  
   |   | Explanation complex psychological one.  
   |   | Individuals, constantly, often unconsciously, obsessed with self-image.  
   |   | How look, how are as person to others, what think of ourselves. |
Survival instincts.
Large part of our self, having ‘a self’ are happy with.
Will never admit to some things.
Intact, flourishing, praised-by-others self more likely to survive, physically, psychologically.
‘Self’ matters, self-image also matters.
Image others see of us, also matters.
Not large jump to see organization also has a ‘self’.
Many parameters of individual ‘self’.
Image of that ‘self’ matters.
Psychotherapists speculated on this. Maslow, concept of self.
Other factors, importance of media, league tables, honours/awards coming out on top, etc.
[.Rat & just’s?] Try to find own justification(R&J).
Try to find people to say nasty things, evidence of fraud, money for personal gain (R&J).
When turn out wrong wouldn’t stand up, justify complaint.
Didn't apologise, say 'got it wrong'.
Happens all time when try to dismiss somebody no good reason.
Try to find as much as can, try to twist and turn, find something to nail [person] with (R&J).
That’s the depth, the end justifies the means (R&J).
It doesn’t matter.
Don't talk to people because don't want to hear the truth.
It's the agenda have got (R&J).
Decide want to get rid of troublemakers (R&J).
Set a trap.
Have it in for people.
Got their overall agenda (R&J).
If agenda is get rid of employee, everything else fails by wayside.
If patient care suffers, staff wellbeing suffers, upset people, have to ruin somebody’s life, doesn’t matter.
Our agenda is, so focus on goal (R&J). Maybe legitimate goal, targets.
Not reaching government targets.
All driven by some higher agenda (R&J).
Instead base principle, ethical, moral standards should stick by.
Should treat patients, staff with care, consideration, compassion, be truthful, compassionate all times in things do. Instead, what are our goals? (R&J).
Goals may be make sure reputation hospital doesn't get damaged.
If person causing damage, say bringing hospital into disrepute (R&J).
Shouldn't be telling people outside problems in working conditions.
None of your business.
Bringing hospital into disrepute (R&J).
Twist things round, scraping for crumbs.
Bringing hospital into disrepute.
Bringing up, used again, again (R&J).
Didn't worry about own procedures.
Don't give warnings.
Didn't matter only do something once.
All governed by own agenda (R&J).
Manager, ‘won't allow say anything about doctor’, as if could suppress right to free speech.
Tried to say not allowed to freely express opinions, views on someone.
Consultant bullied me, bullied somebody else.
"have to show people who’s in charge”.
His excuse (R&J).
Concept of ‘self’ always, unconsciously carry around this self-image.
Do everything to portray it, as being good.
Anything harms self-image, automatically, try to avoid or, oppose.
Individual got self-image, is important, Obviously ultimate self is survival.
Got to survive.
Carry around, image, what like.
Self-image like to convince ourselves, portray to outside world.
If somebody tries to damage self-image, or what think is self-image, say things against us, try to protect it.
Applies to organisation, have self-image, especially when high profile organisation. Got self-image, wonderful slogan.
As if our way is right way, everybody else’s is wrong way.
This image, we are the best.
If someone dents image [examples serious incidents].
Begin to go into paranoid defensive state, no, that can’t be.
Do everything possible to protect.
[People] got negative effects.
Have to show very strict, don’t tolerate.
Sacked couple of consultants, others over minor clinical matter.
As if to say, things were about us being unsafe hospital.
Not unsafe hospital, ‘are whiter than white’.
To show that, consultant, give him the sack.
Shows how good we are.
Partly revolves around self-image, but don’t think about basics.
Hold on the basics is what is important for patient care.
Important for staff wellbeing, how can we be truthful, compassionate in our behaviour.
Forget about our reputation.
Reputation will look after itself.
If clinical error takes place, huge inquiry.
Major error, apologies, compensation, meetings.
What lessons can be learned.
When management error takes place, just buried.
Totally ignored.
No inquiry, nothing.
No apology.
Managers treated differently.
Management error may be unfair dismissal.
Sacked person by mistake, shouldn’t done that.
Admit done wrong? Never in a million years.
Harm to patient care, spending hundreds of thousands of tax payer’s money, stress to staff, families.
Though error, let’s ignore.
People who did management error, get promoted.
Nothing happens to them.
No accountability, no apology, no training course.
Managers protected.
Huge double standards.
Reputation, largely around image.
Carry image of ourselves, organisations sometimes as concerned.
Got huge PR department.
Try to show what wonderful thing are.
Always high profile events.
Proclaim themselves kind, generous, wonderful.
Concerned, partly dependent on public, local MPS, people like that.
Try to manipulate local media; don’t have proof of that.
Probably that going on as well indirectly.
All to do with ‘the self’ and ‘the end justifies the means’.
The end is good self-image, come across well.
If means to getting that break the law, cause somebody to commit suicide, what’s the problem?
 Anything goes.

31 Generally defensive.
Defensive, bullying, blame.
Something goes wrong tendency to blame person, least power to resist.
Doctor at [hospital] perfect example.
Culture means anyone trying to speak to the truth makes group feel nervous, retreat into old comfortable ways being.
What happening so bad, hard to take it on board, may become unmanageable.
Much of response, unconscious drivers.
Responses in groups, sometimes takes us all by surprise.
Can act differently in different groups.
When something strange happens, someone gets very upset/angry stop, reflect why.
When try to speak truth, everyone becomes very anxious.
Response to me probably not unconscious.
Concerted effort to shut me up/put me back in my box.
Hated by manager.
May have a narcissistic personality.
Tension between organisational reputation and professional duty towards patients.
First priority is to my patients.
Once escalated to board level, not listened to.
Expectation is take it externally.
Organisation doesn’t want it to go externally, reflects badly on them.
[Hospital] depends upon charitable funding therefore negative press impact on donations.
Caused unhappiness, many [staff] within [hospital].
Might see it as trouble making, trying to destroy reputation, affecting their work.
My priority [patients] being let down.
Boards must take responsibility to prioritise patient safety, ensure patients safe within hospitals.
Currently no accountability for boards where fail to do this.
Pretty clear board supporting CE in my treatment.
Possibly being misled by CE.
MP went, met with CE, few members of Board.
Didn’t have full picture.
MP said lied to her.
Was collusion between board, CE, others to try and silence me.
[Protecting reputation organisation more important than patient/staff welfare?]
Coming from higher level.
NHS so political.
Failings reflects upon government.
Culture developed, mustn’t have any bad news.
‘Any mistakes have to be buried’.
Back firing because starting to get people coming out of woodwork left, right, and centre.
Stories reported.
Forgotten, patients, families not duty bound by employment restrictions.
Can speak, about things gone wrong to family members.
Definitely a tide within professionals now realising staying quiet doesn’t do anyone any good.
Increasingly difficult to keep lid on this.
But priority, mentality from higher levels wanted to ‘bury bad news’.
Backfiring.
Mentality backfiring, more and more things coming out.
Things get buried/gagging clauses.
Gagging clauses can make sure it’s all, buried.
Something comes up, scandalous, can force doctor out, bully doctor, nurse, whoever.
Force gagging clause; not illegal.
Do it legally.
Not what should be happening in health service.
Wilful blindness.
Meeting, good example, didn’t want to see reality what going on.
People still resisting fact happened.
Didn’t want to believe it.
If can happen to me, can happen to anyone else.
[Too painful?] Perfect example.
Employed, employer, parental role.
Put lot of trust in them to do right thing by you.
Trust you to behave in appropriate way.
When your parent starts behaving like this, it’s form of abuse.
Emotional.
So to believe people can do this.
Just disregard you, here’s some money, go away.
By the way don’t say anything.
Very difficult to believe.  
Find it hard to believe; lived through it.  
People haven’t don’t know fact, can see why might be easier to brush it to one side.  

[Rat & justs?] Justify it in loyalty to organisation (R&J).  
It’s all about, what’s best for [hospital] (R&J).  
If manager known to have failed, CE service failed under, your watch, basically protecting yourself (R&J).  
Might rationalise to themselves, protecting organisation (R&J).  
Actually protecting themselves.  
Potentially could be sacked for what did.  
Went all out to make sure the truth didn’t get out.  
But truth got out, still haven’t been sacked.  
Interesting how serious breaches of conduct by senior managers seemed to be excused.  
Frontline staff get hammered for one little thing.  
Managers treated differently, protected  
[Why?] Investigated allegations.  
Health authority said ‘Oh, they didn’t mean to do it, was incompetence rather than maliciousness’ (R&J).  
Even for incompetence weren’t disciplined.  
Because of culture, just have to bury things.  If discipline someone, it’s admitting made mistake.  
So far on couldn’t bring themselves to admit made serious mistakes.  
Have to try and fudge it (R&J).  
Report by SHA led to meeting.  
Critical of managers, senior staff in report, but, excuse it (R&J).  
Doctors not happy saying ‘How can HR director allowed to behave like this’?  
Need to have looked at, not good for hospital’.  
Wouldn’t have it.  
Resistance to looking at bad practice.  
Bullying organisation some people very favoured, some victimised.  
People favoured think CE amazing, support to hilt.  
Get rewarded.  
Stand up, say CE amazing, supports, prioritises patient safety, blah, blah, blah.  
Come out all this waffle.  
Reality might be something different. People trying to challenge, get victimised.  
SHA were denying evidence.  
Don’t find it stunning because seen how behave senior level.  
Know prepared to lie.  
Know prepared to bury reports.  
Know prepared to do whatever.  
Supported, funds from NHS to do whatever have to do, legally, to sort people out.  
Clearly supported by SHA, possibly next level too.  
Otherwise wouldn’t be authorised to spend money.  
Proven various senior managers, members of NHS, both lied, attempted to cover up serious error.  
NHS money to do it.  
Haven’t been disciplined.  
Not hypothetical, proven it.  
Nowhere are held accountable.  
Needs to be changed.  
[Post recording] ‘Emperor’s clothes’.  

32 Does not encourage constructive criticism or informed dissent.  
Actively discourages or gags whistleblowers, far too often.  
SHA bullying to change clinical priorities to avoid bad press.  
[L&M] huge gap between rhetoric of creative leadership, reality of obedient followership!  
SHA says don’t care how make financial balance, how meet targets.  
Just want to know met.  
Didn’t want any ‘bad news’.  
If send us ‘bad news’, not performing, you are out.  
History shows many, many, many managers lost jobs.  
Usually financial, target purposes.  
Don’t know single manager lost job because failed to improve health of population.
SHAs job, tell NHS Board, ministers ‘all is well’.
There to make ‘good news’.
Appalling behaviour SHAs on PCTs.
Something goes wrong, get blamed, big time.
Not culture, allowed to admit don’t know.
If don’t admit don’t know, how can you learn?
Not enough learning, changing of behaviours.
Doesn’t encourage informed dissent, challenge, far too top down.
Not listening organisation.
If doesn’t listen, how can it learn?
If not learning organisation, just dead in the water, fossilise.
Accountable people, running like crazy, hiding like crazy, hoping whole thing go away.
Delaying it as long as possible.
NHS press officers ‘hide or spin the bad news’, ‘protect the NHS brand’.
Specific sackable offense for managers, damaging NHS brand.
Written into manager’s code of practice, various other things, threatened with that DIRECTLY, to my face, in writing.
SHA telling CE change clinical priorities to ‘avoid bad news’.
What driving that?] Part of SHAs almost unwritten job description ‘relentlessly present good news’.
Will always ‘talk up the NHS brand’.
Always play down negative things.
Extent press no longer trust what comes out.
See it spin and propaganda.
Culture of not learning.
Unless honest about mistakes, struggles, can’t move on and fix it.
Press spin patronising to population.
Taxes fund service, receive its care ought to know, complete impartiality what actually going on.
Make informed choices about engaging with it.
What’s driving it? Underneath this?] Self-preservation, protection for people in senior positions, want to cling onto power, privilege, earn lot of money.
Are well paid. -- 250-000 a year as does wife, runs one of – hospitals.
Half a million pound a year household.
Want to protect lifestyle, privilege, power.
Who wouldn’t? That’s human nature.
Why protection organisation, image more important than welfare of staff, patients?]
Ultra-socialist entirety.
-- ‘s a communist, was, card carrying member communist party.
Into the state knows best, state is the best provider.
It’s all about centralisation, one size fits all, absolute control.
Obedience to the state mechanisms.
Not about local democracy or individuals, taking individual responsibility.
Very, very collectivist model.
[What & just’s?] Say ‘strong NHS’ is their rationalisation, much more important than any individual (R&J).
Told that many, a time.
You are right, but for greater good, greater policy, don’t rock the boat (R&J).
Initiatives came along the line.
Protect the institution, all will be well (R&J).
Take opposite view, most people do, institution actually its people.
Powers currently run it take opposite view.
How justify it (R&J).
Have to have strong untarnished, untouchable NHS, otherwise everything else will fall apart (R&J).
Don’t think right, healthy attitude. Whitewash taking place.
People lie.
Hide or spin the bad news to reassure public, protect NHS brand.
Lying culture.
Data is falsified when is time pressure.
Dishonesty accepted, way of life in lot of NHS.
Warning signs were there.
No personal accountability.
People who do speak up, bold enough to speak up, just left on the sides. Into *labelling*, all that kind of thing. Marginalises opinions. Very oppressive system because people who are there. Do very good job, lot of goodwill. Do long hours, happy to do, love the NHS. No organisation in world like it. But feel distressed by what happening to it. People say, it’s about system (R&J). People make the systems. Abrogate your responsibility by saying it’s the system (R&J). Don’t buy that! It’s not the system makes the decision, it’s people who make decisions (R&J).

Mixed workplace culture. Some places supportive, learning orientated, focussed on evidence based progression, sharing knowledge. Other places dark, blame orientated. Leaders not taking responsibility for poor decisions; blaming others. Include political leaders. Direct correlation support, praise, shared national pride in NHS, alter feeling within NHS workforce. Political leaders critical, without evidence, impacts directly, poor self-esteem, self-worth. Feeling not being able to do right for being criticised. Depends on manager; some good. Some take it as personal criticism. Some say is a business, should all put feelings to one side, concentrate on business (R&J). Trying to point out mediation, facilitated discussions, no blame orientated place to start. Some try this, others insist following formal blame orientated grievance.

Many cultures within NHS organisations. Common denominator, defensiveness. [Org responses] Up to point respond reasonably well. Threshold when perceived too disruptive to service, negative reputational consequences. Not dealt with robustly. Times, reports get three wise monkeys treatment. Executives very wary of washing dirty linen in front of non-execs. If Board meeting public, create even more caution. ‘narrative’, where powerful, deep-rooted belief, can present alternative evidence till blue in the face. Be denied, or re-framed to exclude relevance of new evidence (R&J). When narrative forms part of ‘who I am’, very powerful. To deny narrative means huge personal change. (Relates notion paradigm shifts, term much misused.). Someone say public lot of trust in NHS. Not entirely true. Public’s trust wrapped up in particular narrative in NHS. Revolves around doctors, nurses. Story breaks high number drug errors press say down to poor management, not bad practice by nurses. By putting it in these terms, narrative untouched. Asked midwife what way actions best interests mother, child. 25 years experience, always put interests of mothers, children first. Re-stated because always put mothers’ interest first must have done so, specific occasion. Lack of insight of practitioners, possibility done something, not patients’ interests at heart. Sometimes be defended by Managers, sometimes not. Desire to explain away rather than confront problems (R&J). Sometimes due to lack of insight/awareness. Problems exist due to belief systems. Some occasions evidence accepted as real, but, like scenario, avoided. [Reports get 3 wise monkeys treatment] Any bad news, criticism can get same treatment. Major significal (sic) event, focus tends to be on how well everyone coped, not how happen in first
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| 36   | Culture NHS organisations, enormously variable.  
One extreme, context avoidable injury to patients.  
Organisations appear protective of individual healthcare professionals, possibly to protect organisation.  
Other, organisations scapegoat individuals at frontline rather than address underlying failings.  
Latter, result of creating culture of fear, lack of openness.  
Failing to address systemic problems, failures result in individual causing harm.  
Examples same mistake repeated, unsafe practice persists.  
Description given by some healthcare professionals what happened is Kafkaesque ['overly complex in seemingly pointless, impersonal, and often disturbing way'].  
Mirrors experience some patients/families try to raise concerns about care.  
Reflects common feature how some organisations respond when challenged.  
Both, almost have to become obsessional, to fight way through the system.  
Patients try to raise concerns about patient safety, response receive very variable.  
Involved supporting patients, relatives in situation.  
Exemplifies, not only lacks insight into standards of care being provided.  
Closes its eyes and ears to any criticism or legitimate concerns raised.  
Developed very unhealthy culture filtered down from senior management to frontline.  
Many staff, patients caught in crossfire.  
[Why?] Very similar behaviour patterns apparent when patients challenge poor care.  
Fear, protectionism, trench mentality, ignorance, form of collective stupidity, self-preservation.  
Poor quality management, long standing issue within NHS.  
Lack good quality leadership.  
Reflects prevailing culture of organisation and/or management of organisation.  
’sick’ culture at the top ultimately tends filter down throughout organisation.  
If bullying culture within management, unlikely to challenge bullying culture within staff, or perhaps recognise it.  
If managers out of depth insecure in position, last thing want someone from outside shining a light on problem, challenge prevailing belief system of organisation.  
Organisation lacked insight, reinforcing position by closing its ears to any criticism.  
Persisted throughout subsequent inquiry process.  
Filtered out much of negative data before reached Board.  
Hospital] inquiry report interesting re level of denial maintained throughout inquiry process.  
Perhaps understandably some things just too difficult to face. |
| 37   | [Good news factory?] Nature of bureaucracy.  
Rewarded for taking good news to your boss.  
If take bad news to boss seen “negative”, “not a go-getter” etc.  
Best way not to take bad news to boss, make sure underlings don’t bring bad news.  
By not dealing with problems, dealing with them slowly, cack-handed manner (effortless for many people).  
Personalise it (“no-one else ever complained about person you’re complaining about.  
Are you sure isn’t just personality clash YOU have?”).  
Shift responsibility/blame.  
Lose paperwork, cancel, reschedule meetings until people give up, learn not to bother bringing problems.  
Resistance to knowledge.  
Subtle/explicit manipulation.  
Can say to boss “no-one seems unhappy.”  
Even if does all come out later, can act all injured “well, no-one came to me. If had, would certainly have acted on it...”.  
Lying/untruths to protect.  
Just way bureaucracies work, hierarchies work.  
Evidence people trying to raise problems at coalface over-ridden, ignored.  
Atul Gawande organisational behaviour (Better, Complications).  
“human factors” literature (lot around cockpit communication).  
[Rat & just’s] Yes, lots.  
Usually to do with isolating “trouble-maker”, making them an exception (R&J). |
Most, no, all of us don’t think most of time. Creatures of habit, creatures of organisational cultures. Just what humans do. Not to say cultures can’t change, be changed. Requires lots of effort, intelligence. “Democracy in the Making” Kathleen Blee. Leaders impose their version reality on others, even without knowing, being acknowledged as leaders. Patients unreasonable, unrealistic, not keeping up their end of the “bargain” (all may well be true!!) (R&J).

Probably first line of defence (R&J). Blame the patients. Once slip into bad habits doing things not in best interest service/underlings, feel guilty. Complicit in bad practice, much harder to have “high moral ground”. Contaminated (Erving Goffman, spoiled identity). “slippery slope”, things people will, over time, get used to. Sense all unfolding over time, what gradually become used to; crucial. Presumably, what happened Mid Staffs. “Everyone else is doing it” (R&J). “That’s just how things are done around here” (R&J). “There’s no point telling management; they already know and they aren’t doing anything”(R&J). “If I blow the whistle will be blamed for very failings trying to expose, my record not unblemished, just keep my head down” (R&J).

How fragile our rationality. Prey to false memories, cognitive biases, logical leaps etc. Book “You are not so smart”.

Don’t want to hear what I have to say. [Rat & just’s?] Yes. Hide behind ”THE ORGANISATION”. Without shadow of a doubt. Distance themselves from personal blame, accountability for behaviours. Can, under guise of organisation. Can avoid introspection by blaming it on the organisation. Can twist or ignore procedures. Who is holding them accountable? Tribunal, ”the organisation”, great public expense, defend themselves with Q.C. Victims usually financially ruined. Fact organisation only entity, people in it. Can choose behave professionally or badly. No power of its own seems to elude them. When tribunal upholds employee’s case, CE, Head of HR should be sacked. Made to pay expenses from own income, pension fund. Make them more accountable. Private companies more careful about proceeding to tribunals than public sector.

Increasingly issues in English NHS over best interests of patients, staff. Such political environment, in UK, major need/desire to manage bad news. Ensure things do not become too public. NHS seen within media, public discourse as national treasure.

Means politicians, determine shape, structure NHS, keen to avoid criticism. Ensuring nothing bad, seen to be associated with, is public. Many examples research, evaluations, NHS activity, do not come out as want. Often quietly dropped. Don’t think seen such full on inability to engage with something [scenario]. Part much more complicated situation.

Pretty closed, meaning intolerant of criticism. Introduced policy, have to show it’s a success. Invested political energy demonstrating it to be success. Don’t want to hear it isn’t. Totally defensive of reforms.
Fight tooth and nail to reject criticism.
Very tricky, some problems next few years, whatever government in power.
Whether or not had reforms.
Worries me be big clamp down terms any degree of honesty, where quite clear recent changes led to particular situation.
Already getting increasing fragmentation, post code lottery.
Going to get worse with shoving it down to local level, groups GPs.
Most won’t do it themselves.
Commission management consultants to do it.
Culture combination, publically funded NHS, since 1948.
Horrible centralising controlling culture more recent.
Rise of general management in NHS.
Griffiths did us all terrible disservice.
NHS managers, wouldn’t say commitment to, analysis and honesty high.
However start off, quickly learn questioning things not popular.
Providing information fine as long as is good news.
Doing lot of time, feeding the beast with what it wants to hear.
Not raising concerns, flagging up problems.
‘we haven’t got a choice’ (R&J).
‘we have to do it’ (R&J).
‘there is no option’ (R&J).
Say to CE ‘no idea why doing this?’
But, ‘we have got no choice in this’ (R&J).
‘we have to do it’ (R&J).
Don’t want clear analysis, critical piece of research, well evidenced piece of work flags up problem.
Causes them to panic, indicates what doing not correct.
But feel ‘there is no alternative’ (R&J).
Centralising thing can’t possibly admit things aren’t working.
Presentation, how difficult genuinely ascertain patients experience and want; how might approach it.
Went through things currently happened, flaws.
Resistance to constructive feedback.
Practically torn apart by CE, Chairman.
Although done very academic, calm, unemotional way.
Very moderate, toned it down.
Made transparent flaws, what currently doing.
Because flagged up, drawing out some problems, made quite clear is national policy.
You will not show up any short comings. That’s the problem with NHS.
Like lot of people sometimes begin to believe own rhetoric.
Often found CEs of trusts appalling things happened.
Say extraordinary thing about what had done.
In/out trust 6 months, loads of analysis; flatly contradict what they would say.
Stare at us in horror.
Used to not being questioned.
Their word is accepted.
Some, maybe lot of them, begin to believe the propaganda.
‘there is no alternative’ (R&J) so delude themselves.
Some aren’t very clever, in first place.
Maybe genuinely don’t understand effects.
Others, know perfectly well, carry on regardless.
Depressing.
Other stuff been done about horrible culture in NHS.
Department never wants to have seen light of day.
Sometimes commissioned work.
[What action?] Every bit that exposes [horrible culture].
Some stuff stems from adversarial political system.
Seems impossible to have circumstances people in power can without losing political face, being ridiculed.
Honesty to say got this one wrong.
Minute start doing that opposition cheering from benches whichever colour are.
Bad as each other; media light on it.
Against openness and transparency.
Deadly combination of candid media and politics.
[Teaught to analyse problems] [L] Yes.
Not, what happens in management, pretend they do.
Like lots of things, know what answer is.
Work backwards from that, to present case they want.
‘good news culture’, everything always has to be seen to be working, positive.
If anything isn’t right, isn’t working, opposed to rational analysis, has to be quickly blamed on something/somebody.
All part of picture.
Same thing, all this central controlling.
The ‘good news’ politically driven must be seen as success.
Exact opposite of analytical, reflective, open, transparent, learning.
[Why can’t see destructive?] Because can’t, could argue it’s public’s own fault.
Aren’t grown up enough to accept things will sometimes go wrong.
People will make mistakes including politicians.
People seize on things, rush to call for heads of people.
Partly fault over simplistic media, but reflecting population.
Wants everything to be straightforward.
Unintelligent, rule of mob, ‘off with his head’ ‘you’ve got it wrong’.
Some stems from that.
Rather than living in grown up world realising things more complex.
Should welcome if something tried properly evaluated.
If turns out not to been roaring success.
Fact evaluated, changed, cause for celebration, not screaming ‘U turns’, shambles.
[Moral vacuum?] Spot on describing moral/ethical vacuum at heart of NHS management.
From very top.
[Rat & just’s?] Commonly used, need for efficiency (R&J).
Efficiency often ill defined, understood.
Sometimes claim enforced change works elsewhere (usually completely different circumstances), or different sector (so irrelevant) (R&J).

Framework Theme 14. Actions

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<tr>
<th>FG</th>
<th>Categories for Framework Theme 14: Actions (Focus groups): Organisation/leadership &amp; management/HR</th>
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<tbody>
<tr>
<td>1</td>
<td>Union rep to challenge.</td>
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<td>Inform of wrong doing.</td>
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<td>Tell them to their face; don’t beat about the bush.</td>
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<td>Education.</td>
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<td>Take out layer of management to improve communication.</td>
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<td>Better management, of protection arrangements.</td>
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<td>Need to be removed.</td>
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<td>Line them against wall and shoot them, might be an idea [L].</td>
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<td>[Drastic suggestion! [L]] Acceptance of responsibility.</td>
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<td>Stop blaming, shifting responsibility.</td>
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<td>Don’t make excuses.</td>
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<td>Stop buck passing.</td>
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<td>[If clean slate?] Culture change from the top.</td>
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Message from the top, bullying not acceptable.
Reality not tokenism.
Speak to people.
Face to face conversation.
Build bridges.
Seek to see the humanity.
Have to be something gigantic, something would universally focus like massive court case.
Not ideal solution, but have to be something to break the culture, because hasn’t always been like this.
Need clear structures; now blurred.
Change focus of NHS back to people; is a business.
Now have managers, who manage managers, who manage managers; why don’t make them redundant for God’s sake!
Much fairer way than having them hanging around packing envelopes.
If relevant clinical skills put them back on shop floor. On the ‘coal face’.
[Any actions?] Just get machine gun Rachael [really] just put them against the wall.
It’s best, its best. Quick
[That’s drastic?] Would get there lot quicker.
Less painful.
What NHS needs is less managers and more staff.
[All] Yes.
More people at the coal face

Far too many leaders.
Need good managers.
Address problem people wanting to create power base; desire for leadership/control.
Good established, solid, functional managers to drive things forward, keep things going.
Design for true implementation on the ground.
Design from bottom up not top down.
Need different personalities, qualities.
Don’t interview for ‘best friend’
Interview for person going to do job.
Diversity and difference in teams.
Recognition of importance of diversity.
Respect for others.
Removal of HR!
Do what needed.
Less pussyfooting around.
Be more innovative in how manage.
Less pandering to rules.
Clear boundaries.
Support for junior managers.
Support people, to deal with it, ‘to nip it in the bud’ at lower level.
Clear message behaviour no appropriate.
If don’t address to next stage.
Extra explanation how ‘to nip it in the bud’ at lower level.
Encourage whistle blowing.
More informal than formal basis.
More advocacy process.
Improve communication.
Top levels, directors go back, work on the floor, staff forums.
Regular visits.
Visible, approachable directors.
Generic email; raise concerns.
Culture at the top drives the organisation.
More negotiation between secretary of state and trusts before make decision down to operational level.
Mediation.
Avoid escalation and awfulness.
No point scoring; tell off.
Public message.
CEOs setting positive example, tone of organisation.  
Clear message of standards/zero tolerance.

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| 3 | Extensive engagement all staff.  
*Walking the job.*  
Meeting people, talking.  
Letting staff talk about their issues.  
Addressing issues/problems.  
Management really on top of job.  
*Taking it on board* Trying to find way address problems; improve for future.  
Ask questions re possible action.  
Rectify.  
Accept criticism; do something about it.  
*Face it,* deal with it, find solutions.  
Don’t ignore *bad news*; deal with it.  
Do the job.  
Direct intervention at senior level when problems.  
Listen, reassure, engage.  
Be prepared to listen to criticism, act professionally, appropriately.  
Give opportunity to speak, question.  
Deal with problems. |
| 4 | Set positive example.  
Simple effective appraisal.  
Do the right things not *tick the right boxes.*  
Don’t set out to *tick the right boxes.*  
*Set out to do what is right.*  
Align objectives to what need to do.  
*Make sure the boxes are in the right place.*  
Cultural change, has to start at *the top.*  
Leaders who will lead; take organisation in right direction.  
Real vision for staff wellbeing and OH.  
People with vision.  
Clear vision at the top.  
Charisma, can inspire.  
Exposure; being seen.  
Opportunity to raise issues, confront people.  
Need visibility and transparency.  
Cascading of good management.  
Motivation, enthusing of staff.  
The ship;  
CE in charge, always out and about.  
See passengers.  
Passengers can approach.  
Crew know who CE is.  
Developed management team, always out and about.  
Confidence in people below/deputy.  
Give autonomy.  
Avoid working from position of *fear.*  
Trust people.  
*Allow/free up,* executive team to ‘*walk around the ship.*’  
Centralisation of HR for transactional stuff; advertising, recruitment, in depth legal stuff.  
Everyone take responsibility for own behaviour.  
Set standards.  
Basic respect for all.  
Expectations laid down by management teams.  
Establish culture early on.  
Hold responsible for behaviour.  
Manager takes responsibility.  
Managers setting positive culture.  
Deal with problems.  
Manager taking initiative. |
Decide what is acceptable.
Need arbiter of what acceptable.
Corporate appraisal.
Evaluate what doing.
Look at evidence.
Learn so can set new direction.
Be open to questions and self-assess.
Positive behaviour at the top, on Board.
People skills to communicate on personal level.
See people as individuals in a positive light.
Behave positively, taking interest, valuing what people do.
Be out and about.
Connect with people.
Consider the messages being given; impact on morale.
Ensure people have got skills.
Let people get on with job; trust them.
Monitor in positive way.
Allow to perform to maximum potential.
Acknowled /recognise: If got healthy happy staff are more likely to provide more, better treatment.

5 Adversarial – Clinicians v managers.
Team issues; weren’t addressing issues.
Wanted way getting hands on some systemic organisational issues, to work more effectively.
Problematic complicated/complex situations trust thrown up.
Stimulating, interesting work
Very committed, currently under threat of annihilation.
One to one counselling fine, but limitations.
Symptoms in context of working relationships broken down.
Individual and context; might work within entire team
Mediation, 2/3/4 individuals.
Critical incident stress debriefing.
One to one manager support.
Training.
Clear managers not always equipped, able, knew how to resolve/ deal with problems, difficulties.
Negative behaviour, poor working relationships, need for support.
Lot of work teams that struggle, not getting on.
Disagreements, can’t work together.
Can restore feeling personal power to teams.
Current climate and changes; very disempowered.
Enables teams; take things forward themselves, restores that.
Ownership; ability to change environment working in.
Lot of teams changed, put together, restructured, getting opportunity, allowed to grieve about process going through; have recognition.
Pain of constant change/structure.
Recognition of humanity in a system/machine.
Struck how powerful organisational support is, hopefully powerful therapeutic way.
Guess, very good value for money.
Conflict, difficulties, tremendous financial cost.
Off sick, productivity, performance may deteriorate, patients may be at risk; quality of care.
In absence of informal interventions may rely on formal processes.
Team designed to help; reducing costs.
Develop processes of recognition, find meaning in work doing together.
Not just HRM discourse.
Not interested in instrumentalist way doing things; aligning values or visions.
Interested in quality of conversations.
Main methodology; getting people to talk to each other, explore what going on between them; effective.
Underlying causes, issues, things like power, very interested.
How power gets expressed.
Want people to feel good about being at work; have sense of meaning.
Not just to prop up performance indicators. Difficult, complicated important jobs, want to support them. Conflict/negativity arises inevitably. There to help, come alongside. Conflict inevitable part being in organisation. Patterns, repeated difficulties arise, particular tensions with management. Also repeat attenders; different problem different person. OST always informal. Compliments, often expensive, difficult formal processes. Encourage informal, cost effective resolution, rather 6, 12, 18 months investigation, pain, possible lawyers etc. Same themes arise, not sure same problems. Organisational process iterative, repeats itself. Conflict is one of themes. Over focus on outcomes, targets ways unintended effects, like way people relate to each other. Can mask, what’s actually going on, people engaged in ongoing way, how to get along, relate. Transformational outcomes always looking for are emergent in those relationships. Influence/intervene in complicated difficult situations where people hating each other or things are going down the pan. Get in there and sit with people. Collaborative way, try and influence outcome. [Repeated why nothing done?] Common enough; never want to make it formal. Got to make formal complaint. Frightened, scared of own position, employment, position within team, seen as one raising their hand. Saying problem in team, want something done. It’s like whistle blowing, won’t do it; risk. Talk of change, restructuring; more afraid. Try to protect position. By stepping outside of that, putting themselves at risk. Not happy, redeploy, something different. Some perceived more power than others. Perceived power of person complaining about affects likelihood of action. Some situations get changed others, wouldn’t dare go there. Positioning is around person being complained about. Some difficult conversations possible; confront and effective change. Open conversations, mediation, calling to account. But can create crisis, for person, and group around person. Commonly very senior managers, group has to re position itself. French sociologist Robert Michaels: Tendency for apex organisation, at first, espoused interest protect whole workforce, organisation. After while look after own interests, own particular group interests. Apex, senior management group, start to protect each other, look after what’s good for them. Challenge senior person, challenging whole group that sustains their position. Much more tricky, complicated. A counter, always another side to story. Very different perspectives same situation. Formal investigatory route often fail, too scary. More formalised approach, investigation more polarised views. Split into good and evil, side taking. If resolve informal level might, have more chance to get what really going on. Bad manager why nothing done? Can exist, but usually more complex. Manager asked to do very difficult things. Agendas smashing together, get very personalised. Through trying to talk it all out, get the complexity. Sometimes staff don’t need to see manager all evil. Sometimes manager can learn how staff experiencing them. Behind negative behaviour and conflict are clashing ideologies. Clashing ways of seeing the world.
**Clashing** of what makes sense organisation supposed to be doing.
Conflicts between, market and operational values.
People forget their roles together, forget seeing world in different ways, becomes deeply personalised.
Conflict is to do with where are, what role, how seeing the world.
Lot of work trying to de-personalise that.
[B&H, so low] “Didn’t have to think about it” giveaway phrase.
Painful to think.
Peer group help to collude.
Some live in kind of bubbles.
Will only tell them what think want to hear.
Difficulty, middle management, very reliant on jobs.
Constant reorganisation, have to reposition themselves.
Not highly invested in telling boss things are shit, everyone’s going down the pan, morale is low.
More likely say everything’s great, going really well, performance on target, statistics prove it. [Big grins]
Look at screen, see how well doing.
Rhetoric v reality.
Departments winning awards, know; disastrous shape.
Senior management convey very rosy award winning picture; reality can be very different. Got to.
Can pull it off, can do it.
Under huge pressure to do it all the time.
Inspectorates, CQC, Monitor, rest, checking up.
Status as organisation depends on it.
Foundation this, that status.
Got to be giving ‘can do’, competent image all time.
Sometimes feel sympathetic.
Serious could lose jobs and occasionally get nicked.
Big fraud case, Independent picked it up, it’s a big cover up.
Set up to fiddle everything, cover everything up because didn’t want to lose jobs.
Fear.
That’s other side of story.
All probability, Christ, if this comes up won’t get this, that, star, foundation status, real anxieties,
can be replaced, rid of quite easily, taken over.
Ethical conflict.
Jobs at risk if don’t comply.

6 Bad, unprofessional behaviour, shouldn’t be supported.

<table>
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<tr>
<th>Int</th>
<th>Categories for Framework Theme 14: Actions (Interviews): Organisation/leadership &amp; management/HR</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Negative behaviour, <em>stamp it out</em>. Say this is not on. Senior managers should take action. Matron, HR responsible; unions involved. Interested in all staff. If behaviour not right, gently, properly, have a word. Person interviewed, ruling, consequences. <em>Got it on a plate.</em> If do that, 3 strikes and you’re out. It's not necessary, rude &amp; horrible. If set guidelines right, hopefully employee abides. Got to admit it happens; nobody is infallible. NHS has got a problem. Clarity of message at onset. Clear expectations/setting of standards.</td>
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<tr>
<td>2</td>
<td>Management of trust, HR, direct managers responsible.</td>
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</table>
[Actions] Staff need to believe are important, needed.
To feel valued, not under constant threat of budget cuts, organisational change.
Team meetings.
Staff involved in decisions.
More happy secure workforce mean issues/concerns all staff heard, acted upon without feeling jobs at risk.
Chances for promotion, more training, staff more confidence in abilities.
Would reduce some stresses, negative behaviours seen.

3

4

5 More money but not be spent on managers.
Clinical staff put back in control.
Managers only there, supporting facilitating role.
Recognition of clinicians training and skills. Unhelpful to put unqualified, inexperienced manager above them; avoid.
Managers should be experienced and appropriately qualified.
Drs, not easy to take instruction from somebody considerably inferior academic achievement.
Especially when consider instructions to be absurd, to detriment of patient care.
Clinical staff, put back in control.

6 Clearer codes of behaviour.
Clearer codes for managers (particularly middle managers) what is acceptable when managing employees.
Realistic demands.
Positive language/behaviour
More support for employees feeling stressed, overworked.
Better coping mechanisms in place before take it out on each other.
Focus on prevention.
Requires cultural change; work place culture difficult to change.
Culture comes from the very top.
Change at the top.

7

8 Management responsible for setting clear guidelines expected behaviour.
Ensuring adhered to by ALL staff, even managers.
All staff treated the same; no preferential treatment.
Organisations, clearly defined policies/expectations.
Where commitment to providing good leadership, managers well trained, truly respect staff.
Staff to feel valued, listened to.
True partnership working with joint commitment to staff and unions.
Reality not just rhetoric.
Clear boundaries.
Leading by example.
Positive role models

9

10 Organisations do not have skill sets for identifying issues, knowing how to manage.
Organisational-wide training needs, positive/ negative behaviours.
Training on positive, negative behaviours.
All staff to understand these, and consequential impact.
Understanding proper mediation may work particular circumstances; but not always.
If used, professionally set up, applied.
Some of cause – cuts to services, financial pressures.
Reorganisations risk assessed in the light of impact on behaviours.
Understand need for professional investigations.
Where necessary use expert organisations to assist.
[HR?] Has to be leadership.
Key role employer must play – not just negative behaviour, whole dignity at work agenda.
HR should be responsible for training (Trust Board, CE, all staff/volunteers).
To address negative behaviour issues, essential to understand landscape within own organisation/externally.
Understands way behaviours manifest.
<table>
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<th>Page</th>
<th>Text</th>
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| 4 | How need to be managed, most appropriate training needs to be put in place.  
Employer, show dedication, leadership to dignity at work cases.  
[external to NHS] →, CE, Board at heart of work to improve dignity at work.  
Training by TU representative.  
Insisted all managers, staff, volunteers received training. |
| 11 | Reduce barriers to communication between all levels staff.  
Managers need to get out there on the floor.  
Be visible, observe what happening.  
Articulate expectations to staff regularly.  
Training session equality/diversity once every couple of years not enough! |
| 12 | [Good practice?] Lot negative behaviour from staff; stressful.  
Tavistock Institute.  
Counsellor work with team, really, really, helpful.  
Open confidential environment with counsellor.  
Talk about situations; most positive thing, acknowledgement alright to feel.  
Alright how felt.  
Feelings given validity.  
Getting out of victim cycle.  
Giving authority.  
Courage to nip things straight away.  
Say isn’t right.  
More openness.  
Encouragement more openness.  
More training for every member of staff what constitutes acceptable.  
More support mechanisms.  
Particularly training for managers, to help/support.  
Support dealing with, staff, not leaving them, own devices.  
Deal with, only way know how.  
Bullying, harassing, or ignoring staff, not dealing with issue.  
Can fight somebody being aggressive.  
Very hard to fight covert, being ignored, work being taken off you etc.  
Training, support, confidential environment.  
Staff support to talk through issue.  
Leadership at department level; training and awareness.  
Awareness of what’s acceptable/not acceptable.  
Human nature is human nature.  
Maintain professional front.  
Deal with situations professionally, openly. |
| 13 | Find, promote effective early interventions.  
Identify developing problems.  
Early effective intervention, does not disrupt patient care.  
Show benefits to trusts, managers, patients, of addressing, resolving staff relationship problems early.  
Big focus on leadership, detriment of good management.  
Change focus.  
Often promoted into management posts without all desired skills.  
Train, motivate managers.  
Managers rightly focused achieving trust targets relating to quality of patient care/ outcomes.  
Reminding well motivated, effective staff management best way to achieve these. |
| 14 | Major requirement ‘training of management.  
NHS managers need to be educated in management, leadership by example and finance.  
Core experienced, capable managers selected to do training.  
Another reorganisation; not the answer. |
| 15 | NHS to face up to the mess our beloved institution is in.  
Radical change; who will lead it?  
Treasury has to sign off gagging orders.  
Could be stopped by Chancellor of Exchequer.  
Also signed off by CE NHS Commissioning Board.  
S of S for Health could issue note, ‘no more compromise agreements’, gagging clauses, stop now.  
People in system put back to work. |
Vast bulk trying to do good.
Could be stopped.
Put waffle in NHS constitution.
Set up help line run by Mencap.
Don’t think even 24 hours.
No particular expertise dealing with whistle blowers; pathetic.
That’s politicians.
Word leadership bandied about too much.
Need leadership.
If leadership courses NHS did work, everything tickety-boo.
Don’t because, nobody really means it.
Against that cultural background cannot do anything meaningful.
Unless people living the values.
Unless people understand change got to come, all lip service.
Why head of NHS tomorrow if said everything got to change, do this, do that.
Nobody take blind bit notice.
Know don’t mean it, haven’t operated that way last 10 years; operated opposite way.
Need to see demonstration, by behaviour, day by day; change has come.
Don’t think current leadership can do that.
No credibility.
Leadership, much misunderstood, over used.
Need strong leaders, counter cultural.
Keep organisations with set of values, value each other.
Understand high performance does come with conflict.
Only with most extraordinary leadership.
Organisations do normally change, only with extraordinary leaders [examples given].
Turned it round by walking the talk, getting out there, doing it.
If NHS want vision commercial organisation, bring somebody in, cut hard, cut deep.
Get rid of the well poisoners.
The well is poisoned.
Whole well is poisoned.
Whole of the waterhole is poisoned in this organisation.
Is not cynicism, is from listening.
The reality.
Nobody wants to face it.
Too difficult, uncomfortable.
[Report] more of same.
Leaders must do this, need to do that, have to.
Keeps off really uncomfortable subjects; vested interests.
NHS confederation is body members NHS hospitals, other trusts.
Shouldn’t exist.
Conference; talking to themselves.
Could fix it, could fix it at a stroke.
Why don’t they?
That’s where leadership failure is.
Need to tackle what is uncomfortable.
Face up to real problems.
Leadership, management [Examples] just get things done.
No bullshit, ‘let’s just do it’, ‘let’s do it’.
Know-how, personal qualities to design, lead organisations business, build organisations.
Football, produce, if don’t, have to go.
Mandela, Madiba, character, take NHS forward.
Appropriate character, break the mould.
Looked on, somebody, do things.
Enormous gravitas.
Told it like it was, truth & reconciliation.
Hospitals don’t do that; not brave enough.
Just defend what done; shown not in reality.
Go right back to basics.
Got to start selling a different message.
Before start selling message, got to understand zero harm what should be delivering. Florence Nightingale understood. NHS, one monolithic organisation. Politicians responsible for it. Man in Richmond House dictates whatever goes on, therefore it’s a nightmare. Could change it easily, if wanted to. UK NHS attitudes [contempt for people] may always been there, ‘golden age’ or no ‘golden age’. But got worse, big divide between professions and public, patients. Clinicians, working day one long rampage [LoL] Are gods. Just stuff their mouths with more gold. Give biggy clinical excellence award. CEs have in their power to change things; stop talking about it. Just get on and do it. Little organisations can just do things, get on do things. Values very close to, short gap between person sets up, sets values and front line. Vast organisation, hundreds of layers deep. If could slice, chop organisations into [smaller units/teams]. Still problem when aggregate big decisions, made by massive organisation. Funded, worked on own might be better, but getting bigger. All about behaviour. Requires inspirational leaders. People who understand how people motivated to design, deliver. Based on premise everyone unique vested interest (other than money). If tapped help change behaviour. Culture change programme. Leaders demonstrate behave differently. Every single person find that self-interest with support of organisation. Great leaders done it many times, but never autocrats. Doctors, nurses treat patients not managers.

16 Eradicate endemic culture in NHS; a fantasy! Never happen until another generation! Capitalism does not help cause! Be more clever about interviews. Forget crap about best on day strategy! If got gift of the gab, dazzle panel with bullshit! Definitely get the job! Why NHS problems now! Way forward, emotional intelligence interviews! Need good managers understands patients journey, can inspire, lead workforce. Issue will never be resolved; endemic. Start with leaders, doing right thing! HR, independent sector, to work. Always be negative behaviours, thinking, unwise decisions made. Learning from these, way forward. HR/managers need to facilitate. Do as I say, don’t do as I do culture addressed. Seniors managers influence with positive attitude, behaviours. CE, directors responsible for cleaning up organisation. Sadly, NHS needs leaders, role models, inspirational, can make difference to care and safety for patients.

17 United action from health professions to address issues, compel government to listen. All colluding with politicians; looking only to own interests. Need focus on interest of patient.

18 Listen to patients. Better way to analyse patient complaints. Currently second-level complaints, not resolved locally. More or less ignored. PHS Ombudsman only ‘accepts’ 3% those go to her. 0.1% of written complains about NHS hospitals. Managers must work with clinicians.
<table>
<thead>
<tr>
<th>Only aim, provide better services for patients within resources available (should be culture). Not provide <em>good news story</em> for DH/SoS/Government. Worst last Government, 2000 onwards. Government exercises control via top-down <em>climate of fear</em> through managers. Managers have control over clinicians via jobs, funding, clinical excellence awards, patronage. To change culture - aims of Lansley's White Paper, not subsequent Bill. Bill gives power to managers, can continue to do what described.</th>
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<td>19</td>
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Increasing number websites discussing NHS issues.
Some Trusts creating interactive websites asking for feedback on patients experiences.
More openness about issues less likely Mid Staffs take place.
Some staff need to take risks, test whether Boards/managers want to know what is happening.

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<th>Tough times.</th>
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<tr>
<td>Individual organisations, senior managers concentrate far more on transformational changes rather than transactional.</td>
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<td>Have to be multi-organisational.</td>
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<td>Better developing patient pathways across groups, organisations.</td>
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<td>Senior managers work more closely together across organisational boundaries.</td>
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<tr>
<td>NHS Confederation good work to bring CE together, small discussion groups.</td>
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<tr>
<td>Look at how deal with difficulties as individuals.</td>
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<tr>
<td>Create sense of peer support, small groups of CE’s.</td>
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<tr>
<td>Not convinced all NEDs understand real meaning of challenge.</td>
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<tr>
<td>Some believe is to object, argue against or simply create difficulty.</td>
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<td>Really intelligent challenge does not cause confrontation at Board level.</td>
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<td>Process of understanding difference between assurance and reassurance of Boards.</td>
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<td>Understanding different options may have been identified prior to proposal coming forward.</td>
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<td>Understanding evidence base behind individual proposals.</td>
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<tr>
<th>28</th>
<th>Strong focus on values, common purpose, personal responsibilities, reinforced from top.</th>
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<td>Sanctions/intervention on evident poor behaviour.</td>
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<th>29</th>
<th>Management needs major overhaul; little accountability.</th>
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<td>Proper regulation of managers.</td>
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<td>Mistakes made by managers treated same way as clinical errors.</td>
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<tr>
<td>Some classed 'Never Events'.</td>
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<tr>
<td>Don’t think about basics.</td>
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<tr>
<td>Hold on the basics, what is important for patient care.</td>
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<tr>
<td>What is important for staff wellbeing.</td>
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<tr>
<td>How can be truthful, compassionate in behaviour?</td>
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<td>Forget about reputation; reputation will look after itself.</td>
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<tr>
<td>Major overhaul in management.</td>
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<td>Whole culture has to change.</td>
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<td>All grievance, dismissal, appeal hearings have to be so much fairer.</td>
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<td>Total overhaul.</td>
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<td>Accountability of managers.</td>
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<td>Being honest, compassionate.</td>
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<td>Simple things like that.</td>
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<td>Have to be told, number one priority.</td>
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<tr>
<td>Not, political games, or golden targets.</td>
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<tr>
<td>Moral behaviour must come first.</td>
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<tr>
<td>Hippocratic oath every year, regardless whether CE or junior doctor.</td>
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<tr>
<td>Whole management system has to change.</td>
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<tr>
<td>Leadership from DOH to happen. Guidelines there, pretty pathetic, non-existent, have to be toughened up.</td>
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<tr>
<td>Trusts told got to behave this way, xyz. Management mistakes regarded as serious, as clinical mistakes.</td>
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<tr>
<td>Put in that level.</td>
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<td>Whole culture has to change.</td>
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<tr>
<td>When do whistle blow, raise concerns, shouldn’t be suppressed, regarded as troublemakers.</td>
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<tr>
<td>Whole culture, whole, management system completely overhauled.</td>
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<tr>
<th>30</th>
<th>Front line professionals empowered.</th>
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<tbody>
<tr>
<td>Giving confidence to know how, when, to raise concerns.</td>
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<tr>
<td>Accountability when lie, cover up health mistakes, victimise whistle blowers etc.</td>
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<tr>
<td>Has to be accountability.</td>
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<tr>
<td>At moment there isn’t.</td>
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<tr>
<td>Hoping might come in with Mid Staffs report.</td>
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<td>Proven senior managers, both lied, attempted to cover up serious error.</td>
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</table>

| 31 | Proven senior managers, both lied, attempted to cover up serious error. |
| 32 | Individuals, responsibility set good example.  
Share bad practice, learn from mistakes.  
Sharing good practice.  
Lot of good people still around.  
Give them self-confidence.  
Courage to stand up, say, no, shouldn’t be like this.  
Won’t work like this.  
Huge effort, humility, courage to change culture.  
Listen what staff telling them.  
Look at underlying causes.  
Until top tier NHS management articulates vision all staff see, follow; staff disillusioned.  
[Added to Actions from NB –  
If NHS led, visionary leader, our purpose, mission, vision.  
Everyone, great, can do that, sign up, willing to follow.  
Motivated, content with lot, though struggles with money, patients.  
Difficult, harrowing work sometimes, but know what for.  
Following a leader, want to follow.]  |
| 33 |  
[Added to Actions from NB – Often say perceive colleagues behaviour, in negative ways.  
Colleagues deserve chance to take ownership of behaviours, explain how intended behaviours; not often tolerated.  
Some insist on formal grievance, blame, to uphold own belief in own perception.  
Not allow full understanding to be attempted.  
‘I’m right about you – you’re wrong about yourself’.  
‘Just trying to make excuses to get out of trouble’ etc.  
[Organisational responses] Depends on political leadership.  
If political comment on particular organisation, will be blame orientated response.  
Slowly enabling organisations to see another way; PIN Guideline on Dignity at Work.  
Encourages, try resolve issues first with mediation.]  |
| 34 | HR, got a lot to blame.  
HR need to consider role/practice  |
| 35 |  |
| 36 |  |
| 37 |  |
| 38 |  |
| 39 | Distinctive feature, caring approach to individuals.  
More attuned to understanding what care means for colleagues.  
[Added from NB [Own organisation] New management team, new organisation.  
Thought lot about shared values, show “the way we do things around here.”  
Finding new, different ways communicating with staff, formally, informally, personally, organisationally.  
Access to confidential support, services for those need to raise concerns; unable through line management.  
Add more personal dimension, although agreed policies.  
Launched dignity at work policy personally.  
Own reflections, experiences.  
Open intranet forum to CE, bullying come up.  
Spoken with, met individuals reporting.  
Personal blog to highlight.  
Lack of tolerance for negative behaviour.  
Need process in place to support both perspectives.  
Not all concerns clear cut.  
Confidence to report/address will be based on believing organisation will respond fairly. ]  
Essential to demonstrate basics in place, through agreement, use of clear policies.  |
Mechanism to allow concerns raised up through structures, via staff representatives or, confidential
counselling services.
Application process discharged fairly, professionally.
Always two sides.
Difficult to balance expectations both parties fairly.
Attitude and tone.
Engrained as unacceptable behaviour.
Show organisation does what it said would.
Reality matches rhetoric
CE support/help.
Support not just heroic interventions.
Demonstrate tone/attitude from very top.

| 40 | Organisational culture bullying by top management.  
   | Accountability to government from senior executives.  
   | Presently free to bully staff, government turns a blind eye.  
   | Only recourse down legal route; generally too expensive.  
   | NHS employer come back with big guns at public expense.  
   | Cap how much allowed to spend on tribunals to level playing field.  
   | CE held accountable if employee abuse proved.  
   | Lack of accountability for bad behaviours at the top.  
   | Investigations carried out by external agencies, no dependency on NHS.  
   | Ban on gagging clauses.  
   | Duty of candour for NHS boards.  
   | Whistle blowing is extremely dangerous.  
   | Education for managers on whistle blowing.  
   | Don't think most recognise it.  
   | Whistle blowing line may be helpful; but sign of system failure.  
   | Culture of organisation needs to change.  
   | Until then, managers my level vulnerable if speak out about wrongdoings of seniors.  
   | [Added from theme SMD/ego-defences -  
   | When tribunal upholds employee’s case, CE, Head of HR should be sacked.  
   | Made to pay expenses from own income, pension fund.  
   | Make them more accountable.  
   | Private companies more careful about proceeding to tribunals than public sector.]  

| 41 |  

| 42 | Only change if, really reverse malign influence of management in health service.  
   | That central kow-towing to DOH.  
   | Put power back into hands of clinical staff.  
   | At minute worst of all worlds.  
   | Most GPs aren’t enthusiastic.  
   | If are haven’t got time.  
   | Worry just contract out to private sector consultants, management consultants, have different  
   | agenda.  
   | Large part about generating money.  
   | Purchaser provider split made this worse, army of accountants, bean counters both sides divide.  
   | Whether commissioning done by PCTs, largely a waste of space or devolved to GPs.  
   | Why need purchaser provider split?  
   | Have different method planning, how use resources?  
   | Process of commissioning very second rate, poor.  
   | Commissioners don’t know what doing, costs lot of NHS money.  
   | All to sit down on fat salaries pretending to do it.  
   | Why don’t go back to more, centralised allocation.  
   | Still centralised now, commissioning groups get money centrally.  
   | Handing money over more directly to providers.  
   | Giving autonomy.  
   | Less centralising control over it.  
   | Purchaser provider split, introduced trolley loads of unnecessary bureaucracy.  
   | Lot of pretence commissioners make sure needs of population met.  
   | Robust analysis, shows hasn’t happened; still have mess.  
   | Too little money going into community care side.  

Too much into acute side.  
Acute side perhaps too much diversion away from emergency work.  
Commissioning hasn’t delivered what meant to deliver.  
[What action?] Every bit, exposes [horrible culture].  
Stems from adversarial political system.  
Impossible people in power can without losing political face, being ridiculed.  
Honesty to say got this one wrong.  
Opposition cheering from benches whichever colour are.  
Bad as each other.  
Media light on it.  
Those things, against openness, transparency.  
Deadly combination, candid media and politics.  
Both more powerful than you and me.  
Down at the bottom patients dying, unhappy staff.  
[Moral vacuum?] Spot on.  
Moral/ethical vacuum at heart of NHS management.  
From the very top.

Organisations, parts of organisations, balance of effective management, strong leadership.  
Groups brought together to achieve effective service delivery through mutual trust, commitment.  
Organisations can rely on policies/processes.  
Fail to engage in organisation wide discussion about culture.  
Behaviour change, supporting positive behaviour, culture can only be driven from the top.  
Role modelled by senior leaders.  
Individual negative behaviours must be challenged.  
Only happen consistently within organisations where [positive] culture.

|-----|--------------------------------------------------------------------------------|
| 1   | TU’s support people both sides.  
Boon to management.  
*Smooth over something* they cannot.  
Rep on level with person.  
Don’t always trust management.  
Easier to talk to TU rep.  
A lot comes out; *the nitty gritty.* |
| 2   | [Responsible?] Stewards.  
[Actions TUs/TU reps] Ensure staff retain jobs, have training, feel valued.  
Negotiate good supportive policies, ensure followed.  
Demand managers meet regularly with staff to discuss changes, issues, concerns, open supportive manner.  
Highlight initiatives successfully supported staff; staff seen to be valued.  
Ensure all managers understand effect of negative behaviour. |
| 3   | |
| 4   | |
| 5   | |
| 6   | [TU’s?] Difficult as represent both sides of dispute.  
Make demands regarding what trusts should do; little ability to enforce.  
Vociferously put forward range resolutions to protect member complaining, other staff affected now, in future.  
Influence policies.  
Policies fairly good on paper.  
Reality not applied in way recognises all behaviours.  
Some TUs training workplace mediators with trusts.  
Don’t think progressed, due to resources or success rates |
<p>| 7   | |</p>
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<td><strong>8</strong></td>
<td>[TUs] Open, honest dialogue. Commitment to being fair to all parties.</td>
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<td><strong>10</strong></td>
<td>All employees understand have responsibility to raise issues of negative behaviour.</td>
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<td>Patient and member of staff or staff themselves.</td>
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<td></td>
<td>No one should be <em>silent witness</em>.</td>
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<td></td>
<td>Questionable whether new <em>whistle blowing</em> procedures will assist.</td>
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<td>Training on positive and negative behaviours.</td>
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<td>All staff to understand these and consequential impact.</td>
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<td>[TU’s] Reps training is key.</td>
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<td>Run campaign on Dignity at Work to raise profile.</td>
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<td>Be alert to causation factors.</td>
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<td>Build into industrial agendas.</td>
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<td>Ready to force organisations to manage cases, use risk assessment.</td>
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<td>Ensure management trained.</td>
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<td>Appropriate policies in place.</td>
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<td>Tools available to assist reps supporting members.</td>
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<td>Reps being aware of appropriate support services.</td>
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<td>Sometimes appointed 2 reps.</td>
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<td><em>One fight</em> case technically, other provide emotional support.</td>
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<td><strong>13</strong></td>
<td>Promoting positive strategies, avoiding adversarial complaints based approaches.</td>
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<td>Like trusts, problems with time, workloads.</td>
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<td>Role (FTO) generally reactive rather than proactive.</td>
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<td><strong>15</strong></td>
<td>Professions need leadership,</td>
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<td>Campaign from [TU] blame HCA’s for poor care, repugnant.</td>
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<td>Appalling.</td>
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<td>To say is purely numbers, utter nonsense.</td>
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<td>Profession without proper leadership.</td>
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<td>Individuals, doctors, nurses have forgotten about doing no harm to patients.</td>
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<td>2 and a half thousand years.</td>
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<td>‘First do no harm’, that’s forgotten.</td>
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<td>Change has to come from people on <em>frontline</em>.</td>
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<td>But need to see leadership, models to get them started.</td>
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<td>Suspect lot of people hadn’t realised what doing wrong.</td>
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<td>Poorly trained, by poor instructors.</td>
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<td>On wards, where treatment appalling.</td>
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<td>Normalise poor behaviours.</td>
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<td>Nobody tells them any different.</td>
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<td>Why should 18, 19 year old girl/boy understand what high quality care is?</td>
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<td>Nobody maybe explained it at home. Where are the norms?</td>
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<td>Norms today in homes, maybe completely different.</td>
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<td>Are societal issues, not just in NHS, societal.</td>
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<td>How many professional nurses in NHS? 300,000?</td>
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<td>Dozens, tens of thousands of doctors, consultants.</td>
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<td>They're people provide leadership day by day.</td>
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<td><em>Just standing up</em> for patients, <em>standing up</em> to managers, millions of transactions.</td>
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<td>Get back to 'I'm OK you're OK’ transactional analysis mid seventies.</td>
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<td>Acting as adults, adulthood all of time.</td>
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<td>In NHS, management all parent behaviour, some child behaviour.</td>
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<td>Likewise patients, always parent, child behaviour.</td>
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<td>Not sure what Unions can do.</td>
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<td>Changing behaviours difficult if isn't legal recourse, fines involved.</td>
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<td>United action from health professions. Compel government to listen.</td>
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<td>All colluding with politicians; looking only to own interests.</td>
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<td>BMA’s strike PR disaster.</td>
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429
Lost opportunity to *stand up* for principles of NHS, public sector. Mid Staffs report opportunity for action. Government likely to twist recommendations to support dismantling of NHS. Outcome of Leveson potential for change. Requires internally driven action supported by contextual changes. History of NHS shows internal professional pressures strongest influences in long term.

18 Listen to patients. Better way to analyse patient complaints. Second-level complaints, not resolved locally, more or less ignored. PHS Ombudsman only ‘accepts’ 3% of those go to her. 0.1% of written complains about NHS hospitals.

19 Intelligence *on the table*; begin to address it. Identification of weaknesses clinical areas. Honest and open approach to identify where things going wrong. Learn. ‘No blame’ culture. Clinical audit, evaluations, publishing outcomes results for individual clinicians. Near misses. Learning from serious untoward incidents. ‘no blame’ culture. Personal/family level, normally want somebody to *put hands up*. Admit error. Everybody willing to try and learn. Make sure doesn’t happen to anybody else. When doesn’t happen get into litigation, financial compensation. Lot of time don’t want money. Want to make sure not going to happen to anybody else.

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26 Way organisation functions depends on how Trust Board operates. FT Boards lay Governors; major role to play. Staff get to know Governors. Invite to see what happening.

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30 Don’t think about basics. Hold on the basics; important for patient care? Important for staff wellbeing, how be truthful, compassionate in behaviour. Forget about reputation. Reputation will look after itself. Comes down to individuals. Limit to what can regulate. Regulatory bodies have role, but people have to regulate themselves. Self-regulation. Basic moral principles got to follow. Should behave like this. Come from person themselves. People saying standards have to follow. People good role models. At moment don’t have that. Major overhaul. Lot more transparency. Lot of information is concealed. Wrong doings concealed.
Fundamental change in culture. 
*Silent majority* has to be addressed. Managers, doctors told, expect you to *stand up and speak out*. 
Don't want *silent majority*. 
Requires huge change culture. 
*Silent majority* often stay silent, won’t *march, jump up and down*. 
Got responsibility. 
Got to *take a stand*, especially when see injustice. 
Somebody dying, say hold on I’m busy, got a train to catch? 
Sorry I can’t; that’s the attitude. 
Don’t want to get involved; nothing to do with me. 
Never around when this happened. 
Sorry *bleeding to death*; urgent appointment. 
If dying in street would you walk past me? [L] 
Don’t realise consequences. 
Maybe if had, behave differently. 
Some very senior people think are *God’s gift to mankind*. 
Highly intelligent. 
*Moral pygmies*. 
Encourage moral thinking/decisions. 
Basics of compassionate behaviour. 
Integrity. 
Positive values underpinning actions.

31 More awareness *gagging clauses*

32 Individuals set good examples. 
Share bad practice. 
Learn from mistakes, as well as sharing good practice. 
Lot of good people still around. 
Give self-confidence, courage to *stand up*, say, no, shouldn’t be like this. 
Won’t work like this. 
Only way to stop bullying, *stand up to it*. 
Empowerment

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35 Current arrangement too weak, *chummy*. 
Reluctance to *point the finger*, actually holding people accountable. 
Recognition/understand need to hold accountable.

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| 10 | Clear leadership S of S down.  
     | Highlighting problems negative behaviours, how to address.  
     | Resources made available. |
| 11 |
| 12 |
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| 14 | [Any hope?] May not be [L]; an existential question.  
     | Might be such utter state disarray can’t go forward.  
     | Only one person, can make big difference; Prime Minister.  
     | If doesn’t take it on his shoulders, start transformational programme, are sunk.  
     | PM needs to kick that off.  
     | Classic feedback sandwich.  
     | Fantastic job, BUT, Mid staffs.  
     | Need things done differently. Change your game.  
     | More professional, asserting professionalism.  
     | Feedback to colleagues not performing.  
     | When done that, new NHS, envy of world.  
     | Mid Staffs tainted the brand.  
     | Have to rebuild that.  
     | Says can’t do it. Help you to do it.  
     | You have to do it.  
     | [--] frightened of doing that.  
     | If Cameron frightened, really screwed.  
     | [Fundamental errors?] NHS staff “dedicated”, unconditional.  
     | Entire investigation demonstrated opposite.  
     | Cultures take long time to change; don’t.  
     | True leaders can change them over night.  
     | Evidence every day.  
     | Jumbo jet avoidable deaths per week.  
     | How many jumbo jets since ignorant, complacent nonsense?  
     | Avoid assumptions.  
     | Conflict, any culture change exercise on front line has to start with.  
     | Politicians, scared of it, Royal College leaders, GMC etc.  
     | Nicholson machines needs moral bankruptcy to prevent train derailing at the points.  
     | Leadership - Cameron or Lansley; no-one else.  
     | Little will change without their taking the lead. |
| 15 |
| 16 | Important, greater degree of separation from daily political interference, lines of BBC.  
     | Fundamental changes in government, constitution of UK. |
| 17 |
| 18 | Not responsible for providing and monitoring.  
     | De-politicise NHS so Government, via DH, doesn’t always has to have good news story.  
     | Can admit, publish, some hospitals do not do well.  
     | CCGs July 2010 White Paper "Equity and Excellence: liberating the NHS".  
     | Side-tracked, partly by opposition to suggestions about privatisation.  
     | Delay allowed DH develop 7 layers of management, make Bill very complex.  
     | Listen to patients.  
     | Better way to analyse patient complaints.  
     | Second-level complaints, not resolved locally, more or less ignored.  
     | PHS Ombudsman only ‘accepts’ 3%.  
     | Managers must work with clinicians.  
     | Only aim, provide better services for patients within resources available (culture of NHS).  
     | Not to provide good news story for DH/SoS/Government.  
     | Worst point time last Government, worse 2000 onwards.  
     | Government exercises control via top-down climate of fear through managers.  
     | Managers control over clinicians via jobs, funding, clinical excellence awards, patronage.  
     | To change culture - aims of Lansley's White Paper, not subsequent Bill, implemented.  
     | Bill gives power to managers, can continue to do what described. |
Political level, ‘fessing up’, ‘facing up’, what health service capable of delivering.

Need to face reality.
Politically such a killer any politician.
Can’t afford to keep providing everything.
Conversation, has to be had politically.
Long as, notion, can carry on same stuff, same standard.
Resources simply aren’t sufficient.
Politicians know will be death for them if started to say not doing XY&Z.
Suppose why trying to give it away, in England to GPs; they will have to make those decisions.

[Patients/Public] Much more investment in public health, cleverer way.
Societal design, joining all that up so way live, better for us, [L of L] huge.
Obesity, high BMI costs health service.
Wilder moments, sticking prices on people; cost because obese.
More thought, joined up thinking in way society actually works.
But so imbedded way live now.
It’s huge.
Long as health service role mopping everything up it’s going to sink, it is bound to sink.
Problems too great.
Growing awareness have responsibility for health, but, paid taxes, got to do this for me.
I’d like a new liver please [L of L].
[L] It’s massive, massive, beyond, what NHS managers able to deliver.

[Patients/Public] Customers, patients/carers, staff want to be more proactive.
Public to take some responsibility for way uses, misuses NHS.
Entering new era where all have to change!!.
Here ended the lesson!!!
Look for positive elements change as reorganisation NHS continues.

[Outside organisations] Support people.
Acute traumatic phase, reminding, haven’t done anything wrong.
It’s not them, it’s the system.
Trying to help support them so feel calm.
When feel that alone, much easier to panic.
Empowerment of frontline professionals.
Run training courses so feel more empowered.
Keeping up pressure politically, to try bring something in.
Is about patient safety, rather than people.
Individuals get bullied, lose jobs.
But its patients, patient safety.
Got to help government understand.
If people understood whistle blowing law, what’s expected, speak out earlier.
People hold out too long.
Once sacked, hard to speak, need to pre-empt it.
People very very scared of speaking externally, even MPs.
Build up confidence, so can do it.
Empowering people, need to walk them through.
Once up to this level, within law, go externally.
Have to do it right way.

Struggle to see way forward for NHS until top tier NHS Commissioning Board removed.
Little sign of that.
Awful lot good people still around. Give self-confidence, courage to stand up, say, no, shouldn’t be
like this.  
Won’t work like this.  
Should be National Health Service not series health businesses. Collaboration much more beneficial than competition.  
End up different groups instead members of one family.  

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| 42 | Politicians all colours say, above party politics, have to sort this out.  
Cannot have one lot come up with something other lot say dreadful, get rid of minute come in.  
Come up with something lasts for future.  
Long term solutions.  
Politicians, maybe partly media, not allowed to say, to be honest about things that work, things don’t.  
Have to always speak, know what doing, policy is right, economic or health sector.  
Little room to be honest say, tried A & E target, caused problems, didn’t get it right.  
Other lot howling across benches in commons, ‘shambles’, resign.  
Media saying, government admits policy of failure.  
Nature of politics, media not allow rational evidenced based approach to problems/policy in NHS.  
Almost saying might as well give up, will never change.  
[What action?] Every bit exposes [horrible culture].  
Make room for honesty.  
Allow discussion of problems.  |
Appendix 4. Feedback from the article “A model of organisational dysfunction in the NHS” (Pope and Burnes, 2013)

1) “I have just read the paper you sent and found this very interesting, insightful and compelling. Much of your paper I very much recognise from my own experience and the conclusions and recommendations echo many of my own thoughts.... I’m going to think more about your paper and share with others in ---”.

2) “You have articulated much of what I have been thinking for a long time. Unfortunately I am still part of it. I am still working on the Nurse bank for -----. It is very difficult.... A few Senior Executives have been replaced and that the Trust is in special measures. Communications remain very poor between management and staff. We are constantly having more demands made of us with inadequate staffing. The Trust wants us to 'provide care we can recommend to our family and friends', so do I and that is what I strive for every time I go on shift. Not possible in the current unsupportive climate. There is certainly the denial you refer to in your article and also the bullying. (We have all had letters sent to us stating what is expected from us and the sanctions to be imposed if we fail to deliver!). I won’t go on.

I feel that the NHS has rested on its laurels for too long and as an organisation has managed to escape a certain amount of scrutiny necessary to ensure safety and effectiveness. This may well change with the new commissioning process but it will take time”.

3) “I enjoyed reading the article, lots of interesting and valid points to note. Is it permissible to pass the article on to interested colleagues, particularly ---- and ---?“

4) “I need to study it in more detail and if you do not mind ... I may well quote from it. There is a mountain to climb in parts of the NHS. I wonder if the extract below would apply to Colchester:

Ashforth and Anand (2003) describe a theoretical model of institutionalisation, rationalisation and socialisation, producing normalised corruption. Institutionalisation is where an initial corrupt decision or act becomes embedded and routine. A permissive ethical climate and leadership are key to the initiation and the behaviour, once routine, becomes normative. Rationalisation is where justifications are made to serve self-interests. Behaviours are described such as, denial of the victim and denial of injury and responsibility, which are very similar to those of selective moral disengagement. Socialisation is where new employees are induced by rewards to view corruption as permissible if not desirable (Ashforth and Anand, 2003, p. 1) leading to a gradual escalation.”

5) “Your paper is fascinating and very insightful. The negative behaviour mindset will take a lot of breaking, but we have to be optimistic that it can be done!”
“Thanks Rachael for sending this on to me, and well done for publishing...it makes for depressing reading, and clearly indicates the need for different ways of thinking across all parts of the UK NHS.”

“Thank you for sending this to me. Very well done, and very sobering. I do hope the leadership of NHS will take it seriously. They have involved ---- in a leadership training effort – hopefully it will deal with the elephant as well.”

“Thanks for this excellent paper. Have read but warrants further study. Intelligent kindness arrived today. Waterstones said only available at ---- branch. Library said they could not obtain. Under marketed? This area is massive and vital if NHS is to improve. I am not an academic just a ----- but most of this resonates.’

“Thank you – that was really interesting – and looking forward to next steps. The term ‘corruption’ was initially quite challenging to read because of its modern day association with a deliberate act driven by self-interest (which may also be true) but accurate in terms of its original meaning of something rotten spreading decay. I thought the attached quote from the Chief Exec for Stoke Mandeville from this July’s HSJ was interesting in terms of the opening statement (‘We were encouraged that, overall, there were no significant issues with the safety or quality of care provided at our hospitals’) – although it is subsequently qualified - it suggests continuing denial in the face of clear evidence of serious harm to patients. It chimes with your article.

Are you disseminating your article? Presume there are possible copyright issues with the journal. I am sure it would be of interest to organisations like ---- and some of the whistleblowers.”

“I thoroughly enjoyed your article and strongly agree that its themes apply to all organisations exhibiting bad behaviour. I spent a great deal of my time on circumstances where management of clients were engaged in serious fraud or some other criminal actions. My experience is that behaviours respond to culture and tone from the very top. Critical to this is not what those at the top think they are setting by what they say but rather how their actions are perceived and interpreted from below against just the spoken messages that employees hear. In other words, employees exhibit extreme scepticism to words and put far more store in actions. Hence i suppose the adage that actions speak louder than words. Therefore a neutrality or perceived disinterest towards what culture is growing is as bad as endorsement of a bad culture. It always amazed me how many employees knew of the fraud or bad acts and in many cases participated in them or remained silent. The reason seemed to be that if they could say they were just doing what their superiors wanted then somehow they could divorce themselves from responsibility. The message is that those at the top of an organisation need to be sure they actively engage in establishing a good culture and that all their actions support that and are not in actual or apparent conflict with what that should mean. I fear that as far as the NHS is concerned (and i suspect it goes for other departments as well) the rot starts at the political / ministerial level. Especially for the NHS, ministers in government know that if there is bad news in the NHS and they can be blamed for it then their political life and even the party
remaining in power is seriously damaged. In other words the public believe they cannot be trusted with running the NHS. I would imagine the pressure to deliver only good news and bury the bad is felt through the Department of Health and percolates down through the NHS structure. All, of course, made worse by the emphasis on targets and penalties for missing them so the statistics get 'managed' accordingly. I think this aspect would be a fascinating expansion or, if no data exists, then a series of pointed questions that need to be asked to examine this influence would be instructive.”

11) “Moral disengagement – a good term. Corruption. I enjoyed your article, have now looked through it. Good article, it all needs saying. Well, enjoyment not quite the right word! Not sure whether I have the stomach these days to put it all down on paper. So good that you are!

But is anybody taking any notice? You mention ---- An outstanding, skilled, caring ---- practitioner with ---- people, ---- etc. No longer in the NHS. Recently bullied and harassed out of it for raising safety and quality issues. Thanks again”

12) “I have just come across your fascinating paper and feel quite invigorated by the idea that researchers are looking at this problem.

You mention in the paper the development of a diagnostic tool – do you have any more details about this?”

“This was the search that gave me the link to your paper. I wanted to look at literature on behaviours where the perceived needs of the individual worker and the needs of the organisation were misaligned. Basically, behaviours that were toxic to the organisation (bullying, intimidation) that were directed towards a personal career goals via a stated or perceived organisational goal (e.g. performance targets).”

“My personal reflections on ‘A Model of Organisational Dysfunction in the NHS’ (Pope and Burnes 2013)

Disclaimer: Most of the content has been reported to me rather than my personal experience therefore I cannot be certain of its accuracy. Please do not use content without anonymising.

My background and context: I currently work as a psychological therapist in a -- position in a large -- trust. I have a -- year history of working within the NHS. My direct experience with colleagues and line managers has been very good on the whole and my line managers past and present have rarely, if ever, shown the behaviour described in the paper towards me personally. I consider myself as fortunate to have had this experience, however I shall give an account of observations I have made during my career that link to what is described in the paper.

‘The Darker side to organisational life’...

Today’s NHS seems to be pressured more than ever both externally and internally. Despite corporate pronouncements valuing ‘Compassion’, ‘Integrity’ and
‘Teamwork’, I have seen numerous decisions made centrally or at some distance from the work being carried. Some decisions have, at practice level, potentially compromised the quality of care. Concern about these decisions (their feasibility, impact on morale, impact on quality) has been met with “I don’t care, just do it!” from some manager at different levels. The best team managers act as a buffer to this and attempt a solution at team level (though the impact on them may be considerable); the worst simply repeat the tone and message that has been modelled to them by their superiors.

‘Employees are self-interested...’

As I have become a senior clinician I have been able to observe managers together in various settings that are removed from front-line work and staff. I have encountered, on a few occasions, a jovial disdain and mistrust of front-line staff - groups of managers who are almost all complicit in the glee of ‘getting tough’ with their team members, praising managers who ‘get the job done’ in this way.

One example “If they manage to reach the clinical targets by doing groups, that doesn’t let them off the hook”. When I challenged this idea and suggested that clinicians should be incentivised to reach targets by allowing time for CPD, the conspiratorial ‘them and us’ spell was broken and everyone agreed. Until then it felt like as a group, the managers were sleep-walking into nastiness.

Protection of Image

This case is in the public domain -- . [name] is a clinical psychologist. While working for the Trust in [date] [they] appeared before the British Psychological Society’s conduct committee following complaints by [number] separate patients that [the person] bullied them during therapy sessions and used offensive language. [The person] was found in breach of the BPS code of conduct but was allowed to remain in employment at greater expense ‘Under close supervision’ not able to have contact with clients. Many people questioned why [the person] was not dismissed from the Trust - an avoidance of further negative publicity perhaps? This year the HCPC suspended [name] from their register for -- months (the maximum length of suspension) after a complaint was upheld that [their] sexual behaviour with a patient [they] had seen privately was a serious breach of trust. The message? – ‘You can get away with this here, if you have power’.

‘Bullying is embedded in the act of management’

A senior manager was employed from another Trust. He is alleged to have told a successful and well-respected service manager “This is no place for you in this organisation”. The service manager left, much to the disappointment of many staff. Later some staff informally complained of casual sexism and a bullying attitude from the senior manager. After some time in post the senior manager was asked to resign after a ‘whistle-blower’, who he had ignored (tried to silence), threatened to go to press and informed the Trust board of this.

Another person, appointed as a service manager and then promoted to a very senior position in the Trust became notorious amongst staff for his bullying and controlling attitude. This included ridged [sic] forms of micro-management that
only served to demoralise staff (for example tearing down anything staff had stuck to office walls). One example of his bullying was how he dealt with a clinician who had been booked onto an expensive (non-mandatory) course that was promoted by the CEO without her (the clinician’s) knowledge. The clinician did not want to go on the course as it did not fit with her PDP. She contacted the course organisers to cancel her registration. She later received a telephone call from the manager who is alleged to have shouted “Get your a**e on that course or you are out of a job”. The manager was eventually asked to resign after coming into work intoxicated on several occasions.

‘...many anxious, ambitious and reactive managers’

I have noticed that the flow of managers in the most senior parts of the organisation is swift and marked by people who appear to be personally ambitious and reactive. When one looks at sites like LinkedIn, the CV’s of many senior management include relatively short engagements with organisations rarely more than 3 years. I wonder whether this reflects a lack on investment in the institutions and the people that work in them. I can recall a number of times an employee has ‘burned their bridges’ with poor behaviour only to pop-up in a (often more) senior position in a neighbouring trust.

‘...they endow themselves with rightness’

I will end with a personal hypothesis that is drawn from inferences and observations but no solid evidence.

There are a significant minority of people who seem to struggle to employ ‘intelligent kindness’ and compassion. However, being ‘uncaring’ is socially undesirable and one way to convince themselves and others that they are a ‘good person’ is to work for the NHS, often in a caring role. Unfortunately, once in employment they struggle to deliver warm patient care and get drawn to other aspects of the job that they can do well (organising others, gaining promotion etc.). This provides fragile self-esteem (it only lasts as long as they are doing well) and power whilst maintaining the camouflage of being in the ‘caring’ NHS. Moreover, their inability to respond to difficulty and threat with compassion leads to anxious, reactive and ultimately bulling (sic) behaviour. Once in the middle and higher levels of the organisation there are in contact with a higher concentration of similar souls, where ‘hardness’ is tacitly encouraged and modelled.”

13) “At first I wasn’t sure if the article was a wind-up, surely no organisation could survive like this! Sadly I know it was serious and as you know leads to loss of life and terrible human suffering, for patients and for those in the system. I’d love to have the article on --, either directly or linked, and also to tweet about it --. If that’s acceptable perhaps I could ask you to and my colleague -- to correspond about doing that, -- can make sure it goes on the right place in conjunction with --. Many thanks”

14) “Many thanks for your message and article which I read with interest. It is reassuring that we come to similar conclusions about the dysfunctional circumstances that developed in Mid Staffordshire. What [we] found so striking was why practice of this kind are so resistant to change - despite regulatory, GMC, NMC and DH exhortations to the contrary. Our discussion of [topic] seek to
explain why such a culture develops. We thought, however, that some blame must rest with the bullying and hectoring of NHS boards by the most senior people in the DH - indeed, at ministerial level for draining cynicism into the NHS. That is something Francis hinted at but could not confirm.

As to what must change to make things better, bearing in mind public services austerity, with fewer clinicians and hospital beds, the proposed duty of candour might help - together with Robert Francis’ inquiry into Whistle Blowers. Something like (but not exactly) the Friends and Family Test would surely have been helpful in Mid Staffs. Litigation, however, probably does more harm than good by terrorising people into hiding everything. And events in Colchester suggest inflexible waiting time targets may have a similar impact.”

15) “Thank you so much for forwarding your article to me. I will forward this to the various members of the -- who may not be familiar with your work. I can think of several who would find it enormously interesting and relevant. Sadly I think things have got worse since your article was published.”
Appendix 5. Formal research letters

Three stage e-mail interview letter

Home Address
Home e-mail/University e-mail
Date

Dear

[As you are aware] I am an NHS employee and a part-time doctorate student with Manchester Business School. I am researching the topic of organisational responses to negative behaviour between staff in the NHS. The research study has approval from Manchester Business School to ask you questions in your role as a [role], with experience of NHS organisations. I would like to invite you to take part in this research.

I would appreciate it if you would take part in an interview via e-mail. You will be asked to agree to a consent statement as part of this process. This is to confirm that you are happy for me to use the anonymised information for my doctorate thesis and any subsequent publication.

The e-mail interview will be in 3 stages: Consent form and two initial questions, a further 10 questions, and then for the third stage a scenario will be described and you will asked to comment on this. There may be a short follow-up phone call (recorded) if you are happy for this to take place.

If you choose to do so, you will be provided with a summary of the research findings at the conclusion of the research study.

If you require further information about any aspect of the study please contact me at rachael.pope1@btinternet.com or telephone ---- ------. Or contact my supervisor Professor Bernard Burnes at Manchester Business School - bernard.burnes@mbs.ac.uk

Thank you

Yours sincerely
Dear

I am a recently retired NHS employee and a part-time doctorate student with Manchester Business School. I am researching the topic of organisational responses to negative behaviour between staff in the NHS. The research study has approval from Manchester Business School to ask you questions as a researcher with experience of NHS organisations. I would like to invite you to take part in this research.

I would appreciate it if you would take part via e-mail. You will be asked to agree to a consent statement as part of this process. This is to confirm that you are happy for me to use the anonymised information for my doctorate thesis and any subsequent publication.

The e-mail interview will be in 2 stages:

Consent form and request to comment under a number of headings
A scenario will be described, and you will be asked to comment on this.

There may be a follow-up phone conversation (recorded) if you are happy for this to take place.

If you choose to do so, you will be provided with a summary of the research findings at the conclusion of the research study.

If you require further information about any aspect of the study please contact me at rachael.pope1@btinternet.com or telephone ---- -------. Or contact my supervisor Professor Bernard Burnes at Manchester Business School - bernard.burnes@mbs.ac.uk

Thank you

Yours sincerely
Appendix 6. Consent form and interview formats

1. Consent form and initial research questions

Consent Form

Research Study: Organisational Responses to negative behaviour between staff within the NHS

Method: E-mail/Face to face interview

Role: [e.g. Full-time Trade Union Officer]

Contact:
Researcher: Rachael Pope – rachael.pope1@btinternet.com or telephone ----- ------

Supervisor: Professor Bernard Burnes, Manchester Business School - bernard.burnes@mbs.ac.uk

Research is being conducted on the topic of organisational responses to negative behaviour between staff in the NHS. The research study has approval from Manchester Business School to ask you questions in your role as a [ex/retired NHS employee/ ex/retired NHS trade union representative/ ex-trade union full-time officer/ person who has had experience of working with NHS organisations] with experience of NHS organisations.

All the information collected will be anonymised and all personal data will be kept confidential to the Chief Investigator (Rachael Pope). The academic supervisors will have access to all of the anonymised data.

I consent to taking part in the above research study and interview. I also agree to the information collected being used anonymously within a doctorate thesis and any subsequent publication. [For employees in Non-NHS organisations - By consenting to participate in this research study I am not contravening any ethical process within my own organisation]

[Statement added after first e-mail interview completed - I also agree not to send the interview e-mails to any third party or share the interview record with a third party]

Signed............................................................

Print............................................................

Date..............................................................

If you wish to receive a copy of the summary of the research findings, please give details of your e-mail address here:

.................................................................................................................
Research Questions

First stage:

From your personal observations and experience of work situations within the NHS:

1) Please describe the culture of NHS organisations

   To summarise - use up to only three words to describe the culture of NHS organisations

2) Are there any workplace issues which are difficult to raise/discuss with managers in the NHS?

   Yes       no
   If yes, please give details:

   Why do you think these issues are hard to raise/discuss?

Second stage:

For the purpose of this research

Negative behaviour is defined as: ‘Any behaviour that is disrespectful and undermines/violates the value/dignity of an individual. It is behaviour that harms individuals and organisations’. It includes incivility, aggression, bullying, harassment or abuse.

3) Who is responsible within an organisation for addressing the problems of negative behaviour between staff?

4) Regarding the problem of negative behaviour between staff is there anything that is particularly difficult to raise/discuss with managers?

5) What are the organisational responses when staff & trade union representatives raise concerns about negative behaviour between staff?

   Why are organisations responding in this way?

6) What are the key blocks to organisations addressing the problems of negative behaviour between staff?

   Why is this happening?

7) Have you seen any examples of particularly good practice/intervention?

   Yes       No
   If yes, please describe:

8) Why do people behave negatively to other staff in the workplace?

9) There have been some examples of organisations actually resisting taking effective action. Why do you think this is happening?
10) What needs to happen/be done in the NHS to ensure that actions are taken to minimise the problems of negative behaviour between staff?

11) What needs to be done by trade union representatives & trade unions in the NHS to ensure that actions are taken to minimise the problems of negative behaviour between staff?

12) Please comment on the role of HR regarding the problems of negative behaviour between staff

Third stage

Scenario:

‘Research had been conducted on negative behaviour between staff in two NHS trusts. It had been arranged that the research findings were presented to a range of staff (Directors/senior managers, trade union representatives, research coordinator and harassment advisor) from the two trusts [at the end of an existing meeting]. As the equipment was prepared for the presentation, to the stunned shock and amazement of all, the directors/senior managers walked out of the room, saying they were busy and had other things to do. They had never been seen to behave in such a manner before. The presentation continued without them.

A staff member wanted to write a short article about the research for the Trust News; this was blocked. There was resistance to a brief summary being placed on the research section of the Trusts website. A letter critical of the research was received from a senior manager. A year later, an offer was made to share the research findings with the Board; the offer was refused’.

What is going on in this situation?

Why did they behave like this?

Any other comments:

2. Amended interview format

First stage:

From your personal observations and experience of work situations within the NHS:

1) Please describe the culture of NHS organisations

   To summarise - use up to only three words to describe the culture of NHS organisations

2) Please share your thoughts on:

   a) Raising/discussing concerns/issues with NHS managers
b) Leadership and management in the NHS

c) Negative behaviour between staff in the NHS

(Negative behaviour is defined as: ‘Any behaviour that is disrespectful and undermines/violates the value/dignity of an individual. It is behaviour that harms individuals and organisations’. It includes incivility, aggression, bullying, harassment or abuse.)

d) Organisational responses to negative behaviour between staff in the NHS

3. Amended and simplified interview format for Chief Executives

From your personal observations and experience of work situations within the NHS:

1) Please describe the culture of NHS organisations

   To summarise - use up to only three words to describe the culture of NHS organisations

2) Please share your thoughts on:

Negative behaviour between staff in the NHS

(Negative behaviour is defined as: ‘Any behaviour that is disrespectful and undermines/violates the value/dignity of an individual. It is behaviour that harms individuals and organisations’. It includes incivility, aggression, bullying, harassment or abuse.)

   a) In the NHS as a whole

   b) Within your own organisation

3) Please share your thoughts on:

Organisational responses to negative behaviour between staff in the NHS
Appendix 7. Lower and Higher Level Classes

1) Framework Theme 1. Structure/form/groups

Lower Level Classes:

1. Huge and vast
2. Diverse
3. Complexity
4. Tiers/hundreds of layers deep
5. Distance and separation
6. A structure; a top, middle and a bottom
7. A huge big monster/one monolithic organisation/superstructure
8. A whale versus shoal of fish
9. Tribes, clans and silos; different conflicting cultures
10. Tension and conflict
11. Weird, strange and peculiar
12. Brittle and lean
13. Weird dysfunctional family with hickey cousins and black sheep
14. Organisations under one umbrella
15. Fragmentation/disjointed/confusion
16. Insularity/enclosed/inward/isolation
17. Politically led; a political pawn/machine
18. Politicians determine shape and structure
19. A vast machine
20. A system
21. A citadel with broken down walls
22. A gang, club and secret society
23. A train, tanker and ship
24. Unimpeachable
25. Powerful management structure; tentacles of DOH reach down and control
26. Restriction and limitation
27. Same, but not the same; common themes
28. Spreading of same behaviour/ideas through whole system; endemic
29. Not a national health service
30. Ladders and greasy poles
31. Born and died at age 52
32. Fossilising, dying on its feet, breaking apart
33. Private sector sweeping like vultures to pick up the juiciest pieces left over
34. Public discourse; beloved, respected and national treasure

2) Framework Theme 2. Positive characteristics

Lower Level Classes
1. Clearly positive characteristics
2. Positive characteristics, with some qualification
3. *Blue sky thinking/want to believe NHS is positive*

3) Framework Theme 3. Hierarchical/top down/power

**Higher Level classes**

1. Multi-layered hierarchy
2. Centralised rule by power, domination and intimidation
3. Political control
4. Culture of fear
5. Culture of elitism and superiority
6. The need/desire for status, power and position
7. Difference and distance; a gap
8. Inequality
9. Disempowerment/powerlessness
10. Higher levels valued/lower levels (*coal face, shop floor, frontline*) not valued
11. Conflict
12. Power to define
13. *Kowtowing*

**Lower Level Classes**

1. Hierarchical organisation/hierarchical power
2. Central *kowtowing* to DOH
3. Elites/as Gods; very powerful/arrogance
4. General managers superior and all powerful
5. Top down/command and control/driven not led
6. Tendency towards totalitarianism; rises up in modern organisation
7. Totalitarianism; power to define thought, what talked about, can do
8. Power *at the top*
9. Paternalistic
10. Autocratic decision making
11. Lot of managers, their way, or the *highway*
12. Bullying from *the top; corporate bullies*
13. Political power/politically driven; pressure from above
14. Specialist ability power
15. Powerlessness of politicians
16. HR powerless/HR more power than CEOs
17. Culture of blame; *scapegoats lower down the pecking order*
18. Blame person least power to resist
19. Defence of people in power
20. Power and the powerful; power matters
21. Position of power; just want ‘yes’ response
22. Appoint managers ‘yes’ *written on foreheads*
23. Senior managers; habit of appointing puppets
24. Powerlessness/lack of autonomy/no power, influence
25. Butterfly effect; good idea at high level, massive piece of work at the bottom
26. Not empowered
27. If no money, managers feel powerless
28. Powerlessness against insensitive bureaucracy/system
29. Power imbalance; one sided
30. If no power frustration builds
31. Inability to challenge powerful people; fear reprisals
32. Powerful groups
33. Power differentials; reason for bullying
34. Putting people down; display of power
35. Like using power
36. Power increases when not challenged
37. Desire for status and position
38. Desire for power and control/hang, cling, hold onto, power
39. Protect power, privilege, money, lifestyle
40. Desire for power and control produces negative behaviour
41. At the very top power of patronage, knighthoods, honours
42. Managerialism; managers have greater power/powerful management structure
43. Informal (staff) power parallel to legitimate power
44. Power to sabotage; people have to want to follow
45. Cascade of maladaptive behaviour down; self perpetuating dysfunctional system
46. Culture of fear
47. Pressure to conform
48. Normalisation/perpetuation of poor practice, behaviour
49. Lack, avoidance of accountability/responsibility
50. Rhetoric not reality; empty words
51. Distance/detached/disconnect
52. Lack of care/uncaring
53. Assumptions/bias: culture, manager is always right; serving, meeting organisational needs/purpose
54. Rationalisations/justifications
55. Get into positions of power through R&J mind-set
56. People in power do not want to know about problems
57. People who support senior managers get promoted; more power
58. Positions of authority, power, control, inhibit challenge.
59. Creating names for themselves/empire building
60. Power struggles and alliances, power bases; works against learning and change
61. Personal agendas and power bases
62. Create power bases; desire for leadership/control
63. Power, money and nepotism
64. Misuse of entrusted power
65. Conflict and power; repeating themes
66. Fear of naming and shaming; threat to power
67. People in power cannot lose political face
68. Avoidance and denial; shows powerful role
69. Powerful narrative in society; positive image
70. When narrative forms part of who I am; very deep rooted belief, powerful
71. Power wielding person like a Hitler; great threat
72. System will eliminate people not in position ultimate power
73. Organisation; no power of its own
74. CEs have it in their power to change things
75. Organisational support to employees can be powerful/can restore personal power

4) Framework Theme 4. Bureaucracy/policy

Lower Level Classes
1. Too much bureaucracy and red tape
2. Need for bureaucracy
3. Ticking the right boxes; rhetoric not reality
4. Focus on paperwork and computers/distraction from the patient
5. Focus on formality/lack of informal process
6. Breach, ignore, misuse policies
7. Lack of planning, forward thinking, decision making; fighting the fire
8. Inadequate appraisal process, performance management/need for simplicity
9. Lack of autonomy/powerlessness
10. Restricted by rules/disempowerment/paralysis
11. Policies; a way of closing down complaint/problem prematurely
12. Works better in the private sector
13. Insensitive bureaucracy/ignore individual concerns
14. Perception of unfairness/injustice re application of policy
15. Hiding behind policy & process/avoidance of responsibility
16. Any dispute; HR resort to disciplinary procedures/politically correct action
17. Inflexibility/lack of discretion
18. Ineffective formal process
19. Lack of independent thought
20. Lack of moral judgement, positive values, humanity
21. Distortion of priorities
22. Regulation – light handed and ineffective
23. Commissioning second rate, poor; trolley loads of unnecessary bureaucracy
24. Nature of bureaucracy; rewarded for taking good news to boss.
25. Rationalisations/justifications

5) Framework Theme 5. Finance/business/targets

Lower Level Classes
1. Politically led/driven
2. Lean, stretched and brittle organisation
3. Relentless focus on cost cutting/drive for efficiency
4. Target driven
5. Bullying to meet financial targets
6. The business model; conflict of values
7. Lack of focus on patients and staff; negative impact (The money comes first)
8. Money; not the patient
9. Money inhibits speech/money speaks
10. Waste/lack of efficiency/disconnection
11. Some positive interventions
12. Sensitivity to ‘bad news’ drives behaviour/priorities
13. Sensitivity to ‘bad news’; affects funding streams
14. Pressure/working over capacity, capability; chaos
15. Some departments run on skeleton service; patients not seen
16. Rhetoric not reality (talk and lip service)
17. Perverse incentives distorting behaviour
18. Lack of financial checks/governance/control/accountability
19. Conflicts of interest/fraud/corruption
20. Don’t care/not bothered/values ‘delivery’ over care and compassion
21. Lack of humanity
22. Meeting/serving the needs of the organisation is the priority
23. Private health care provision; comparisons.
24. Negative behaviour ignored if perform/cut budget
25. Money/finance used as rationalisation/justification
26. Could list, screw up, move, more responsible job, more money; corruption
27. Some CEO’s/senior managers offered as a “...free good” to other organisations, salary paid
28. Managers expect large payments when sacked for failings
29. Failed managers reappear at other hospitals on higher salary/bad managers go onto subsequent trusts
30. CEOs look after each other; massive payoffs
31. Institutionalised dishonesty; fiddle waiting lists times, targets or finances
32. Waiting times; politicians wanted to be able to brag

6) Framework Theme 6. Change/variable

Lower Level Classes

1. Constant organisational change, restructuring; disruption
2. Politically driven change
3. Change of culture; nothing like it was, used to be/bears no resemblance
4. Change from benign dictatorship to malign organisation run by professional managers
5. Rise of general management
6. Horrible centralising controlling culture more recent
7. Cultural, organisational variation/difference
8. Lack of learning/culture of learning from mistakes lost
9. Some places learning orientated, some places dark, blame orientated
10. Variation of practice/contrast/‘anything goes’
11. Constant change of focus/shifting priorities/never finish anything
12. No time for consolidation
13. Paranoia and paralysis
14. Constant change leading to confusion, inefficiency and demoralisation
15. Chaos/instability; ‘shifting sand’
16. Change, but nothing changed
17. Slow to change/inertia and paralysis; trying to run through treacle
18. Change producing fear/fear of change;
19. Constant change of managers; ‘revolving door managers’
20. Shift of power to managers
21. Negative impact of change on staff, patients; worsening of services
22. Move to utilitarianism; personal to impersonal
23. Change from non-punitive to punitive; lack of humanity
24. Openness discouraged
25. The need for change
26. Change of HR roles to business orientated

7) Framework Theme 7. HR/other roles

Lower Level Classes

1. Change of name, HR role; confusion/different pictures around the room
2. Separate/detached/lack of access/want to stay away from problem
3. ‘NHS think’; HR different outside the NHS
4. HR ‘NHS think’/no HR; felt free; not having to pussyfoot around
5. Taking sides; not neutral/support the organisation/tool of management/drive agenda of manager
6. Not honest; two faced
7. HR have own negative behaviour
8. Overall function, HR dysfunctional
9. Supporting hard line management approach rather than what the service supposed to be about
10. Not following policy
11. Tendency towards formal process; need for informal approach
12. HR resort to disciplinary procedures/politically correct action
13. HR look for quickest, easiest resolution
14. HR want problems to disappear
15. HR pressurise, bully, bulldozes staff
16. Imbalance of power/on a losing wicket; fear
17. HR rule; not allowed to challenge
18. Supportive, effective HR; if seen as independent
19. Lack of, no support for staff/don’t look sideways at staff
20. Dehumanisation/denigration/people as resource
21. Lack of action/ineffective/dysfunctional response
22. HR corrupted; embroiled in organisational failures
23. Incestuous in NHS; promote who you like
24. HR talent spotting; against principles of equality principles
25. HR Director; real vision an exception/singing a corporate tune; detached
26. HR; quite depressing/some members first rate
27. Rationalisations/justifications
28. Risk Managers stay with the problem; bearers of ‘bad news’
29. Trade unions make deals/involved in negotiation of confidentiality/gagging clauses
30. TU representatives may have cosy relationships with managers
31. Trade Unions need to be stronger/more independent
32. Non Executives; part of the problem not the solution
33. Non Executives go native
34. Non executives; passive and useless
35. Occupational Health; a tool of HR
36. Organisational support team; informal process
37. Silence, get rid of whistle blower; CEO drives process

8) Framework Theme 8. General lack/dysfunction

Higher level classes:
1. Lack and inadequacy
2. Systemic dysfunction
3. Disorder
4. Distorted priorities
5. Lack of positive moral values
6. Lack of efficiency and effectiveness
7. Working beyond capacity

Lower level classes
1. Unmanaged/poor management/mismanagement
2. Demoralised/defeated/staff struggling/exhausted/battered
3. Staff not valued, empowered/not a priority/lack of support
4. Lack of training, skills and ability, knowledge, experience, learning/deskimled
5. Understaffed/reduction in staff
6. Constant change/no consistency
7. Lack of responsibility, accountability
8. Managers lack appreciation, understanding and awareness
9. Un-dynamic/slow – very plodding, complacent/entrenched/paralysis/slow to move things
10. Chaotic/frantic responses/rushed/overstretched
11. Lack of effectiveness, efficiency/reactive not proactive
12. Lack of care and humanity
13. Negative impact on patient care and staff wellbeing/neglect
14. Dysfunction/disorder/confusion/shambles
15. Defensive/resistant to research evidence
16. Punitive, damaging, blame, bullying
17. Lack of coordination, *joined up thinking*, connection, intelligent planning, communication
18. Unequal/managers treated differently/unfairness/bias
19. Excellence discouraged, mediocrity encouraged/promote people not performed well
20. Perverse incentives, dynamics; quality of service secondary
21. Worried/nervous/ fearful/stressed
22. Incivility and lack of respect/lack of basic standards
23. Lack of *moral fibre*, values, courage, honesty/ethical fading
24. Dishonesty
25. Lack of vision and purpose
26. Lack of evaluation and regulation
27. Rhetoric not reality
28. Appraisal inadequate; tick boxing
29. Recruitment processes inadequate/flawed
30. Person who gets job most inappropriate
31. Survival of the unfittest; reward for the wrong behaviours
32. Bad managers go onto subsequent trusts
33. Self perpetuating dysfunctional system
34. A ‘system’ not a ‘service’
35. Hubristic tendencies screened in at interview
36. Values delivery over care and compassion
37. Driven by government priorities
38. *Crippled/buffeted by* government priorities/director politics
39. Increasing fragmentation; post code lottery
40. Shoving down to GPs; get management consultants in
41. Some CEOs not very clever
42. At the bottom have patients dying and unhappy staff
43. No proper evaluation of, and learning from, management initiatives
44. *Make do and mend*

9) **Framework Theme 9. Raising concerns/communication**

**Higher level Classes**

1. Deafness
2. Rejection and suppression of truth and reality; cover up
3. Silence; no voice
4. Protection of image is paramount
5. Powerful alliances against the powerless
6. Conflict, intimidation and retribution
7. Lack of morality, ethics; corruption
8. Destructive culture
9. Presence of fear
10. Dishonesty
11. Disorder
12. Pretence, lip service and spin
13. Inability to learn and take action
14. Absence of accountability
15. Lack of care and concern

**Lower Level Classes**

1. *Deaf/don’t listen*
2. Don’t want to hear, listen/selective hearing/don’t want to know/closes eyes and ears.
3. Multiple issues difficult to raise/facing ‘brick walls’
4. Able to raise/issue dependent
5. Positive response to concerns
6. Complaints; electronic waste paper baskets
7. Try to silence whistleblowers, critics
8. People who question, challenge, seen as negative/trouble maker/enemy/not ‘in the team’
9. Unable to voice, speak up
10. Choose not to speak up/keep heads down/don’t put head over the parapet/Emperor’s new clothes/sea of silence/silent majority/don’t put yourself in the firing line
11. Gagging clauses/compromise agreements
12. Not an open learning culture/mistakes not learned
13. Active suppression of concerns/suppression of ‘bad news’/bury bad news
14. Reluctance to share bad news up the management chain
15. Fear
16. Retribution/penalised/get shot down/flak/slapped down
17. Telling tales frowned upon
18. Same problems cropping up, same themes
19. Difficulty having difficult conversations
20. Deflection of responsibility downwards/blame/lack of accountability, responsibility
21. Lot of managers ‘Yes’ people/ lots of very grateful managers; no one questions
22. Managers learn questioning things not popular
23. Status influences how much listened to/important people matter
24. Need to create environment can raise issues/need neutral support mechanisms
25. Unable to meet expectations/bronze not gold service/struggling
26. Rationalisations/justifications
27. Not interested/managers ‘happy’ for units to be low staffed
28. Nothing done/lack of action/slow to respond/ineffective
29. How things look, more important/don’t want truth/don’t want reality
30. Protection of image, organisation more important than patient, staff welfare.
31. The golden rule; keep stum/don’t let it out/keep the lid on it/don’t give the game away/don’t expose dirty linen
32. The Citadel – is notional home of big secret/something hidden/culture of dishonesty
33. Pretence/the Emperor’s new clothes
34. Clinical excellence awards buy silence/money speaks
35. Patients treated as whistle blowers
36. NHS: primary purpose to look after itself/protect politicians/primary concern not patients
37. Rhetoric not reality/lip service/spin
38. Lack of care for patients/lack of focus on patients
39. Executive team perceived as in a silo/not ‘at one’ with workforce/separation/remote
40. Lack of connection/poor communication
41. Unexpected responses/staff expected to be ‘heard’; shock
42. Free thinking not prevalent/little leeway outside rules/lack of common sense
43. Stop raising concerns/dropped out of it/what’s the point?
44. Lack of order, organisation/lunatics are running the asylum/a dangerous madness
45. Up against the system/bias and corruption/the end justifies the means
46. Lack of courage/moral pygmies
47. Telling lies to cover up
48. Morality and ethics go out of the window/put aside moral, ethical considerations/ the end justifies the means
49. Nothing matters except the goal
50. Finance more important than patient, staff welfare
51. Self-interest more important than patient, staff welfare/lack of caring, concern
52. Witch hunts/set a trap/just trying to dig dirt/savaged by mob of wild dogs, still baying for blood
53. Mutual benefit from alliances/give me pat on back/nepotism/cronyism/incestuous
54. Powerlessness to influence/‘learned helplessness’.
55. Positions of authority, power, control inhibit challenge; power matters
56. Whole iceberg thing; a lot of people are bullied and go quiet
57. Black balling in the NHS if speak out; one organisation
58. Trade unions need to be stronger
59. Whistle blowing becomes employment issue; trick they use
60. Incestuous in NHS; against grain of equality
61. Put aside Agenda for Change/do what they want, no rules
62. Experiences of whistleblowers Kafkaesque
63. Fragile rationality
64. Adversarial political system drives the culture/deadly combination candid media and politics
65. If want to prosper just join corporate line
66. Believe own rhetoric, propaganda/delude themselves
67. Unhealthy tendency to dismiss views of clinicians/do not want to listen to clinical concerns
68. Head on conflict with management view of the world
69. Horrible culture
70. Perception of great injustice; being failed

10) Theme 10. Negative behaviour

Higher level classes

1. Disrespect and negative behaviour; normalisation
2. Culture of fear and blame
3. Dysfunctional and corrupt system
4. Lower staff not valued
5. Lack of care, concern, humanity
6. Conflict; divisive culture
7. Perversity and distortion
8. Pretence, dishonesty and cover up
9. Systemic hierarchical domination and control
10. Power imbalance/misuse of power
11. Turn a blind eye/three wise monkeys
12. Sweep under the carpet/leave sleeping dogs lie/better not to rock the boat
13. Managers stick together
14. Protection for certain groups/apex
15. Alliances providing protection
16. Nasty culture
17. Destructive impact
18. Inadequate management of negative behaviour
19. Perverse/corrupt management of negative behaviour
20. Need for action to address negative behaviour

Lower Level Classes

1. Systemic culture of disrespect and negative behaviour
2. Lack of communication all levels
3. Lower staff not valued/disregard for subordinates/dignity and respect not lower than management/not seen as individuals in positive light/lack of support/not treated well
4. Board not valuing staff/some staff, managers; expendable, 10 a penny
5. Spectrum from lack of support, impoliteness to outright bullying/threats
6. Entrenched bullying and harassment/plenty nightmare behaviour/very few organisations where isn’t widespread; endemic
7. Bullying and harassment; a lot of it/common place/prevailing culture/frequently bullying/bullying and harassment increasing, staff sniping at each other
8. Deeply engrained malaise; culture of bullying and dishonesty
9. Negative behaviour mostly behind closed doors; subtle, insidious
10. Negative behaviour all levels
11. Putting people down; display of control and power/behaving badly in positions of power/use hierarchical power against junior staff
12. CE of NHS threaten CEs with the sack if don’t deliver
13. Power imbalance/bullying linked to power differentials/powerful people difficult to challenge
14. Perceived power of person complaining about affects likelihood of action
15. Junior staff use specialist ability/capability to undermine authority senior staff
16. Belief general management superior, all powerful
17. Staff so defeated/no power; frustration, things explode in the workplace/no strength to fight/managers feel powerless if no money to recruit
18. Everybody knows, but nobody does anything/don’t want to stick head above parapet
19. Conflict between peers, hierarchies, professions/jealouslys and ganging up
20. Negative behaviour between senior staff different trusts/lack collaboration/egos
directors, CEs, cannot be seen to back down/avoid intelligent compromise;
stalemate and patient detriment
21. Homophobic/colour prejudiced/racism not well managed/harassment around
disability, learning disability, race; nobody tackling hardly
22. Medical staff still inappropriate treatment of patients/other staff groups
23. Senior managers; lack of challenge to consultants
24. Middle ranking managers/admin receiving end of most difficult behaviour; sit
between senior managers and clinicians
25. Top down culture of fear and blame; sick culture at the top filters down
26. Historically blaming and bullying; always someone else’s fault
27. Bullying organisations, shadows of each other; every unit a microcosm
28. Nasty culture enforced by Whitehall; bullying from the top, down through system/
cascade of maladaptive behaviour all the way down/permeates down
29. Bullying comes all down the lines to people doing shop floor work; totally cowed,
demoralised
30. Centralised bullying tactics via very strict management system
31. More pressure on clinicians from top management, more likely cycle of negativity
32. Conflict/adversarial culture; fight between managerial dictatorship and
professionalism/dynamics create ‘them and us’/prefer to get rid of clinicians who
disagree
33. Bullying organisation some very favoured, some victimised
34. Half time; manager the bully
35. Bullying enormous part to play in failure to uncover problems at Mid Staffordshire
36. Bullying management culture/inadequate managers adopt bullying, autocratic,
repressive management style
37. Managerial inadequacy/poor, weak management, leadership; long standing issue
38. Lack of management skills, competencies, confidence, communication, people
skills, training, support, knowledge and time/not equipped, know how to resolve
behaviour difficulties
39. Don’t people manage anymore; lack skills/where lack skills, behaviour unchecked
40. Up to point respond reasonably well, but not robustly; threshold when too
disruptive to service, other negative reputational consequences
41. Leadership failure at NHS Confederation level; could fix it/organisational and
managerial inertia; belief nothing can be done
42. Corporate bullying; Corporate thuggery at the highest level
43. Arrogant, narcissistic behaviour; hubris
44. Million different, wide variety reasons for negative behaviour
45. Normalisation, acceptance, toleration; allow it to happen
46. Negative behaviour seen as normal/don’t notice, used to it, think it’s normal;
ever ask a goldfish for its opinion on the water!
47. Some areas tolerate foul abusive language between colleagues; routine
48. Negative behaviour causes hell/havoc/disruption/upset/corrosive effect on team
behaviour and performance
49. Is malicious/horrible/vile/awful
50. Destructive impact of negative behaviour; damaged staff
51. A nasty can of worms to open/If open a can, the worms will come out, unleash
something/are a lot of worms
52. Resistance to hearing and knowing; The three wise monkeys treatment/turn a
blind eye
53. Pretence negative behaviour not there; denial, dishonesty and cover up
54. Pressure from the top to deliver; targets
55. Managers bullied by bosses to save money; pass it on down, pass the pain down the line/middle managers particularly under pressure to meet targets; not met, failed/unreasonable, unrealistic expectation of delivery; is culture
56. Competitive environment breeds negative behaviours
57. Very difficult to change; if swimming against that culture seen as abnormal
58. Middle managers very frustrated; forced to carry out actions don’t believe right
59. SHA don’t care how meet targets, just want to know met; don’t want bad news
60. Lack of accountability/director, executive level not accountable for how treat staff/anti-social behaviour
61. Lack of accountability how treat staff, key to behaviours
62. Inadequate policy/not fit for purpose/not robust enough/absence of legislation
63. Lack of informal stage/straight to formal/formal often fails; ineffective
64. Informal process still in writing; no one will use, are nervous/ tied up in bureaucracy/waste of time, damaging
65. Poor use/misuse of policy, process
66. HR do nothing/not proactive/have their own negative behaviour/encourage, facilitate bullying
67. Difficult to access HR, senior managers/distance, separation
68. CE, directors too detached from frontline/most people hearing bullying claims so far up food chain
69. Top level managers little understanding of frontline pressures; created bullying organisation
70. Nothing anecdotal to HR/only act if grievance/refusal to act outside policy/won’t try and tackle before kicks off/don’t get involved until formal
71. HR don’t know how to investigate; poor investigations
72. Individual bullied, go through grievance; it’s double whammy/when lose grievance; message shut up and sit down
73. Staff very damaged by process/grievance; soul destroying process
74. Refuse to buy in mediation/grievance; it’s not work, makes matters worse
75. Mediation rejected by some people; want justice not resolution/some insist on formal grievance, blame, to uphold own belief; not allow full understanding
76. If political comment on organisation, tendency of blame orientated response to negative behaviour
77. Have to push manager to investigate/manager throws it in the bin
78. Assumptions: If manager says didn’t happen, didn’t happen/deduce staff liars, managers always tell the truth!
79. Mainly inadequate responses/lack of action/investigations take forever and a day/delay
80. Counter claims; not straightforward/cases very rarely clear cut
81. Problems swept under the carpet; like to leave sleeping dogs lie
82. Turn away from B&H; hard to pin them down/lots of excuses, very busy diary/in too difficult box
83. Organisations, individuals avoid conflict; active management sometimes seen as conflict/conflict avoidance can lead to inadequate unsatisfactory outcomes, non-resolution or punitive responses
84. Constant change, who is the manager?/cannot keep handle on who responsible/difficult to speak to right people
85. Rhetoric not reality/Not walking the talk/lip service/dignity and respect taught but not used/lots of fine words bullying won’t be tolerated
86. Apply large pinch of salt to self-reported success stories from organisations/need views from nearer shop floor
87. Passive aggression; pretend to go along with it, but do nothing
88. Powerful versus the powerless; difficult to challenge
89. Powerful alliances
90. Managers stick together; loathe to criticise another manager/managers; police investigating police
91. Many barriers to crappy behaviour being challenged/high cost to manager ‘calling out’ another manager
92. Better not to rock the boat
93. Certain groups (e.g. Doctors and managers) not challenged, protected, nothing done; treated differently/managers never tackled; green light perfectly acceptable
94. Doctors appear untouchable/as Gods, just stuff their mouths with gold; rewarded for appalling behaviour, biggy clinical excellence awards
95. Inter group behaviour tolerated more than intra group
96. Apex of organisation; protect each other/challenge senior person/challenge whole group/culprit protected
97. CEs look after each other; massive pay offs
98. Treated differently: HR, managers make a mistake, it’s OK plausible/some people get pay offs, some don’t/mistakes by managers downplayed; clinical mistake major inquiry
99. Rationalisations and justifications
100. Redefinition of what is, or is not bullying
101. It’s all about how it looks
102. Witch hunts/organisational vendettas
103. Survival of the un-fittest
104. Self perpetuating dysfunctional system
105. Selective pressures, behavioural drivers; only ones thrive, enjoy culture become managers, move up hierarchy
106. Bullying teases out who is going to survive; survival of the fittest, no good being a shrinking violet
107. Negative behaviour meets organisational need
108. Perversity; reward for failure, negative behaviour/managers behave badly, get moved, promoted
109. Require negative behaviour to move up
110. A malign organisation/management; a malign influence
111. Some good behaviour; negative behaviour not everybody, not everywhere
112. Some good practice (local not systemic)/pockets extremely good practice/timely
113. Dominant, pervasive bullying culture conflicts with need to protect whistleblowers
114. Strong perception bullying and harassment from managers, maybe linked with suppression of bad news, persecution of whistleblowers
115. Good people do not speak up, publically humiliated if disagree; response to challenge, almost bullying
116. Good managers not valued either by management/not team players/don’t do as told/waste time listening to genuine concerns.
117. Rarity get good result/people leave, *draw out of it/cases NOT upheld; good demotivator/*if managers not going to listen only go down that route if desperate
118. Staff backing down, why manager gets away with it/*scared* of retribution/*look other way, pretend didn’t happen/can’t recruit reps/*silent witnesses
119. People moved from place to place/*shunted around
120. If not saving money negative behaviour not a priority/*don’t want to spend money, time, supporting staff/*less tolerance of staffing, personnel issues
121. *All doom and gloom* by the time members contact TU/moving people is best outcome
122. *Big blocks* ministers in government, pressure senior managers to meet targets leads to negative behaviour/*government not listening/*powerlessness of politicians
123. Lack of training; not a priority/*mass training need to manage dignity at work issues, every level
124. Malevolent group of staff ruin professional life; don’t like people with high standards
125. Ludicrous claims of bullying; clinician told to stop wearing dangly earrings
126. Public services; difficult to discipline
127. Lack of performance management
128. *Fine line* between performance management and bullying, harassment; process used to get people out/turns from allegation of bullying to competence issue/*good social control/*victimisation
129. Bullying in all workplaces, endemic in humans; bullying in workplace all about caring, hopeless
130. Bullying rife lot of sectors but can have good cultures, safe supportive, excellent bosses
131. Habitual bullyer get rid of one person, move onto next/*build own little clans/cliques, others excluded
132. Mobbing is about fitting in, peer pressure/*intolerance of difference; opportunity for display of negative behaviour
133. Some managers like supervisor to bully to *corral/control group; so bad news never from manager
134. No one cares/*lost our humanity, but now talking about compassion/*if don’t respect staff, don’t respect patients
135. Organisational support team – recognition of humanity in *a system, machine; need quality conversations, informal actions
136. Not seen good practice/behaviour not challenged; move on through recruitment, promotion, many years/poor negative performance unchallenged long periods time/failure to deal with display negative behaviour
137. Rely on policies, process; fail to engage organisational wide discussion about culture
138. Resist action because lazy/*don’t want to do it/*can’t be bothered/*don’t know how to/*complacency/*life is frenetic/too much hassle
139. People difficult to manage
140. *Don’t want to face it*; too difficult, uncomfortable/pattern, real genuine concerns *brushed aside; too difficult/easier to let things go* than sort it/not dealt with or dealt with badly
141. “*The system will eliminate*” people: If someone *face up to it*, not in position of ultimate power, *system will eliminate them/part of a game*
142. Reflect badly on them, so let’s pretend it’s not happening/reflect in bad light/don’t want any mud sticking to me/it’s the profile raised/Nothing is done because of how it looks/big stigma/want to close issue down quickly to reduce impact
143. DOH wants good stories/anyone trying to do good things; problems if shows up results politicians, Number 10 don’t like/SoS concerned with reputation, suppression of bad news/do not win votes for NHS, could lose them/SHAs job to tell NHS Board, ministers ‘all is well’; to make good news
144. Nothing is done because know where the bodies are buried; the unofficial culture
145. Key blocks: time, leadership, arrogance and power
146. Culprit tolerated, protected until do something outrageous
147. Difficult to get rid of people
148. Don’t get rid, still value person, still delivering the goods; ignore evidence/suits organisation/unwelcome behaviour in valued member of staff excused, dismissed/behaviour serves organisational need; ignored as ‘performs’/not tackled if takes position organisation wants/actively benefit from culture
149. Difficult for organisation to say produce the goods; not always sure about the methods
150. Don’t want to acknowledge; easier/can’t talk about it out loud/pretence/disattending of highest order; from all levels
151. If hasn’t got a name it doesn’t exist/if don’t say X happening then it’s not happening
152. Don’t want to know, admit/avoidance/denial/keep off really uncomfortable subjects/deniability; unwilling to admit/denial, dismissive; push things under the carpet/don’t want to hear what say
153. Reports get three wise monkeys treatment
154. People in wrong jobs/wrong people/problems with recruitment; wrong balance
155. Inadequate selection processes; appoint managers with ‘yes’ written on forehead/signal sent to youngsters Lancelot Spratt lives OK
156. Personalities a problem, hubristic tendencies should be screened out at interview; actually screened in/wrong sort of people end up leading NHS; corporate bullies
157. Need to nip it in the bud at lower level/set expectations, standards
158. Every person responsible for addressing negative behaviour/managers/CEO/HR responsible
159. Negative behaviour, poor working relationships; need help/lots of teams struggle/conflict inevitable/pain of constant change, restructure; allow to grieve
160. Focus on outcomes/targets – unintended effects on way relate/primary focus patient services not relationships
161. If ignore negative behaviour – a cancer eating its way through organisation
162. Behind negative behaviour clashing ideologies, ways of seeing world/organisation; conflict between market and operational values/agendas smashing together/driven, business model imposed, purchaser, provider split, alien to culture, value system
163. Always another side/different perceptions/complexity
164. Unofficial culture, deals are done; informal relationships inhibit action
165. Trade Union rep try to ensure support, proper management; need training
166. Trade Union rep; never seen appropriate, proportionate response to disciplinary issues/too much weight on punishment
167. Trade unions part of the problem/reluctant to pursue case unless 100% clear cut; tone things down, half arsed job/signal to members won’t be supported
168. Trade union reps overworked volunteers
169. Culture attacked by relationship between SS reps and managers all levels
170. No recourse except expense of tribunals/organisations gleefully spend public money on top QCs to defend wrong doings/some defend the indefensible/wilful mismanagement to see someone break, leave
171. Victims lose confidence/blame themselves
172. Private sector staff treated better
173. Don’t see if happy staff, moral high
174. Witch hunt/scapegoat; easy to scapegoat those low down pecking order/use capability route
175. Made to feel no good, no support, no voice, no fairness or justice
176. Addressed when negative stories from range of places; hard to ignore/action prompted by high turnover, and/or sickness, financial implications, so hurts organisation
177. Passive bullying, subtle aggression; exclusion, no consultation, freezing posts, delays to increase pressure
178. Lies and bullying, cover up, deliberate concealment, more lies/trust easily hide dirty linen/system, covers up for person, people who do wrong/lack of transparency.
179. Defend those in power; to cover up/senior people get lots of power; like using it
180. Searching office, hacking computer seen as acceptable by managers
181. Goal-driven culture, end goal justifies means/as long goal achieved lies, bullying fine
182. Money often talks, guiding principle, not excellence in patient care
183. Rogue doctors do managers favour, vica versa; nepotism/managers, doctors support each other
184. Titles, remind is hierarchy
185. Attempts to see person as problem; refer to OH/reluctance to have external independent input
186. Like Jimmy Saville, powerful image, generating lots of money, no one can criticise, protected, sheltered/if enough key people in system support; hushed up, suppressed
187. Three things – powerful, money and organisation defends no matter what; unable to challenge, difficult to break that down
188. Overriding failure to deliver no harm health service; technical reasons not behavioural/shrug of shoulders, you kill people, is way it goes
189. Contempt for people; worsening/big divide between professions, public and patients
190. Spend lot of time train to be exemplary clinicians, but not team working and good individual behaviour/more time with colleagues than close family
191. Courtesy should be apparent/caring approach to colleagues; more attuned to care/positive culture can only be driven by the top; senior leaders must role model/negative behaviour only challenged consistently when positive culture
192. Employer, parental role, when disregard, say go away, gagging; emotional abuse
Need strong leaders counter cultural with set of values; to challenge the status quo

11) Framework Theme 11. Self-interest/relationships

**Higher level Classes**

1. Desire for power
2. Desire for reward/status
3. Self-promotion
4. Achieving benefits through relationships
5. Disregard for others
6. Personal agendas

**Lower level Classes**

1. Self-interest/ambition; *empire building*
2. *Creating names* for themselves
3. Protective alliances/mutual support
4. Managers stick together
5. Apex of organisation looks after own interests
6. Apex of organisation; protect each other/challenge senior person challenge whole group/culprit protected
7. CEs look after each other; massive pay offs/expectation of pay offs
8. Interrelating networks with loyalties
9. Corrupt individual behaviour; ‘ethical fading’
10. Compromise to meet political objectives
11. Self-serving complicity throughout the system
12. Misuse of entrusted power
13. Personal agendas and power bases
14. Drive through personal agenda through operation of trust
15. Pressure to toe the party line/play the game/join the club
16. People *sing the corporate tune/sing from the same hymn sheet*
17. Prosper if *join the corporate line/careers enhanced by being corporate*
18. Dependency on *grooming from above*
19. One minute in cardigan, next a cocktail dress, heels and jacket
20. *Shed a previous life*
21. Cronies, cliques, and coterie
22. Nepotism/cronyism/favouritism
23. Promote somebody’s friend
24. Favouritism, special projects, promotion; divide and rule
25. Favoured support CE to hilt; get rewarded
26. Bullying organisation some very favoured, some victimised
27. NHS is incestuous
28. Self-serving elite; “closed circles”
29. Need to “*kiss arses*” of the managers
30. *Give me pat on back will give you pat on back*; lot of that.
31. Appoint managers ‘yes’ *written on foreheads; puppets*
32. Stalin syndrome; all bullying figures have coterie around them
33. Rotten from top to bottom
34. Protecting individual image; creating a name/reputation
35. Conflicts of interest; distort priorities
36. Managers control clinicians via jobs, funding, clinical excellence awards, patronage
37. Pressure on doctors; patronage, knighthoods, honours
38. Rewards buy silence and obedience
39. Money speaks
40. Refusal to accept blame/lack of accountability
41. Lack of care, concern and humanity
42. Rhetoric not reality; self-interest under the surface
43. Loss of values; sacrifice them on the altar maintaining/developing career
44. Career managers; committed to career progression/career comes first; just there to deliver, not to genuinely to run things
45. Require negative behaviour to move up/if join in with management lies, more pay
46. Lie to protect position
47. Some good at ‘managing up’, giving good impression
48. Self-interest affects behaviour
49. Self/vested interests block action
50. Manipulative behaviour; working the system for own benefit not uncommon
51. Almost value free at work; just take on the next thing
52. Managers expect large payments when sacked for failings
53. Rationalisations and justifications
54. Organisational support team relationship with senior managers; OST sometimes seen as a threat/not always comfortable relationship
55. Unofficial culture; informal relationships affecting behaviour, “…they know where the bodies are buried”, “…deals are done”
56. Habitual bullyer get rid of one person, move onto next/build own little clans/cliques, others excluded
57. Nature of bureaucracy; rewarded for taking good news to boss
58. TU representatives may have cosy relationships with managers

12) Framework Theme 12. Scenario

**Higher Level Classes**

1. The Elephant in the room
2. Ostriches with heads in the sand
3. No airing of dirty linen
4. Shooting of the messengers
5. Sticking fingers in my ears, humming loudly; it’s not happening

**Lower Level Classes**

1. Resistance to hearing and knowledge; avoidance, closing its ears
2. Active rejection, suppression of negative information; removal of evidence
3. Focus on the positive; fantasy
4. Don’t want to know/choose to ignore; wilful blindness
5. If don’t acknowledge, not there
6. Denial and pretence (*Elephants and Ostriches*)
7. Resistance to action
8. Don’t care, not interested; distance and disengagement
9. Directors seeing themselves as ‘untouchable’
10. Suppression, avoidance of thought and discussion
11. Inability to learn
12. Don’t know what to do
13. Not important, not a priority
14. Negative impact of avoidance
15. Power, control, personal agendas and arrogance
16. Influence of group dynamics/*sing from same hymn sheet*
17. Scenario; typical of NHS behaviour, a typical *cameo*
18. Fear/scared of blame and shame
19. Fear of bad publicity, bad image; *don’t want dirty linen aired*
20. Undermining credibility of research and researcher (*shoot the messenger*)
21. Protection of individual ego and self confidence
22. Individual image identified with image of trust (protect both)
23. Individual and group rationalisation and justification
24. Need to accept truth and bad news; take action
25. Idealised NHS narrative, part of national identity
27. Controlling what thought about
28. Nothing talked about, nothing thought about, nothing done
29. Walking out for effect; wanted to be seen to be leaving
30. *Frightened of snakes; don’t walk in long grass*; felt threatened


Higher level classes

1. Retreat/hiding from reality
2. *The three wise monkeys/turning a blind eye*
3. Detached from reality
4. Unable to cope with reality
5. Refusal to face reality/address problems
6. Inability to learn
7. Redefinition/reframing of reality
8. Orwell ‘Nineteen Eighty Four’
9. Distortion of behaviour
10. Ethical fading/distorted morality
11. Protection of image is everything; *don’t expose dirty linen*
12. The *Emperor’s New Clothes*
13. Creation of a positive reality; good news factory

Lower Level Classes

1. Rejection of any negative information; burial of bad news
2. Avoidance of truth and reality; brush under the carpet/air brushed out of history
3. Rejection and cover up of truth and reality; denial and pretence
4. People live in La La Land; not on this planet
5. SHAs job description to produce good news
6. Government turns a blind eye
7. Leaders impose their version of reality on others
8. Protection of individual and organisational image
9. Worried if open a can, worms will come out
10. Coping mechanisms; resolving cognitive dissonance
11. Slippery slope; things get used to/contaminated
12. Situational behaviour; compartmentalism
13. Altered behaviour driven by desire to benefit/survive
14. Concentration camps during war; doing anything to survive
15. Dangerous chameleons; almost value free, just take on the next thing
16. One minute in a cardigan, next day a cocktail dress
17. Some put on a mask
18. Betrayal by the NHS family; erosion of good will and trust
19. Staff need to disengage, distance/protect themselves
20. Need to be seen as perfect/whiter than white
21. Punitive response to show whiter than white; lacks proportionality
22. Voluntary choice not to see and hear; wilful blindness
23. Culture of secrecy
24. Lack of concern with reality; all image
25. Lack of honesty
26. Manipulation of figures
27. Lack of care and concern; protection of image and reputation more important
28. Preoccupation with self-image and self-interest
29. Rationalisations and justifications to support action/lack of action
30. Acronyms close down thinking/conversation; Orwell’s 1984/NHS full of acronyms
31. Cultural/organisational language detached from reality
32. Rhetoric, not reality/image not substance; spin, painting veneer, fabrication, maximum gloss, charade, whitewash
33. Very little attention paid to patients, though lot of noise made about that/Blah, blah, blah, waffle; reality different/lots of fine words bullying won’t be tolerated/not open and transparent, but claim are
34. Feeding the beast with what it wants to hear
35. Iced cake syndrome; lovely on outside, mouldy on inside
36. 1984: No-one has got any bread to eat, it’s all absolutely ghastly, drinking horrible, cheap spirits to keep hopes up, is announcement, fantastic news grain yields up by million percent this year
37. Politicians want pretty picture fed up to voters
38. Politicians want to be able to brag
39. Defensiveness
40. Rejection and displacement of blame; scapegoats
41. Culture of fear, blame and punishment
42. CE’s externalise problems of organisation, blaming other organisations; stimulated by regulators
43. Egos directors, CEs, cannot be seen to back down
44. Senior managers, autocratic decision making; egos never deflated
45. Undermining credibility of research/researcher/attack those who expose dirty linen (shoot the messenger)
46. Inability to learn and change
47. Culture driven by political system; desire for good news and avoidance of bad news
48. Desire for the rosy picture
49. Distorted values and priorities/perverse incentives
50. Ethical fading/conflict, moral vacuum; corruption
51. Resistance to looking at managerial bad conduct/practice; won’t admit
52. Take bad news to boss seen as “negative”; “not a go-getter”
53. Management error buried/ignored
54. Societal narrative, belief in an idealised, perfect NHS
55. Reward for good news
56. Progression, habituation of bad practice
57. Apply large pinch of salt to self-reported success stories from organisations
58. Negative behaviour: Up to point respond reasonably well, but not robustly; threshold when too disruptive to service, other negative reputational consequences
59. Painful to think
60. People don’t think most of the time; creatures of habit, creatures of organisational cultures
61. Lack of rationality
62. Defensive of reforms; fight tooth and nail to reject criticism
63. Big clamp down on any degree of honesty
64. People begin to believe own rhetoric/own propaganda
65. Horror when CEOs hear reality; their word is accepted, not used to being questioned
66. Saying it enough, hearing it enough, putting it in black and white enough; saying we are all OK Jack
67. CEOs believe “there is no alternative”; delude themselves
68. Nature of bureaucracy; rewarded for taking good news to boss

14) Framework Theme 14. Actions

Lower Level Classes

1. Major overhaul/whole culture, management system has to change
2. Culture change has to start from the top/driven from the top/demonstrate tone, attitude from very top
3. “Would have to be something gigantic...to break the culture”
4. Huge reserves of effort, humility and courage to change culture.
5. Need to break culture of denial
6. Get rid of the well poisoners; cut hard, cut deep.
7. Exposure of horrible culture; shine a light/expose to light of day
8. Reverse malign influence of management and central kowtowing to DH
9. Clear message bullying not acceptable
10. CEOs and directors held accountable for abuse of staff
11. Proper regulation of managers; accountability/toughen up guidelines
12. Discussions about culture
13. Alert to causation factors of negative behaviour/need to understand landscape
14. Understand change has got to come
15. Openness, transparency, honesty
16. Free up executive team to walk around the ship/directors visible, approachable
17. Connect with people/extensive engagement/speak face to face/managers out there on the floor/build bridges/improve communication/listen/articulate expectations regularly
18. Focus of NHS back to people
19. Act with humanity and respect
20. Function with integrity and trustworthiness
21. Basics; truthful, honest and compassionate
22. Moral behaviour to come first/encourage moral thinking, decisions/positive values underpinning actions
23. Strong focus on values, common purpose, personal responsibilities; reinforced from top
24. No political games or golden targets
25. Increased professionalism
26. Regulatory bodies, but also self-regulation
27. Groups brought together with mutual trust, commitment; provide effective service
28. Recognition, acknowledgement of problems and pain
29. Recognition of humanity in a system, machine/validity of feelings
30. Acceptance of criticism/facing up to problems, mess/don’t ignore bad news
31. Commitment to monitoring what do/clinical audit/learning from experience
32. Tackle what is uncomfortable; address vested interests
33. Admit negative behaviour happens
34. Learning from failure/everyone willing to learn; open honest approach
35. Forget about reputation
36. Examine, address issues/problems/concerns
37. Reality not rhetoric/reality not tokenism/reality not lip service/walking the job/living the values
38. Turn it round by walking the talk
39. Set out to do what is right, not ticking the boxes
40. No bullshit; just do it/stop talking about it just get on and do it
41. Back to basics; start selling a different message
42. Need leadership and vision/need extraordinary leaders/leaders who can inspire
43. Need a person of Mandela character; to break the mould
44. Leadership/management with positive values/integrity; role models
45. Appraised on values/demonstrate positive values
46. Senior managers to influence with positive attitude, behaviour/positive role models
47. CE/directors responsible for cleaning up organisations
48. HR/managers responsible for facilitating way forward/setting clear guidelines expected behaviour
49. All employees responsible for raising issues of negative behaviour; no one should be silent witness
50. Put power and focus back to clinical staff/clinical staff back in control/power back in hands of clinical staff
51. Recognition of clinicians skills and training; unhelpful to have unqualified inexperienced manager above them
52. More clinicians in management
53. Give autonomy; trust people/avoid working from position of fear/confidence in people below
54. Allow people to perform at maximum potential, monitor in positive way
55. Take responsibility; hold people accountable
56. Clear expectations, boundaries, codes, setting of standards/clarity of message at outset/positive behaviour adopted, promulgated, role modelled throughout
57. Robust responses to negative behaviour; zero tolerance
58. Zero tolerance; keep it on the agenda/keep talking about it, raise constantly
59. Early intervention/nip it in the bud
60. Focus on prevention of negative behaviour
61. Don’t beat about the bush; tell them/stamp out negative behaviour/stand up to it
62. More support for staff/staff valued/caring approach to staff
63. More support for staff feeling stressed, overworked
64. Confidential advice/support
65. Poor working relationships/organisational conflict inevitable; influence/intervene collaborative way in complex situations
66. Transformational outcomes are emergent in relationships; come alongside
67. Respect for staff/mutual respect
68. Teach new norm of positive behaviours/care
69. Training on positive and negative behaviours, impact, for all staff
70. Training on management/investigation of behavioural problems
71. Training for managers in management; leadership by example (major requirement)
72. Managers experienced and appropriate qualifications
73. Support for junior managers
74. Encourage whistleblowing/raise concerns/more openness
75. Whistleblowing facilitators
76. Shouldn’t be suppressed/regarded as troublemaker/frontline professionals empowered
77. Accountability when lie, cover up mistakes, victimise whistleblowers
78. Education for managers on whistleblowing
79. Investigations external agencies; no dependency on the NHS
80. Ban on gagging clauses/SoS stop compromise agreements, gagging clauses
81. Duty of candour for NHS boards
82. Cap on how much allowed to spend on tribunals to level the playing field.
83. Refocus on management, not leadership/too many leaders; need solid functional managers to drive things forward/balance of effective management, strong leadership
84. Focus on best interest of patient/only aim better services for patient not good news story for government/listen to feedback from patients
85. More investment in public health/better patient pathways across groups/collaboration across boundaries
86. Should be National Health Service not series of health businesses/collaboration better than competition
87. Better way to analyse patient complaints; more openness
88. More awareness public responsible for own health/take responsibility for way uses, misuses NHS
89. Greater involvement of stronger trade unions/increased training for/by representatives
90. True partnership working
91. Campaigns on dignity at work
92. Dignity champions
93. Professional investigations; expert organisations to assist
94. Change coming from frontline/staff standing up for patients, up to managers/staff taking risk to find out if Board, managers want to know what happening/internal pressure strongest influence long term
95. Recognition welfare of staff linked to better patient care_clear vision for staff wellbeing and occupational health/remind managers well motivated, effective staff management best way achieve quality outcomes
96. Fair, just, supportive policy and process
97. All grievance, dismissal, appeal hearings have to be fairer; total overhaul
98. Commitment to fairness
99. Greater discretion within policy
100. Use common sense which could rely on moral judgements and empathy
101. Focus/priority on informal solutions
102. More advocacy and mediation; avoid escalation/awfulness
103. Critical incident stress de briefing/one to one manager support/open conversations, calling to account/informal, chance to take ownership of behaviour; explain and allow full understanding/talking gets to complexity
104. Proper professional mediation may work
105. Situations two sides; provide support for both - balance
106. Range of solutions/promoting positive strategies
107. Clear formal agreed policies, procedures
108. No preferential treatment/all staff treated the same
109. Management mistakes regarded as serious as clinical mistakes
110. Remove HR/HR external (independent sector) to organisation/centralisation of HR for transactional stuff/HR need to consider role, practice
111. CE/HR when tribunal upholds case, made to pay expenses own income, pension; make more accountable
112. Get rid of all middle managers/reduce layer of middle managers/decrease layers of managers; reduce complexity
113. Removal of top tier, NHS Commissioning Board
114. More staff at the coal face/less managers, more staff/more money but not on managers
115. Managers there as supporting, facilitative role
116. Removal of purchaser provider split; revert to central allocationcentralised allocation direct to providers; give autonomy
117. More money community, less acute/more money on emergency work
118. Improved recruitment; emotional intelligence/values
119. Forget crap about best on the day strategy, gift of the gab dazzling panel with bullshit
120. Screening out of hubristic tendencies at interview
121. Recruitment; need different personalities, qualities/recognition of importance of diversity, difference
122. Improved appraisal; value based/greater simplicity/avoid tick boxing
123. Do as I say, don’t do as I do culture must be addressed
124. Increased public responsibility
125. Smaller units/organisations
126. Reduce gap between those set values and frontline
127. Clear structures
128. Avoid reorganisations/organisations risk assessed in light impact on behaviours
129. Design from bottom up not top down/involve staff in decisions
130. Stop blaming/stop buck passing/no blame culture
131. Lay governors important role to play
132. To change culture, aims of Lansley White paper, not the bill
133. Better management of protection arrangements for managers/redundancy of managers/put back on coal face
134. Less pussyfooting around/more innovative in how manage/less pandering to rules
135. Mid Staffs tainted the brand; have to rebuild that
136. NHS Confederation; peer support for CEOs
137. Non Executives understanding difference between assurance and reassurance of Boards/understanding evidence base
138. Government not to turn a blind eye/face up to reality/politicians admit failures/inadequacy
139. Honest political conversations around capability/weaknesses
140. Responsible media to allow honesty and discussion of problems
141. More negotiation between SoS and trust before come down to operational level
142. SoS down, highlighting problems of negative behaviour/Prime Minister start transformational programme; has to lead
143. De-politicise the NHS; so doesn’t have to always have good news story/greater separation from daily political interference
144. Fundamental changes in government, constitution of UK/politicians not responsible for providing and monitoring
145. Politicians all colours have to sort it; long term solutions
146. Nicholson machine needs moral bankruptcy to prevent the train derailing at the points
147. Organisational support team; seen as positive cost effective service/focus on informal interventions
Appendix 8. ‘3 word summary’ analysis and grouping

The ‘3 word summary’ words were first re grouped to assess the most commonly used words. The most commonly used were: Hierarchical (x 9); Defensive (x 6); Bullying/harassing (x 6); Top down (x 5); Bureaucracy/bureaucratic (x 5); Variable (x 5); Control (x 5); Oppressive (x 4); Pressure/pressured (x 4); Not/un-caring (x 4); Lack (x 4).

Next the words were used to assist in forming the Framework Themes for analysis. [Text in square brackets, researcher comments]

Positive aspects/characteristics:

Patient focused; effective; committed; committed; dedicated; caring; caring; caring; caring; compassionate; supportive; supportive; creative, aspirational; helpful; inclusive; professional; professional; professional – means different things to different people; professionalised; hardworking; hardworking; clinical (focused); evidenced base; centred on evidence and proof; Value-based; trusting

Open, proactive, supportive [but related to comment about ‘blue sky thinking’ later in the focus group]

Other characteristics:

- Hierarchical/top down

Hierarchical; hierarchical; hierarchical; hierarchical; hierarchical; hierarchical; hierarchical; hierarchical; top down culture; top down; top down driven; paternalistic (top down); paternal; paternalistic; top down oppressive; oppressive; oppressive; oppressive; driven, not led; controlling; controlling; control; centralised & controlling; command & controlling; command & control; authoritarian; dictatorial; politicised; politics; politically reactive teams; reactive; reactive; bullying; bullying; bullying; bullying; bullying; still harassing; fear [oppressive/bullying/harassing/fear also could be in dysfunction section]; corporate thuggery at the highest level; influenced;

- Bureaucracy

High bureaucracy levels, bureaucratic; bureaucratic; bureaucratic; bureaucratic; bureaucratic; too much paperwork, everything geared to computers and paperwork; ‘red tape’ often; our trust is good in implementing policy, but bad in not following it; machines

- Cost/money centred

Cost orientated; money centred; finance orientated; resource led; money not patient, forget the patient; saving money above patient care; financially constrained; cuts; business; performance; market

- Closed/defence/resistance
Uncommunicative; deaf; restrictive; closed; closed; enclosed; enclosed; inward looking; 
(a) club; insular; insular; rigid; resolute; entrenched; resistance to change; defensive; 
defensive; defensive; defensive; defensive; defensive

- Variable/changing:

Varied; variable; variable; variable; variable; patchy; unequal; inequality; changing; 
changing; ever changing (therefore not stable leadership); re- organisation [this could also 
fit into the ‘Pressure’ category]

- Pressure/stress

Pressured; Pressured; Pressurised; pressure; target driven; target driven; target driven; 
over stretched; over worked; under-staffed; time; challenged; competitive; busy; busy; 
busy; rushed; frantic; stressful; stressful; stressful

- Dysfunction/disorder/lack

Damaging; dysfunctional; dysfunctional; regressive; dishonest; dishonest; negative; 
negative; conflict; blame; blame; unstable; unsafe; self-interest; ‘out for themselves’;
quietly accepting failure; battered; defeated; exhausted; not the caring profession;
uncaring; uncaring; it’s not caring (for the people who work in it); NHS struggles with 
helping their own staff; confused; nervous; worried; impulsive; divisive; divisive; 
incestuous;

Inefficient; inefficient; disorganised; disconnected; disjointed; fragmented; 
uncoordinated; chaotic; chaotic; NHS organisation...is an oxymoron; slow; slow to adapt; 
complacent; cautious bordering on fearful; no synergy (within or between organisations); 
ignore it and it will get better;

Unfocused; deskilled; lack leadership!; uninspiring leadership; poorly educated (as 
managers); lacking accountability; lack of financial expertise; unmanaged; un-dynamic; 
indecisive; indecisive (excluding clinicians and nurses on medically related matters); short 
term thinking; poor consolidation; lack of support; undervalued; demoralised; 
demoralising; disillusioned (sic); lost;

- Different groups

Nursing/consultant dominated; multi-professional; tribal; relationships

- Other

Collective; emotive; complex; multi-faceted; ‘taken for granted’; death by conservatives; 
tolerant [this was in the context of ‘variable, tolerant, undynamic’, so not put as a positive 
attribute]

A further stage was to consider the words with reference to lack, and words beginning 
with ‘dis-‘, and ‘un-‘. Also, the use of the words ‘no’, or ‘not’.

- Lack - Lack leadership!; lacking accountability; lack of financial expertise; lack of 
support
• Dis - Disorganised; disconnected; disjointed; disillusioned (sic); dishonest; dishonest
• Un – Uncommunicative; under-staffed; unstable; unsafe; uncoordinated; un-dynamic; Unfocused; undervalued; uninspiring leadership; unmanaged; uncaring; uncaring; unequal
• No or not – Not stable leadership; not the caring profession; it’s not caring (for the people who work in it); not the caring profession; not led; our trust is good in implementing policy, but bad in **not** following it; no synergy (within or between organisations).

The processes detailed above contributed to forming the final fourteen Framework Themes for the process of the analysis.
Appendix 9. ‘3 word summary’ of extra participants

The following data was collected after the main research from 2013-2015

1) “Inefficient; poor; low morale” (Non-clinical Manager)

2) “Over managed; bureaucratic; caring. Bureaucracy and paperwork gets in the way. Become two sets of people. Caring set, part of vocation, and management set. No ‘on floor’ nursing/medical experience. Two don’t seem to mix very well in places. Interfering government not realistic e.g. 4 hour targets. Frustrating. Targets affect behaviour. Some managers brilliant. Frontline caring. Lot of wastage. Driven by public’s expectation. NHS overloaded. Expectations higher than can provide” (Nurse)

3) “Pressurised; unforgiving (No training to do what is wanted but then disciplined if don’t achieve); bullying; deskilling (no respect for skills); endemic bullying” (Ex-Community Psychiatric Nurse)

4) “Disorganised; thoughtless; no care; frustrating. Do see positive but...” (Nurse)

5) “The NHS has lost its way” (Doctor)

6) “Top heavy management; bullying”. [A discussion followed about relationships and the NHS being incestuous. They made the comment that one person “rose through the ranks and took all the gays with him” (Ex-Nurse)

7) “Demoralises; over worked; underpaid” (Theatre Nurse)

8) “Top heavy; bureaucratic; oppressive” (Specialist Nurse)

9) “Negative, negative, negative – Introverted; dictatorial; target driven. It’s like a cancer in the system. It’s flawed at top level, due to a lack of transparency. Faith has been lost in the senior management” [How is it going to be cured?] “Needs a complete wipe-out. Take everybody out and put them back in again. Retrain the managers. Need to have people in the caring system who care. Taking the bureaucracy out of the care system. It is plagued by bureaucracy” [Cancer?] “Whole of system is flawed. Lost in politics” (Radiographer) [This person later provided three more words “Immature, introspective, foolhardy”]

10) “Protection from litigation; oppressive” [They made actions with hands of downward movement. What does that mean?] “Pressure from above, oppressive. Pressure to do things that stop us providing a service for the patients. But there are some very good services in the NHS” [In what way?] “Innovative, some very good, but...” (Nurse)

11) “Over managed; overpaid; nurses are lost. Too many empires, little empires. The patient is used” [What do you mean?] “They are used for their aggrandisement” (Ex-Consultant Radiologist)

12) “The situation in the NHS is dire. [3 words] Money-led; unfeeling (dehumanised); tick-boxing.” [They shared about experiences of down skilling and down grading of staff, of people retiring early and leaving their mental health unit]. “Everything is
‘measured and mean’. Can’t be human beings anymore. A blame culture. They always want to blame the people on the ‘coal face’. The NHS is a piece of gold. [The NHS] It’s definitely sick. The government – I could string them up. They’re destroying it. They are cutting off the life blood of the service. It’s really sad, heart-breaking. I am going to leave. They want to privatise the NHS; get rid of the NHS” (Artist providing art therapy)

13) “My 3 phrases for NHS culture would be: Complicated; Unhelpfully competitive; Delusional. Though this seems to be negate those who do a lot of good work despite it all so if I was to add a fourth it would be ‘Heroic’. [Why do you say delusional?] “Elephant in the room stuff. The culture is deluded and deluding by pretending the behaviours described in the paper don’t exist. Like a family that that has a terrible secret that is not discussed and has a shared delusion that everything is OK” (Cognitive Behavioural Therapist who had seen the article and independently contacted the researcher)

14) “Denial. Disempowerment. Dishonest.” (Representative of external organisation)

15) “No-one listen, no-one listens”. [They then went onto describe a situation where local clinical teams were giving presentations about their services. It was made clear to the staff that they were not able to mention anything negative such as the difficulties of the increasingly long waiting lists. It all had to be upbeat and positive. This person was a mature newly qualified Occupational Therapist and had worked for only 10 days. They were also concerned at the disregard of due process at the way jobs were being allocated without proper advertisement and also downgraded] (Newly qualified Occupational Therapist)

16) “Equality for all/accessible – or it should be. Not always that. Greatly variable. Constant change.” [Made comments about people knowing one another and not working anywhere else which suggested insularity and being inward looking. Different to other larger places where there would have been a greater movement of staff. They thought Scotland might be worse than England. Their companion who used to work in large mental institutions made reference to the old mental hospitals where everyone was related or had close contacts. A discussion followed about these relationships and how this inhibited improving practice. These relationships then moved into the community trusts when the large institutions closed down.] (Community Nurse and ex-Mental Health Nurse)

17) “Fear, control and command, target driven” (Nurse)

18) “Hierarchical. Influences every layer. No opportunity to speak. Not a blame free culture. They say they want you to speak. People are very subtle in the way they can pinch you. Clinicians are fatalistic.” [Added a comment later that when people questioned about what has happened re a particular concern they say things like “We did things but we didn’t communicate it” and that they “haven’t remembered to tell us” (Anaesthetist and Nurse)

19) “Stuck; going round in circles; too heavy on management; too many tiers.” “...am an NHS trained nurse, and I would go private”. “A lot of stuff gets buried”. [Targets] “There’s statistics alterations” (Nurse)

20) “ A life saver, essential” (Mental Health Worker)
21) “Communication failure, sinking ship, no direction” [Later said about people “They don’t want to know what they know” (Managerial Secretary)

22) “Bullying, stressful, overworked. It’s who you know, nepotism, a lot of nepotism” (Staff Side Partnership Chair)

23) “Stressed, non-compassionate, hard-working” (Health Intelligence Officer)

24) [This person is the only person to provide 3 words for the different layers of the NHS. Specific words in bold]

[Top layer] “Aggressive, avaricious. CEO brought in Mckinseys, Goldbergs and others. Used to work for McKinseys, a Mckinsey boy. ‘The Suits’ are only in it for what they are tasked to do, and for the money and for their CVs, and to advance their political careers. CEO ‘TOP 10 level’ applying pressure down. Nepotistic, at the top. Self-fulfilling prophecy at the top. Only in it for what they can get out of it, ‘end of’. Don’t invest in the staff they have”.

[Middle level] “Ruthless, Uncaring and singular [What do you mean by singular?] Out for themselves on a fast track to the top”.

[Lower level] “Compassionate, caring, supportive”.

[This person also highlighted the inverse structure, inverse triangle, where there are multiple layers above the clinician. More managers than clinicians. Twelve layers above them through the two strands of the nursing and medical line of hierarchy. More than there ever used to be] (Nurse)

25) “Red tape, meetings, low morale” (Secretary)


[This person was asked for further information about culture. Part of their response was]

"As above, the 'why' of NHS bullying being what it is can only be answered by looking at the collective managerial psychological status. They have the defensive default and supported ability/expectation to twist almost any action into a justifiable action, hence legal/appropriate /within guidelines. And in my view it comes from the very top. For which there is some evidence."

[They went on to write]

“HR is perceived as, both by 'managers' and all others in the NHS as an integral part of the management establishment. Not as a neutral body in place to manage the rules which govern everyone but; on the one hand to wield the authority of management for management and on the other - exactly the same.

In fact, managers turn to HR for guidance on how to enforce their 'rule' and few outside management see HR as a body which is (but should be) supportive in issues such as bullying, whistleblowing or as a resource in disciplinary/grievance matters or even as a conduit to proper procedure, due process and justice or truth. This is the perception - and I would suggest that people in HR see themselves as part of 'management' rather than as anything else. Arguably, the
most powerful Board member is the Director of HR, in many ways. In my perception HR 'represents' management. Look at many of the legal cases which have erupted with doctors and whistleblowers, for example, and spot the ones wielding the power.”

“What can change this? What would I like to see change?... I would like to see independent or external personnel involved in investigation of disciplinary and grievance issues as a matter of course. Also in the hearing of them - after all, the NHS is a public body. This sometimes occurs with Doctors, as said passim, they have their own procedures, which include suchlike, and I suspect that keeps the extreme cases well down.

One has to accept that there are times when straightforward application of discipline by managers is required and that not on every occasion is a claim of bullying true. I have come across quite a few. But these are easily weeded by independent and neutral analysis.

What I think also is that managers in the NHS expect unconditional support from HR and the wider/ higher managerial apparatus - and invariably get it - when an individual is at variance with someone not of the managerial clan. I have known of a number of middle managers who have cocked up and instead of facing the music (as everyone else would) they are transferred elsewhere, sometimes promoted and on many occasions their faults/ failures whitewashed.

In my personal experience a 'manager' had an investigation into alleged bullying. An investigation was held. None of the people who had raised the allegation(s) were interviewed (or were aware of the investigation!) and so the outcome was....pretty obvious.

There are of course legal perspectives to this as HR making a legal screw up brings the whole world down on the NHS body. Managers in the NHS would rather have chickens than clash with (or blame) another manager of equal or higher level on an issue of right or wrong. They would go through the usual - avoidance, blame chucking (on the messenger), etc., basically twisting reality. The 'blame the messenger' position may be historic, but it is alive and well in the NHS. Thriving. It’s much the same as the legal eagles do in court - destroy the credibility of the witness and the case is won, irrespective of the truth.” (Nurse)

27) “The NHS culture in 3 words - Shambolic, dysfunctional, dark. It will take a miracle to change the NHS but some of the bad pennies being removed, might help. Private Eye seems to be flagging up some of them” (Ex-Health Visitor)

28) “Truth suppression”. “All this talk about protecting whistleblowers is nonsense”. [They had worked for the NHS for 6 years but left because they couldn’t stand the stress and anxiety of working in the NHS] “Just needs to be broken down into smaller manageable units” (Administrator)
Appendix 10. Quotes relating to the Framework Theme headings

Framework Theme 1. Structure/form/groups

1) Focus group 2

“It’s not cliquey, but it is something about that, and I have put down”

“It’s a gang isn’t it?”

“I’ve put down, it’s like a club [yes] because if you work in the NHS, it’s like we have all got a same sort of language, it’s like we are all in it together. And I think we understand how it really is and the outside world doesn’t. They just look at performance. I think there is something about, we are like our own little organisation. Its, I don’t know, if you get what I mean... but it is not cliquey, as in the horrible cliquey, but it is like that sort of...um”

“Like a secret society”

“It is almost...But I do think it is a little sort of, you don’t understand our language, cause you are not part of the NHS”

“Like we are different”

“I picked up on that and put ‘closed’”...

“Yes and it is that. You sort of do it, but you know, in the real world, um, you do what you want to do.

“I had for all of those reasons I had the word dysfunctional because it is like some weird dysfunctional family...Because that’s how I see the NHS, for all of those reasons. In the fact that as a group of people who are individuals who come into the NHS. Creative caring, um all of the positive creativity that we all bring. We all end up in a, to a degree, frustrated unable to do our jobs efficiently and effectively. Then as an organisation, we... almost cripple ourselves within the wider NHS and are just buffeted by government priorities, um, director politics, um, whether it is at SHA level, whether it’s higher up, or even internally. And for those reasons I think the NHS overall is dysfunctional, is the top word for me”

2) Focus group 4

“I’d like to believe that the, from my experience, that the underlying culture within the NHS is both caring and supportive. Um, however, there is an issue in that it is actually very disjointed. It’s disjointed within individual organisations, but it is disjointed across the NHS. Shared this sort of thing before...somebody once said, the NHS isn’t like a whale, it is actually like a shoal of fish, and that to me actually summarises quite well the structure of the NHS, in that it’s made up of lots of different organisations each with their own sub cultures, organisational needs...targets that they are working to, and so they
have got a significant amount of autonomy. So that does mean that things are done differently across the NHS, but it also goes on a lot within trusts, in that you have micro cultures, mini organisations within organisations. So the challenge is actually trying to pull together all of those threads together. But I say I think it is underpinned by people come into the NHS generally because they want to be supportive and they’re carers. But there are lots of things that actually eat away at that concern.”

3) Interview 3

“It’s doubtful whether there is a single NHS culture. Organisations vary and it is also possible to identify different cultures within large units, such as general hospitals, so the staff experience will differ depending on what department they work in. There is also a high degree of “tribalism” which pits one group against another – this could be identified as part of NHS culture. The medical model of healthcare also introduces a hierarchy with elites and this in turn hampers team working. Leaving aside senior management it is not unusual to find medical staff as one group with the rest as another group.”

4) Interview 32

“And dear old NHS, in my mind, is fossilising, dying on its feet, breaking apart and the private sector is sweeping like vultures to pick up the juiciest pieces left over”

R  “Sad isn’t it?”

“It’s sad, so that’s a very gloomy outcome. “It’s not, it’s no longer a national health service in my view, it is a series of competing health care businesses and it shouldn’t call itself the NHS anymore.

5) Interview 42

“...I think this idea of introducing a powerful management structure in the NHS, is what has allowed the tentacles of the Department of Health to reach down into every organisation and control it. And that I think is where the horrible culture comes from.”

Framework Theme 2. Positive characteristics

1) Focus group 3

“Yes, Um a good deal of my contact is with the more senior levels of management at director level, chief executives and um, I am reminded of that little nursery rhyme. “There was a little girl and she had a little curl right in the middle of her forehead. When she was good she was very, very good but when she was bad she was horrid’ [laughter]. And my impression of NHS management is exactly that. That there are some managers
that are very, very talented, and their talent um shines through their organisation which runs smoothly and effectively and aren’t getting into big financial problems, and I don’t get very many complaints, coming through to me as a case worker, from individual staff. And then there are others where they are detached, arrogant, paternalistic. They ‘know best’, um and they, and their work is characterised by failure to engage with staff at all levels. Um, and they drive their personal agenda through the operation of their trust. Um, the ones that are good, engage extensively with staff, um, not just their immediate managers at senior level, but they engage extensively through staff side, through walking the job, really. And I have got a whole load of examples of where it works well. Where management is really very good, where... and I do... I do monitor where the problems come from, that cross my desk. And there are some places I never hear from. And the reason is, there aren’t any problems because the management is really on top of the job, and doing a great job. And when you talk to the stewards it’s because there is good quality engagement. And when there isn’t that good quality engagement people get fed up and get disenchanted, and that’s when the problems arise.”

2) Interview 13

“I deal with [clinicians] in the NHS so see the NHS very much through their eyes. It seems to me that the culture I meet is overwhelmingly concerned with patients and their well-being. The focus is on getting the best for patients, sometimes to the detriment of staff health and well-being. At the same time there is a pride in the quality of work done which can occasionally become arrogant and patronising, perhaps a “we know best” attitude. Nethertheless, the focus definitely seems to be on the patient as an individual, though individuals, both staff and patients, can also sometimes feel powerless against an insensitive bureaucracy/system. There is a culture of continuous improvement and a willingness to change, but also a continuing awareness of funding cuts, services under pressure and reduction in higher graded posts so that many experienced [clinicians] feel undervalued and overworked”

Framework Theme 3. Hierarchical/top down/power

1) Interview 5

“The NHS has developed from an originally benign dictatorship run by clinicians (GPs, Consultants and Senior Nurses) into a malign organisation controlled by professional managers...The patients and clinical staff suffer whilst the managers try to meet targets.”

2) Focus group 5

“I think totalitarianism also rises up in modern organisational life. It’s to do with having the power to define. What can be thought about, what can be talked about, what people can do. Through threats of exclusion, and worse, sacking.”
“Yeh, and I think that's even the split within that, between the clinical side and the management side and I think it is becoming more that the management side have more power, whereas before it was like, it was more led by clinical thinking whereas I think now, it is more emphasis on the corporate approach and a management style that, and don’t know whether that makes sense. So that there is that, that they hold the power that the more corporate thinking. The management style has more power than the clinical side”

“The whole managerialist thing has a lot to answer for, hasn’t it?”

3) Interview 20

“The NHS is a vast organisation and consists of many cultures. The culture amongst clinicians for example will be different from say support staff. They will all be affected by the culture from those at the top of the NHS.

That culture at the top is controlling rather than liberating. It is opaque rather than transparent. It is more concerned with its reputation than delivering safe care. A culture has been created where you get on by never making a mistake that can be pinned on you. This therefore creates the one of the worst aspect of culture which is a blame culture.

Those in more senior positions will blame others lower down the management chain and they in turn, to avoid such blame, will act in inappropriate ways by for example manipulating waiting lists or concealing clinical incidents.”

Framework Theme 4. Bureaucracy/policy

1) Focus group 4

“I understand it is a big organisation, and it needs to be quite bureaucratic and have systems in place, but they can be quite complicated and quite time consuming and then within organisations that are not used to that, and the cultures are not used to that, systems, I don’t think they work at all…”

“Yeh, um, something else that sort of following on from that really is something that the NHS is actually very good at, is actually ticking the right boxes. Um, whereas it should actually be about doing the right things, which actually ticks the right boxes. But it is actually good at ticking boxes, to say we have done this. We’ve got an appraisal process…”

“...So there is a pressure, to tick, to tick those boxes.”

2) Interview 6
“Overly bureaucratic run by policies, rule and rather than common sense which could rely on moral judgements and empathy.”

“Issues that are difficult to discuss include any issue not covered by a policy or agreement, free thinking is not prevalent. Trying to get a response based on a sensible moral argument is difficult there appears to be little leeway outside of the rules.”

3) Interview 14

“Few individuals appear prepared to make an operational decision and take responsibility for it. All decisions appear to require a committee and formal minutes to make most decisions.”

4) Interview 35

“In [Country], my observation is that the NHS has become more compliance based over the past 10-15 years, so rather than make decisions there is a reliance on doing what regulations or guidance require, and if these are not clear then refer it up”

Framework Theme 5. Finance/business/targets

1) Interview 29

“Money. It’s all about money, and the budgets. They try constantly to balance, improve services with less real money... Quangos and administrators and finance people managing budgets instead of the health professionals. It’s gone, all a bit crazy really.”

2) Focus group 1

“...I think they are about saving money over patient care, but I couldn’t put that into 3 words”...

“Chaotic, because of the cost cutting”...

“I think quite a common thing is that it is now business, it’s not people, its business”

“Yes, definitely”

“I agree with that”

“I think the sad part of that is that as employees we are expendable as part of that business”

R “Why are we expendable?”
“They don’t invest in staff. It’s a kind of like something we were discussing earlier we are getting rid of qualified nurses and bringing in low paid health care’s to do the job, so nobody’s safe, so we are can all be got rid of.”

“It’s putting patients at risk”

“Yes”

3) Focus group 3

“Money centred, hierarchical. Feel that although we are supposed to [be] moving to a culture where frontline staff are supposed to be able to influence services for their patients this isn’t happening due to senior management making decisions based around cost savings/budgets and government ideas. Feel like cogs in a machine – just supposed to get on with our job as we are told to do it.”

“Money, not patient. Money orientated. Forget the patient.”

4) Focus group 4

“There is the concept of the brittle organisation following on from that. Whereas an organisation becomes so lean and so stretched that it does become brittle, only needs a slight fracture”...That is a real potential danger I believe in parts of the NHS where it is becoming so stretched that it is becoming brittle. And there is a real danger, a danger that things could actually start collapsing”

5) Interview 5

“The managers refuse to accept any blame for the wrongdoings of the health service. Indeed they expect to get large payments when they are sacked for failings...... witness the Stafford case where so many people died.

The managers do not get "struck off" like clinical staff. Usually they reappear at another hospital on a higher salary. The only "managers" who get severely punished are those who were originally doctors. They may lose their jobs and be struck off by the GMC even if they have been acting in a purely managerial way since the GMC have the view that "Once a doctor, always a doctor"”

Framework Theme 6. Change/variable

1) Focus group 2

“It just seems to, all the time change, doesn’t it? So you get a new chief exec, everything changes, the focus changes. Or a new directive, and then you stop what you are doing. We all seem to stop what we are doing and start something else, and never seem to finish anything.”
“And we don’t seem to measure either, that, was it any good? Why did we stop doing it, until we know whether it works, or didn’t work? No, a new initiative will go on and do that”...

“But, I think, we might have got an 10 year plan, but no one at the end of the 10 year is going back to look at it because it has changed ten times”

2) Interview 4

“There seems to have been a significant cultural shift in the organisation I worked for, in being non-punitive, to being very punitive, and the culture of “learning from mistakes” seems to have been lost. Openness in the organisation has been discouraged.”

3) Interview 15

“And you think all these wonderful things are going on, but that’s a hospital where they have had very serious whistleblower problems, and covering up failing medics...And it’s this variation you see all these medics in the most fantastic things and then down the corridor there is just utter and absolute chaos. Utter and absolute chaos.”

4) Interview 29

“I was absolutely gob smacked, that straight away almost before they had got their coats off, the patient. They were planning for discharge. One of the first questions were, you know, when do we expect to discharge this person. And I was, it was just oh..where are the good old days when somebody was given a bed, and, you know, settled in, and one thing and you will go when you are better [L of L]. I don’t know, it was quite powerful impact that was.”

5) Interview 37

“One of the problems that has beset the NHS particularly over the past 25 years in addition to the continual ‘re-organisations’, is the revolving door managers i.e. career managers who move posts every couple of years without ever seeing through the changes that they put in motion.”

Framework Theme 7. HR/other roles

1) Interview 42

“Ohhh I don’t know, to be honest, I find HR quite depressing really [L] I think you come across some members of HR staff who are first rate and you know suppose, I have also
found managers in other areas who are first rate as well in that. It’s just overall taken as a group I am not impressed by them. But again we say HR it often seems to you know function, I don’t know, perhaps they would say that’s our job, but to function too much as the ‘tool of management’, to drive the management agenda as compared to having a function where they are there to maximise, if you like, what they are supposed to be about, the human resources in the best interest of the patients. So I don’t know, I think, I mean, I imagine that HR probably does have a very difficult job. We all know there are some very tricky nasty characters in the operation of the NHS you know clinical and non-clinical, but particularly I have encountered some very, very difficult consultants and so on, um, where you know I think HR probably are at their wits end, but on the other hand I think it’s sad that when you get a genuine whistle-blower raising concerns about standards of care. That somehow HR always seem to be on the opposite side of the line to that individual or individuals.

And supporting a hard line management approach rather than again as I would say looking at it in terms of what is this service supposed to be about? It’s supposed to be about providing you know the best possible safest care for patients. Not, it’s supposed to be about you know delivering a government agenda come what may.”

2) Interview 5

“The personnel department used to be responsible for addressing this but they have been taken over by "Human resources" who have their own negative behaviour. In particular they resort to disciplinary procedures and politically correct action as soon as there is any dispute...

Human Resources are a source of problems within the NHS. Even the name is a problem since it denigrates human beings to the role of a resource (like power, water etc.) and indeed that is how the modern HR department acts...

HR are managers who have been taught how to manipulate people and situations in a Machiavellian way. They are not there to help the workforce, they are there to keep the workers working in whatever way is deemed necessary by the chief executive. Unfortunately occupational health have also been dragged into this and have become the tool of HR.”

3) Interview 26

“I have never had any problems raising concerns with managers but I mentor people who do experience difficulties. The most recent one was a Ward Sister in a famous teaching hospital who has had trouble getting support from the Human Resource Department (HRD) in helping her manage a nurse whom she (Ward Sister) felt was an unsafe practitioner. As the nurse was from an ethnic origin the HRD was more concerned about a claim for racial harassment then concentrating on the unsafe clinical aspects of her performance.”
Framework Theme 8. General lack/dysfunction

1) Interview 43

“In organisations that are not demonstrating effective leadership and where there is no clear purpose or vision this can become an environment where there is mis-trust and demotivation – this occurs where staff feel disconnected from what they see happening around them.”

2) Interview 37

“Poor quality of management – a long standing issue within the NHS - and lack of good quality leadership.”

3) Interview 2

“It is such a large organisation and management are completely obsessed with the cost of treatments. Staff and their needs are given lip service but it is my experience that rarely have changes taken place that truly support staff.”

4) Interview 5

“In the NHS there are many ways in which excellence is discouraged and mediocrity encouraged. Disagreement with management is treated as a disciplinary matter by HR.”

5) Interview 7 (from written notes)

“Blasé attitude towards change”. “No-one is accountable, managers not accountable”. They “pretend they are interested but don’t care”. “A [person] has got to where she wants to be”. “Want to get rid of health and safety”. “Ethos is not there anymore, where you’re going, lost the purpose, the value, supposed to be ‘patient centred care’”. “It’s not quite right, don’t do assessments like we used to”. “Holistic approach gone out of the window”. “Staff going off sick left, right and centre”. “Something’s not quite right, cannot put your finger on it”. [Observation about instability] “Replacing with people who don’t know what is going on”. “Difficult to feel enthusiastic”.... “No continuity of care”. “Communication is non-existent”. “Staff come in just for a shift and then clear off”. “The morale is low, very low”. “Nobody cares”. “Difficult watching, being....”. “Simple things get blown out of proportion”. “Crazy stuff”.

6) Interview 11

“Slow to respond to requests for change. Hierarchal and divisive- although much talk is given to the idea of ‘teamwork’. Generally staff do not feel they have much input regarding how services are managed although their ideas may be elicited, they more
often than not are not acted upon. I have found the organisation to be reactive rather than proactive and this is very frustrating for staff who I think like to be able to be involved with a plan that has a clearly defined timescale with a clear purpose. Even when certain changes have been agreed in principal it can sometimes take ages to implement them.”

Framework Theme 9. Raising concerns/communication

1) Interview 37

“In response to the specific question on the culture of NHS organisations, this can best be described as enormously variable. At one extreme, in the context of avoidable injury to patients, we have experience of organisations that appear protective of individual healthcare professionals but possibly in order to protect the organisation and at the other, organisations that will in effect scapegoat individuals at the frontline rather than address any underlying failings in healthcare provision. The latter approach has the result of creating a culture of fear and lack of openness as well as failing to address the systemic problems and failures that may have resulted in that individual causing harm. This is evidenced by examples where the same mistake keeps being repeated or where unsafe practice persists...”

“...an increasing number of healthcare professionals are contacting us who have been involved in whistleblowing specifically in relation to patient safety issues. The fact that healthcare professionals are seeking...support is perhaps indicative that there are still issues around the NHS as a whole, as well as individual NHS organisations, in listening to the legitimate concerns of healthcare professionals who are trying to safeguard patients. From the individuals that we have worked with, their experience of trying to raise concerns often leaves them isolated, threatened, distressed and professionally compromised, with a significant impact on their health and well-being. Certainly the description given by some healthcare professionals of what has happened to them is Kafkaesque. However, this also mirrors the experience of some patients and families who try to raise concerns about their care and perhaps reflects a common feature of how some organisations respond when they are challenged. In both instances, you almost have to become obsessional in order to fight your way through the system.”

2) Focus Group 1

“I put I thought they were deaf”

R “Deaf?”

“They don’t listen”...

R “I am going to draw us back to what you said right at the beginning, what was it you said?”
They are deaf"

R “Ok, you said it very emphatically”

“Well the NHS doesn’t listen to the shop floor workers [others agreed] and it doesn’t listen to the service users. They get a fixed business plan in their head and don’t take into account the people who work in the service and the people that use this service, so they might as well be deaf”

**Framework Theme 10. Negative behaviour**

1) **Focus group 6**

R “Ok... talk to me about negative behaviour in the NHS, between staff. So that’s bullying harassment, aggression, abuse, incivility, any nasty stuff really. Any thoughts on that?”

“I think um, that it doesn’t get challenged enough. I, um, you know, I can talk again about my own service that I manage. I’ve been there 9 months and I currently, have commissioned 4 investigations into staff, because there was, again that word, entrenched. Entrenched, what I think are bullying and harassment behaviours happening in the service that have been going on for years and years, but nobody has ever done anything about. And I know because the previous managers were bullied by the staff, you know and I guess maybe I’m just thicker skinned, but there is just no way I can watch and tolerate it.

However, as a manager who has commissioned these investigations I feel I can completely understand why people have not done it before, because I feel um, not say bullied, but I feel an element of harassment from the unions who are supporting their staff and from those staff, you know, and I think, um, and you have to stay, you have to stay really strong throughout it. Because, you know, you get the barrage of every single thing that you do, you feel is being scrutinised because you know, they are waiting to get you.

Um, so which is probably, I don’t know maybe a different story to what you’re getting from other people, because I think there is a big onus on sort of...Making sure that staff are supported. Um, I don’t know if they are accused of something or whatever. Which is absolutely fine, but there has to come a point where I think, where there is clearly bad behaviour, and unprofessional behaviour, that shouldn’t be supported”

R “mm”

“So um, so yes, and again that going back to that word it’s entrenched behaviours’…”

“I was about to say I kind of feel, sadly, it’s part of the organisational culture. And um, well, for instance I felt bullied by a director at a meeting. Um, and I held my own but it was bad, to the extent that people were cuddling me after the meeting, and I don’t think I am that cuddly [L] I am not a person who goes out looking for cuddles! [L]. Anyway, however, you know on attending further more senior meetings, I realised that the
behaviour that I had experienced was at these senior meetings as well, so it was ricocheting down the organisation. Really, I saw this same director get torn apart so I realised where his anxiety came from”.

R “So it’s like going home and kicking the dog?”

“Yes exactly. Em, and I now actually work very closely with him, and I realise he is not a bully, he’s a lovely man, but there was pressure. You know, and obviously I was…..”

R “In the way?”

“Yes, but everybody... the meeting was such that everybody was in disagreement, but everybody was frightened to speak out. And I, I spoke out and I took the, and even then, they were saying to me ‘I know I should have said something, but I was too frightened’. You know it was horrible. Em, so, I just feel it is all, it comes at all levels, but I think it starts at the top and permeates down. If there isn’t that caring for staff, and involving them and things. It goes almost with the ‘command and control”

R “Mm mm”

“The bullying becomes part of it. Because you know, at every level people feel they have got to eh, you know, perform”

“I think there’s a really good point there. Because it is about the support you have around in the sense that, I know, I have been able to commission these investigations into people in my service, because I know my director is supporting me”.

R “Yeh”

“And the one of the HR managers is supporting me, and I feel that I have got them. However um, thinking back to my last job my line manager was a disgusting bully, that um, and I’m quite a resilient person”

R “And that was in the NHS as well?”

“Yes, mm, oh yeh, this was in the strategic health authority, so...And her behaviour was accepted by everybody around. And I felt I was the only one who used to challenge her and complain. And you know, and the sort of, directors within that part of the organisation would go. Well, have you never worked with someone like her before? And it was like...hang on a minute why is this kind of my fault that she behaves like that? This is her disgusting behaviour, you know, yelling at people across the room”

2) Focus group 2

“We are very tolerant of some really awful behaviour sometimes”

“Yeh”

“Yes”

R “Can you just tell me a bit more on that please?”
“Um I think it’s across the range it happens, I think its maybe it’s because we are historically used to tolerating consultants that we then tolerate bad behaviour [laughter, comments] from other people....”

“It’s just tolerated”

“Yes”

“I’m not tolerating it from my member of staff. [said very firmly and tapping the desk - plus laughter]”

“Mine’s from a different perspective and it’s that a manager will use the performance process to try and, use that like, process to say that person is not performing, to get them out of the department. But that person has actually been bullied by that manager and possibly another person within that department. And therefore they use the performance management process to try and get that individual out of their department. Not that they’re not performing, cause they are, or were performing. But I think they maybe view them as a challenge. But, it was known within the trust of these individuals and those individuals remain in post. And once that process had finished the following year it happened again, with another individual within that department. That were using the performance route to try and get those people out of their department.”

R “Why is nothing done about that?”

“Alright then...weak management.”

“I think managers aren’t trained, in how to manage things like that. I think everybody...we certainly don’t have a management programme that says how do you actually go through managing poor performance. How do you go to talk to somebody to say, you know I’m your manager. You know you do actually have to speak to people, you know this is the culture, and this is the behaviour I expect in my team. And to do that is quite difficult, because it’s probably the person you don’t particularly want to speak to either. Um, and you know that it will just get worse before it gets better. And I don’t think we are taught how to do that.”

“And HR are fully aware of these individuals, but nothing is happening.”

“They just move them, they move them somewhere else”

“No, no those managers are still in post. It’s the people, other people who have moved. They are still in post doing exactly the same thing to individuals. [noise of hitting on the desk –making very firm statements]”

R “So why don’t HR do something?“ [Laughter]

“I’ve said to HR, cause that individual, one of those individuals was me. And I complained against the two individuals, and it went through to the director. They retracted everything, in the end, but it was so stressful that I decided that I’m not letting these two bullies push me out of here. [hitting the table] And I didn’t and I have retained there. The following year they tried to do that to one of our colleagues. He left. And, cos, I said to HR, how many times are you going to allow those individuals to get away with this [hitting the table - emotion] and still remain in post? I didn't really get a very good answer, and they are still there.
Every single time I have seen it happen, I’ve seen HR turn round and say...well that’s the way it is. You can’t really do anything about it. That’s the way it is, and those, I, using the whistle blowing policy. That in itself um, hasn’t been of much benefit to them...What has...alongside that policy is using a risk assessment type process, as a, as a tool, in terms of actually taking it out from being the individual. But putting together evidence, details and an action plan of what you’ve tried to do, to stop it, and to prevent it. And then taking that to HR.”

“I think the difficulty is if those people are performing and delivering the results that the organisation wants them to deliver.”

“There is nobody else who can do that job in a sense, to what they are doing. But they are not respected with the people above them, or below them. But they are still in post.”

**Framework Theme 11. Self-interest/relationships**

1) **Interview 16**

“If you work for the nhs! Please have a good relationship with your manager and colleagues and kiss there arses from time to time so you should be in their good books in case you need their support! Do not challenge poor clinical practice, safety issues or whistle blow otherwise your life will be made hell directly or indirectly!”

“Managers are there to line their pockets and get away with it! How many patients do they see? I hold a strong view that middle management should go! Corruption is what comes to mind!, lack of transparency and accountably with public monies”

2) **Interview 21**

“Some people are very good at 'managing up' so they give a good impression to those above them whilst being very unpleasant to those who work for them. I have certainly seen that here on several occasions.”

3) **Interview 15**

"...*kiss up kick down*" as Prof Calum Paton said in one of his books...We found out...that chief exec -- got promoted for *'doing the dirty' on* -- on behalf of --, chief exec of the SHA, and looking to impress --. It worked!...*Rotten from top to bottom*."

4) **Interview 42**

“I mean, I have since I am on my soap box a view that every chief exec, or senior manager who stands in front of the television cameras and says patient safety is our first concern should be put in the stocks and paulted with rotten eggs [L] because it is a lie.
“It is a lie [L] and I’m afraid that I, I do not have overall much respect for managers in the health service...But otherwise if they want to prosper, they just join the corporate line. And they repeat endlessly about patients being their first priority, whereas in huge swathes of what they do, it is quite apparent that it is not right.”

Framework Theme 12. Scenario

1) Focus group 1

“You are responding to an Elephant in the room or the person was responding to the non-spoken about issue, I think, because it’s, once it’s out of the bag, once these conversations have taken place that there are negative behaviours between these two NHS trusts, then it is evidence

R “So you think that negative behaviour is an NHS “Elephant in the room’?”

“Mm I do, yeh”

“I think as well had these senior managers stayed for the presentation it puts the spotlight on them, because if they listen to what was being said then there is an expectation that they will do something about it. If they are not there they can’t hear it, it can’t be publicised, they don’t have to do a thing”

2) Focus group 2

“I’ve personally seen it, similar scenario and this one is probably likely to be a mixture of things. A level of arrogance. A level of ‘I am not interested, I don’t want to know’, because actually then we’ll have to do something about it. Um there is a level of fear because I’m expected to know what to do about it, but actually I don’t, maybe this is actually pointing at me as an individual. And then I think there is probably something about also as a group. It’s easier to put their ‘heads in the sand’ and providing they all maintain ranks, then they can get away with it. And if one of them breaks ranks and says actually we need to know about this, um then they may get ‘outside of the club’”

“I have just written down there ‘ostrich effect’. Put their ‘heads in the ground it may go away’ stroke forgotten. But it will raise itself if it’s important enough, again and again and again.”

“I put not being engaged and thought it nothing to do with them and then...Don’t want to know, not interested, don’t want to make the changes or acknowledge the results of the research and anticipate the results aren’t going to be complimentary. And maybe feel got at because at the end of the day everything always goes back to blaming senior managers. So...”
“I would also say, as well, that they may know that this is about inappropriate behaviour. But they actually don’t care because I certainly am aware of director’s comments to a member of staff that they were ‘untouchable’. So in this scenario the directors might think”

“So what!”

“Doesn’t matter what you have got to say about negative behaviours as far as I am concerned. We will carry on, and therefore the information won’t get out, so they are perfectly aware of their behaviour. They just don’t feel the need to change it. Which it then that goes back to our other conversations around personal agendas and power bases.”

3) Focus group 5

“They went to be seen to be leaving”

R “What…it was agreed, but they were at the meeting, but as it was set up to run...”

“So that was making a statement wasn’t it?

“Yes, it was. Yeh, yeh, to be too busy, so this is of little importance”... it’s like mummy and daddy disapproving and walk off and the rest of you will do as you’re told and not”

“Mm”

“They certainly got caught up in something very powerful haven’t they? Which, they would then need help to think...”

“Mm”

“ Probably behind closed doors somewhere about what was going on, you know, why, why did you get caught up like that?”

“Well, avoidance is a very natural reaction to fear isn’t it?”

“Yeh, fear”

“So if I’m frightened of snakes, then I don’t walk in tall grass”

“Yeh”

“Um and so my guess will be there were individuals in the room who are frightened that in some way or another they personally or the staff that they are responsible for, are going to be blamed, there will be something shameful for them”

“Yeh yeh yeh ....pause

R “Anything else?”

“I put that they felt threatened”
“Yes they come across as feeling threatened, but also they are trying to control the definition of, um, what can be talked about, aren’t they? They are sort of, and they are hoping that if nothing gets talked about, nothing can be thought about

“And then nothing needs to be done”

**Framework Theme 13. Selective moral disengagement/ego-defences**

1) **Focus Group 2 – follow-up discussion with participant**

“It is very tempting to join the club and be part of the ‘good news factory’. I dip in and out of that. Trying to protect the organisation, but also trying to protect the interests of patients and staff as an advocate. I can accept giving people (commissioners) a positive picture as long as the real issue, as long as they cooperate with me to implement solutions. But often I am let down by that. Not managed to do that. Fall into the trap. Avoid reporting things up. Sometimes make a decision to withhold information to have time to deal with the issue.

They don’t care about anything else as long as not reported. They then leave it behind. The executives and directors, a bit of a game. How do they get away with doing the least possible when trying to do other things? Balancing act”

R “Talk a bit more about the ‘Good news factory’. Is that a term you use normally?”

“Not used it before. It’s like, no...Somebody told me...‘Iced cake syndrome’. Lovely on the outside, mouldy on the inside. Part of a culture being led by the government. Present a pretty picture fed up to the voters. Underneath it’s a bit of a shambles.”

R “Mid staffs – How did Mid Staffs happen?”

“I don’t know much about that’ but kidded themselves. We do it a lot. We cannot bear doing any more work putting it right, so much to do, almost go into denial. It’s like...there is some power wielding person like a Hitler figure going to do something really nasty to them. Under great threat. Something really, really nasty. Why don’t people say no?

R “It’s like one person said – why don’t people push back?”

“Only interested in themselves, in the next job. People are very short term at that level, looking for the next job”

2) **Focus group 6**

“In terms of the culture there. Um, the indication there was that particularly senior managers ‘don’t want bad news’

“One of the things I was referring to obliquely was that exactly same issue.

“And, and [the Board] where I worked um, the Board had a meeting to discuss the Lothian problem to say do you think we are we like this? And they all said ‘Oh no’...You have got to be kidding!”
“Even though there’s been a million grievances against senior managers there”

“Yeh, and within each operational unit if there is some sort of ‘bad news’ they want to wash their own washing, and not have anything unpleasant being reported up the line. Bad news needs to be managed and doesn’t get addressed. And there is some awareness of this. One of the clinical leads in the operational unit I was based in, said, we just don’t learn. We have a situation, it happens in one health board, or health authority, and that should really be a lesson, for everywhere else. But they just say, oh, we’re not like that. That couldn’t happen here.”

A similar observation was made about the NHS in England around the inability to receive negative information and to learn.

“There’s not another English trust that thinks that they are Mid Staffs”.

“Yes”

“And Mid Staffs wasn’t the worst”

“No...no”

“By definition it is not going to be the worst, and yet somehow, every one of them has assured their SHA. Has had to do their Francis report reviews dah, de, dah, de, dah, that clearly says to the SHA, that no trust is like Mid Staffs. That’s rubbish, but somehow, just saying it enough, and hearing it enough and putting it in black and white enough, is saying to people that we are all ok, Jack”.

3) Interview 15

“It can be a career ending move to, um, raise concerns with NHS managers. Basically another element of the culture is, you ‘keep the lid on’, you ‘don’t expose your dirty linen in public’. And if people want to do that you attack them professionally, personally, you make them go and see psychiatrists. You, if they beat you at an industrial employment tribunal you pursue them for costs. There is no end to what the NHS will do to people who try to break open ‘the citadel’.”

“And we are not very good at challenging these institutions that we have set up. The key um critique being Hans Anderson story about ‘The Emperor’s New Clothes’, King’s new clothes. It takes a little boy to say but, yeh, look what’s going on. And all that drives the culture of the NHS, Thou shalt not break the golden rule”

R “And the ‘golden rule’ is?”

“The golden rule is keep stum’, don’t let it out”

R “Please could you tell me a little more about 'the citadel'?”

“The citadel is the notional home of the big secret that the NHS cannot do better than killing an awful lot of people and treating tens if thousands, largely elderly, in an appalling manner. Does that help?”

R “Thank you, - very interesting - Please can we develop this?”
The citadel is a metaphor for the NHS - picking up on AJ Cronin's title. Its primary purpose is to protect itself even though the public believe it is there solely to make them better.

When individuals see what's going on in the Citadel and try to advertise it they will generally be repulsed. [...] broke down the walls of the Citadel because among other things it suited a new ruler to help [...] to break them down. Now many of the insiders are wondering how to respond to being on display; first response, pretend nothing has happened and hope that the walls can be rebuilt”

R “A couple of comments from other research participants. One of them described the NHS as 'a good news factory'. Have you anything to comment on that?”

“Spot on! Alternatively, it has two manifestations - great when things go well, nasty, aggressive, dishonest, vindictive, and much more when they go wrong.”

R “Please could you explain to me a little more about the NHS train?”

“The train is just a metaphor. In normal mode the NHS runs along quite smoothly as it covers up all of the chaos; it gets to a complex set of points, slows down swings and sways (the Mid staffs disaster), but spins and lies it way past it, then goes smoothly on.”

4) Interview 17

“Insatiable political demands for promulgation of good news and for burial of bad. Manipulation and corruption of data to deliver good news.”

R “Can I come back to you on one of your words, of three - 'dishonest', and also you used the word 'corrupt' at one point?”

“I think I used the word dishonest to encapsulate...the difference between the 'good news factory' and the reality on the ground and the associated self-delusion/wilful blindness of many politicians and some managers. There is also a mismatch between reality and aspiration in relation to what level of quality can be achieved for patients given the constraints of the context. I said 'corrupt' in the context in which I said it to denote the deception and manipulation of the truth in relation to the denial of reality when things go wrong. There is also the corrupting impact of the context (e.g. perverse financial incentives).”

5) Interview 21 [A fuller section of text is provided in Appendix 17]

“Yes I think that, if you view it as a change of behaviour. I mean this is another extreme metaphor, but if you think about people who had to do all sorts of things to survive in the, in the um, in the concentration camps during the war. I know it is an incredibly extreme example, um, but it is that type of thing. It is what do I have to do to survive around here? You know, I have got a mortgage, I have got a family. How do I do this?

The other thing that I, I, I know it is another extreme metaphor I know, but you understand what I am saying, but it is about reducing that dissonance. Whether they
begin to believe what they are doing, I don’t know. I think that afterwards people really suffer because they recognise what they have had to do, if you see what I mean. “

6) Interview 30

“I entirely agree that there is a ‘good news factory’ that operates in many Trusts”. [This quote is given in full in Appendix 17]

7) Interview 32

“...there is a specific sackable offense for managers which is damaging the NHS brand. It is written into the manager’s code of practice, and various other things, and I have been threatened with that DIRECTLY, you know to my face and in writing....”

“...our SHA specifically told my chief executive who changed clinical priorities to ‘avoid bad news’...”

R “But what’s driving that?”

“...it’s this, it’s part of the SHAs almost unwritten job description to ‘relentlessly present good news’. Yes, they will always ‘talk up the NHS brand’, and they will always play down negative things to the extent that the press generally no longer trust what comes out...They just see it as spin and propaganda. Um, and it’s back to this culture of not really learning, because unless you are honest about your mistakes, or honest about your struggles, you can’t move on and fix it.”

R “Yes, but what’s driving it? What’s underneath this?”

“What’s driving it? It’s self-preservation and protection for people in senior positions who want to cling onto power and privilege, and earn a lot of money.”

This person also gave a response regarding possible rationalisations linked to protecting the organisation and the image of the organisation.

“Well, they say that a ‘strong NHS’ I think, is their rationalisation, um, is much more important than any individual...So that’s what they think. Um, protect the institution and all will be well. Those two...I take the opposite view, and I think most people do, the institution is actually its people, um. The powers that currently run it take the opposite view. And that’s how they justify it. We have to have a strong untarnished, untouchable NHS, otherwise everything else will fall apart. Um, I don’t think that’s the right or a healthy attitude.”

8) Interview 38

R “Also are you aware of any rationalisations/justifications that people use to support actions or behaviours which are not in the best interest of patients or staff?”
“That’s a long question!! Yes, lots. Usually to do with isolating the “trouble-maker”, making them an exception. But also, most of us don’t think most of the time. No, all of us don’t think most of the time. We are creatures of habit, creatures of organisational cultures. It’s just what humans do. That’s not to say cultures can’t change, be changed, but it requires lots of effort and intelligence.”...

“Hmmm. Mostly I think it’s about patients being seen as unreasonable, or unrealistic, or not keeping up their end of the "bargain" (all of these things may well be true!!) I think that’s probably the first line of defence.

And once you slip into bad habits (of doing things not in best interest of service or your underlings, then you feel guilty and complicit in bad practice, and it becomes much harder to have "high moral ground" - because you are contaminated (I am thinking in the Erving Goffman thing of spoiled identity, and maybe also of "slippery slope" and the things people will, over time, get used to. I think this sense of it all unfolding over time - of what people gradually become used to - is crucial. Presumably this is what happened at Mid Staffs?”

“Everyone else is doing it" "That’s just how things are done around here" "There's no point telling management; they already know and they aren't doing anything” "If I blow the whistle I will be blamed for the very failings I am trying to expose, and my record is not unblemished, so I will just keep my head down.

Have just read an interesting book on how fragile our rationality is - prey to false memories, cognitive biases, logical leaps etc. The book is called "You are not so smart".

9) Interview 42

“But, in the last 10 years I was basically doing [--] and I found it riddled throughout. It was quite clear that you know not all clinical staff are goodies, some of them were at the root of some of the problems, but by and large, the problems were that management did not want to listen to clinical concerns and for all the rhetoric, actually, as you said their primary concern was not patients. I mean, I have since I am on my soap box a view that every chief exec, or senior manager who stands in front of the television cameras and says patient safety is our first concern should be put in the stocks and paulted with rotten eggs [L] because it is a lie”

R “[L] Yes”

“It is a lie [L] and I’m afraid that I, I do not have overall much respect for managers in the health service. As I say I’m afraid to say that I think that whatever they came into the service with, most of them um, either give up and get out because they can’t cope with it or perhaps try and move sideways into some area where they are less exposed to the worst of it. But otherwise if they want to prosper, they just join the corporate line. And they repeat endlessly about patients being their first priority, whereas in huge swathes of what they do, it is quite apparent that it is not right”

R “How do they live with themselves?”
“Uh well, I’m afraid I think like, uh, a lot of people they sometimes begin to believe their own rhetoric. That was one of the things that we quite often found in chief execs of trusts where appalling things have happened. That they would say when you interviewed them some extraordinary thing about what they had done and so on, and then we, because we would by then, have been in and out of the trust for 6 months and had done loads of analysis would flatly contradict what they would say, and they would stare at us in horror, because they are used to not being questioned.

Their word is accepted and I think some of them, maybe a lot of them, begin to believe the, the propaganda really. I think they, you know, I think they ‘there is no alternative’ so they actually delude themselves. Some of them aren’t very clever in the first place so, you know. Maybe they genuinely don’t understand the effects of it, others I think, know perfectly well, but as I say, carry on regardless really”

R “Yes”

“Um, it’s depressing isn’t it?”

Framework Theme 14. Actions

1) Focus group 2

“I was talking to someone from workforce development and she was a nurse by training...and she said, oh for God’s sake...“we have got far too many leaders in this organisation, what we need is some good managers”. And that was actually quite interesting. Cause actually, you do. That’s where it comes from, creating your power base with people wanting to be leaders. Just needing good established, solid, functional managers to actually drive things forward or keep things going.”

2) Interview 6

“Clearer codes of behaviour in the workplace, in particular clearer codes for managers particularly middle managers on what is and isn’t acceptable when managing employees in terms of demands, language and behaviour. More support for employees who are feeling stressed, overworked so that there are better coping mechanisms in place before employees take things out on each other...”

“Difficult as we obviously represent members on both sides of any dispute or complaint. Although we make demands regarding what trusts should do we have little ability to enforce such suggestions, we should though vociferously put forward a range of resolutions to protect the member complaining and other staff who may also be affected either now or in the future. We can also influence the policies that are in place although policies are usually fairly good on paper but in reality they are not applied in a way that recognises all of the behaviours which are quoted in policies. This requires culture change, a work place culture is difficult to change, culture comes from the very top. Some Trade Unions did start training workplace mediators in collaboration with
Trusts. I don’t think this has been progressed, this may be due to resources or success rates.”

3) Interview 43

“Organisations can rely on their policies and processes and fail to engage in the organisation wide discussion about culture. Behaviour change and the supporting of positive behaviour and culture can only be driven from the top of the organisation and must be role modelled by senior leaders. Whilst individual negative behaviours must be challenged where they occur this will only happen consistently within organisations where there is such a culture.”

4) Interview 2

“Staff need to believe that they are important and needed in the health service, they need to feel valued and not under constant threat of budget cuts and organisational change.

Team meetings need to take place and staff should be involved in all decisions that will mean changes to their working practices. A more happy secure work force would mean that issues/concerns of all staff could be heard and acted upon without staff feeling their jobs are at risk.

Chances for promotion and more training would allow staff to have more confidence in their own abilities and this I believe would greatly reduce some of the stresses and negative behaviours currently seen in the health service.”

5) Interview 1

“Well surely I mean, before all that happens, surely when you have your interview something like that should come up Uh, about, you know, if you XYZ then this will happen, I mean, then perhaps a lot of it wouldn’t happen”

R “Anything else?”

“Well, as long as they told them, told the person being interviewed that you know this was our ruling and if it reoccurred the consequences could be whatever.

If people know when they take the job that cannot be negative or whatever, the better chance it might go aright, because they have got it on a plate then, if I do that, you know, and three strikes and you’re out. Cause, it’s not necessary is it?”

R “No”

“It’s just being rude and horrible”

R “Anything else you can think of, needs to be done?”

“No, I think if you set your, um, guidelines right, then hopefully and can only hopefully, hope that the employee abides by them.”
6) Interview 5
“The NHS needs more money but this should not be spent on managers. The clinical staff should be put back in control and the managers should only be there in a supportive and facilitating role. When a doctor, nurse or other clinical staff (e.g. physiotherapists, medical physicists, OT etc.) have spent years gaining qualifications and experience it is very unhelpful to put a manager above them who has neither the experience or qualifications but simply a managerial qualification. Certainly doctors do not find it easy to take instruction from somebody who has considerably inferior academic achievement...especially when they consider those instructions to be absurd and to the detriment of patient care.”

7) Interview 13
“We need to find and promote effective early interventions. These include how to identify developing problems and early effective intervention that does not disrupt patient care. We need to show the benefits to trusts, managers and patients of addressing and resolving staff relationship problems early.”

“We also need to be promoting positive strategies and avoiding adversarial complaints based approaches. Like trusts we too have problems with time and workloads. My role is generally reactive rather than proactive.”

8) Interview 40
“Organisational culture of bullying by top management. Accountability to government from senior executives. Presently they are free to bully staff while government turns a blind eye. The only recourse for the employee is down a legal route which is generally too expensive and anyway the NHS employer will come back with the big guns at public expense. Needs cap on how much they are allowed to spend on tribunals to level the playing field. Chief executive should be held accountable if employee abuse proved. There is a lack of accountability for bad behaviours at the top. Investigations should always be carried out by external agencies with no dependency on the NHS. Ban on gagging clauses. Duty of candour for NHS boards.

Personalities of senior managers are part of the problem. Huberistic (sic) tendencies. These people should be screened out at interview stage. Regretfully, I think they are actually screened in.

Whistleblowing is an extremely dangerous thing to do. Education for managers on whistleblowing. I don’t think most of them recognise it. Whistleblowing line may be helpful, but it is a sign of system failure that we need it”
Appendix 11. References to fear

Words used:

1) Fear, fearful, frightened, frightening, fright
2) Scared, scary
3) Anxious, anxiety, anxieties
4) Worried, worry
5) Petrified
6) Nervous
7) Threatened, threat
8) Panic
9) Cowed
10) Nightmare

Lower and Higher Level Classes

a) Higher Level Classes

1) Fear of higher authority
2) Fear of threat and punishment
3) Fear of blame and shame
4) Fear of impact on individual and organisational reputation; bad name/image
5) Fear distorts thinking and behaviour
6) Fear produces negative behaviour/outcomes
7) Fear of the truth
8) Fear relating to change
9) Fear for personal security and benefit (job/role/position/promotion)
10) Awareness of lack produces fear
11) Fear of standing up and being counted; speaking
12) Fear of problems
13) Fear of journalists/the press/getting monstered/"...a journo doing a ‘beat up’"

b) Lower level classes

1) Culture of fear/growing fear/a lot of fear/pervades NHS, management/constant fear/fear and arrogance
2) Fear of management and higher authorities (e.g. DOH, Whitehall)
3) Bullying culture (command and control) leads to fear, insecurity, and cover up
4) Staff cowed by bullying behaviour
5) Fear of punishment/persecution/retribution/reprisals/penalised/shafted
6) Fearful of making mistakes/failing/getting it wrong
7) Fear of being seen as really are/seen in a bad light/seen as lacking/organisation named and shamed/show bad image, name/public embarrassment/put on the spot
8) Fear of the truth/truth makes people nervous, anxious
9) Petrified about any negative information; paranoid stance
10) Fear of blame and shame; feel threatened
11) Worried; senior managers don’t like dirty linen aired
12) Fear due to lack of knowledge, skills, training, can’t cope/manage
13) Fear; no one dares challenge/too frightened to challenge powerful people; need to leave
14) Don’t like challenge to authority; scared to admit flaws/expose problems in system
15) Fear of raising concerns/fear black mark/consequences/persecution of whistleblowers
16) Raising concerns is dangerous/ unsafe; a lot of fear
17) Scared to speak/silence driven by fear/keep their heads down
18) Frightened to stand up and be counted/head over parapet/shoot me
19) Fear of getting caught up in a problem
20) Fear for survival
21) Fear, scared for jobs/position/cuts/freeze of pay
22) Fear of being overlooked/got rid of/replaced
23) Frightening ; concerns not listened to
24) Fear of change (imposed change)/change creates fear, insecurity
25) Increased workload produces fear, pressure and uncertainty
26) When scared display aggressive behaviours/staff sniping at each other because of fear/fear; a reason for negative behaviour
27) Fear being accused of bullying and harassment
28) Fearful if manage staff ‘go off sick’
29) Frightened of bullying and harassment, turn away from it/scared of B&H and H&S/unsure how to respond
30) Managers/leaders fearful when patient safety issues raised
31) Nightmare situation
32) Fear produces cautiousness
33) Disempowerment due to fear
34) Fear CQC
35) Fear ‘finger pointed at them’/feel accused; backed into a corner/fear hearing negative things about themselves/fear impact on reputation
36) Fear of flood gate of litigation
37) Fear; easier to put head in the sand/ignore
38) Fear responsibility
39) Avoidance natural reaction to fear; feel threatened
40) Fear when patients challenge poor care; similar to whistleblowing
41) Panic when flag up a problem
42) Threat of power wielding person like Hitler figure; really nasty
43) Threat to self-interest/benefit
44) Threat of criticism of organisation and senior management
45) Worried if open a can, unleash something, the worms will come out; are lots of worms,
46) Anxiety at the top
47) Function of DOH is to manage good news stories; very scary
...live in fear of a journo doing a ‘beat up’; drives clinical decision making

Categories referring to fear under the Framework Themes

Theme 1. None

Theme 2. None

Theme 3. Hierarchical/Top down/power

FG 2 Frightened in light of changes, driven from the top, not driven from the bottom

FG 3 ‘fear ‘of upper management.

FG 4 Fearful of making mistakes.

Int 4 Conflicts of interest; no one dares challenge. Fear.

Int 15 Afraid not to do Whitehall’s, DOHs bidding. Fear; translates into bullying.

Int 16 Lots of bullying, staff scared to speak out in fright of retribution.

Int 17 Cowed clinical professionals.


Int 22 People behaving badly in positions of power. Those beneath fear reprisals if speak out. Fear, especially if most senior managers won't tackle issue.

Int 32 Prevailing culture bullying, command and control leading to fear, insecurity and cover up. Constructive challenge or inquiry seen as disloyal; frowned upon. Dissenters not welcome as agents of change; marginalised as trouble makers.

Int 35 Cautious bordering on fearful.

Theme 4. Bureaucracy/policies

Int 35 More constrained by procedures and legislation re making decisions. Fear getting it wrong, having complaint against them.
Int 40  Not about *whistle blowing* policies, nobody paying any attention to them. So concern hasn’t been listened to. Frightening. All saying will get listened to. Awful. Unbelievable. Focus on policies. Passed from place to place.

**Theme 5. Finance/business/targets**

FG 3  Anxiety on job security

Int 15  Fear of failing

**Theme 6. Change/variable**

FG 2  NHS needs to change, but not way proposing. *Fear in light of changes.* Changes *driven from the top.*

FG 5  Increased workload ➔ fear, pressure & uncertainty.

So much talk about change, talk about lots of restructuring. People more fearful. Try to protect position.

Int 2  Most staff too frightened lose jobs if demand ‘rights’; ‘keep their heads down’.

Int 7  Staff worried about jobs. Moved HQ; everyone applying for their jobs.

Int 24  Change creates fear if not handled sensitively.

**Theme 7. HR/other roles**

FG 2  Repeated behaviour nothing done. Lack of effective response/action from HR. [HR] Way it is *(R&J).* Can’t do anything about it *(R&J).* Fear of raising; will deny it. HR view always unless complains cannot do anything, forget it *(R&J).*

FG 4  Fear of making mistakes, incredibly important.

Int 33  Possible delaying tactics/avoidance. Nobody said anything, nobodies done anything. [Why HR no action?] Perhaps don’t know how to, or reputational risk. Lack skills, frightened; don’t know. Unless *tackle issues head on* cannot deliver a fair system. Perceived unfairness/injustice.

**Theme 8. General lack/dysfunction**

FG 2  Lack of understanding. Aggression because scared. No knowledge; unable to ask. Lot of people don’t have general management skills. Lack of training to know how. Fear of being found lacking.
Worried.

Int 7 Stress factors gone up. Staff worried about jobs.

Int 18 Culture of fear pervades NHS management. Managers ‘look up not out’.

Int 24 Change creates fear if not handled sensitively. Need to work harder at this.

Int 31 [Leadership and management] Poor on whole. Not many inspirational leaders, not sure any. Many managers poorly trained, supported. Immediately fearful when issues patients safety raised.

Int 34 Cautious bordering on fearful.

Particular, fear getting it wrong having complaint against them

Theme 9. Raising concerns/communication

FG 1 Shortage of staff, incidents, feedback always, no, bad skill mix, not lack of people on the floor (R&J). Possible rationalisation, deflection. Frightens staff; disempowered.

FG 2 Its fear, fear. Fear of not being seen to be something are not.

Everybody fearful organisation going to be named and shamed. No press around when good. Constant fear.

It’s not H&S, is looking at who monitoring us. Fear CQC most.

FG 4 Lack of autonomy; second question yourself. Fear of making mistakes incredibly important.

Int 4 Feel unsafe. Lack of trust; don’t know who to trust. Fear have black mark if speak out.

Int 6 Everybody in disagreement, but everybody frightened to speak out. Spoke out. Saying to me know should said something, but too frightened’. Was horrible.

Even staff frightened to complain at ward levels.

Whistle blowing policies in place, but nobody paying any attention to them. Concern hasn’t been listened to; quite frightening.

Int 10 Outcomes of decisions detrimental to staff and patients. Growing fear culture; no longer feel secure. Know consequences to raising issues.

Uncomfortable raising issues, afraid perceived ‘unable to cope’/‘weak’, found not have serious case.

Int 12 Afraid to bring stuff up. Consequences personally; seen people shafted.
Int 16  [Diff to raise?] Lots of bullying, staff scared to speak out, fright of retribution.

Int 18  Doctors fear penalised if do raise things with managers. Fear of punishment. Attempts to solve problems of whistle blowers; not totally effective. Steve Bolsin to Australia because blown the whistle at Bristol. Fear. Culture of fear pervades NHS, problem of whistle blowers. Still gagging clauses, preventing speaking. Even people at Mid Staff inquiry subpoenaed to give evidence. Gagging clauses in contracts. Culture of fear, unsafe in hospitals, possibly general practice as well.

Int 22  Weak/inexperienced management, may be linked to suppression of bad news or persecution of whistle blowers. Sometimes people behaving badly in positions of power. People beneath them fear reprisals if speak out, especially if perceptions senior managers won’t tackle issue.

Int 30  Silence, driven by fear re own jobs. Managers went to staff said no account are you allowed to talk to [person]. One or two people wrote letters, but ‘body of silence’ there. Driven by fear.

Int 31  [Raising concerns] Dangerous; most people do not realise. A lot of fear.

Many managers poorly trained, supported; fearful when issues of patients safety raised.

Int 32  Command and control leading to fear, insecurity and cover up. Constructive challenge, inquiry seen as disloyal, frowned upon. Dissenters not welcome as agents of change, marginalised as trouble makers.

Int 40  Colleagues sympathetic, but afraid to speak out.

Theme 10. Negative behaviour

FG 1  Many staff sniping at each other because lack of morale, fear of jobs, cuts, freeze to pay/job.

Don’t like B&H, tend to turn away from it. Frightened. Hard to pin them down. Oh my God got to go to HR! If don’t deal with it, it’s not happening.

Don’t hear anything, despite manager shouting. Scared of retribution. Divisive. Frightened to stand up be counted. Cuts; don’t want ‘putting head above the parapet’, say ‘shoot me’. Look other way, pretend didn’t happen. Don’t want to be tarred with it. Worry about job; can’t recruit reps.

CE well-known bully; bullying comes down all the lines. Comes further and further down line to people doing the shop floor work. Totally cowed, demoralised by behaviours.

FG 2  People in wrong jobs. Poor behaviour comes from fear not coping, can’t manage, or hate coming to work. Fearful to admit; need job. Difficult to say is there something else? Put good face on. Recognition people in wrong jobs.
When scared display aggressive and unpleasant behaviours. They’re scared. Need help, knowledge. More senior harder to ask.

Fear. Training, experience of managers; fear factor. Fearful if manage, staff may go off sick. Better someone disruptive or below par performance, is 50%, but in job, than off sick. About the system, comes back to training and confidence. Fear accused of bullying and harassment, investigated themselves. Performance review immediately bring in bullying and harassment. Under pressure and stress.

[Repeated why nothing done?] Common enough; never want to make it formal. Got to make formal complaint. Frightened, scared of own position, employment, position within team, seen as one raising their hand. Saying problem in team, want something done. It’s like whistle blowing, won’t do it; risk. Talk of change, restructuring; more afraid. Try to protect position. By stepping outside of that, putting themselves at risk.

**FG 6** Everybody in disagreement, but frightened to speak out. Saying should said something, but too frightened.

**Int 10** [Why negative behaviour?] Range of issues; pressure, stress, politics, fear, other external factors

**Int 15** Top down culture. Every unit NHS, microcosm. Why want to do Whitehall’s, DOHs bidding; afraid not to. Translates into bullying problems.

**Int 16** Lots of bullying. Staff scared to speak out in fright of retribution.

**Int 18** Culture of fear pervades NHS management. Fear. Culture of fear pervades NHS. Problem of centralisation. NHS managers look up not out

**Int 21** One person serves ‘attack dog function’. If challenge her, probably need to leave; is quite powerful. Staff too frightened to raise allegation against such people, make life very difficult.

**Int 22** Sometime people behaving badly in positions of power. Those beneath them fear reprisals if speak out, especially if think most senior managers won’t tackle issue.

**Int 24** NHS as whole, often negative behaviour results from staff feeling undervalued, under pressure. Change creates fear if not handled sensitively. Need to work harder at this.

**Int 31** Bullying arises through insecurity, fear. Many managers poorly trained, supported. Immediately fearful when issues patients safety raised.

**Int 32** Symptomatic of wider, deeply engrained malaise, culture of bullying and dishonesty. Prevailing culture is bullying, command and control leading to fear, insecurity and cover up. Constructive challenge, inquiry seen as disloyal, frowned upon. Dissenters not welcome as agents of change, marginalised as trouble makers.
Member of staff tries to raise concern, criticised or ignored. Those involved in whistle blowing experienced all aspects negative behaviour. Guilt because involving colleagues. Colleagues can take a step back. Fear caught up.

Theme 11: Self-interest/relationships

Fear, frightened.

FG 2 Fear of being overlooked for career progression.

FG 5 Real anxieties; can be replaced, rid of easily. Taken over.

Int 10 Afraid perceived unable to cope/weak, be found not to have case

Int 21 One person serves 'attack dog' function. Generally acknowledged if challenge need to leave; quite powerful. Staff too frightened to raise dignity at work allegation against such people. Make life very difficult. Need ‘class action’ group of people acting together

Int 35 Another strong cultural norm, don’t land colleague in trouble. Don’t point the finger. Fear that Incident reports will be used to do that.

Theme 12: Scenario

FG 1 Looked in the mirror’. Frightened ‘finger is actually pointing at them’. Attack is best form of defence. Don’t want evidence. Prefer hearsay. If acknowledged then fear of opening flood gate for litigation.

FG 2 Worried. Senior managers don’t like dirty linen being aired; being surprised. CQC, HSE debrief with senior managers; have to deal with fall out. Need to not be put on the spot. Do not want our dirty laundry aired, in public.

Fear of being found lacking. Being responsible for action. Create work. Don’t want to be responsible.


FG 3 Fear would look bad. Fear of public embarrassment. Desire to avoid problem didn’t wish to face. Insecurity, of senior managers. Didn’t want to hear negative things about themselves/trust. Denial, disbelief. Blocking to decrease chance of bad publicity. ‘Head

FG 4 Fear of failure. Fear of failing, admitting are problems, issues. Dismiss it, just bury it, dismiss it. Don’t want to learn. Don’t want to identify issues where need to change; can be improved.

FG 5 Fear of naming/shaming. Avoid negative consequences. Opportunity to look at how values functionalised, operationalised, but avoiding it; obviously scary. Avoidance very natural reaction to fear. Fear. If I’m frightened of snakes then I don’t walk in tall grass. Personally or staff responsible for, going to be blamed, something shameful. Felt/Feeling threatened.

Int 1 Scared of H&S and B&H. Don’t want to admit. Don’t know how to deal with it. [Why scared?] Very bad name if goes about. Whole trust very bad name. Not on same level, don’t know how to deal with it.

Int 10 Whether legal advice on current case taken against Trust, fear of embarrassment, denial, fear raising awareness increase workloads, demands on tight resources, not 100% clear.

Int 11 Didn’t want to acknowledge. Unprepared, fearful, unsure how could respond. [Why?] Fear.


Int 15 Accurate of what going on; that’s your NHS. If got into newspaper, research journals. Whitehall ringing up, politely, perhaps not politely. What the hell doing, let this get out? Hospitals PR/communications manager; wanted nothing, even slightest thing. Didn’t want PPI forum to say anything. Didn’t uncover any great scandals, but was petrified about anything. That’s the way do things.

Int 30 Senior management trying to suppress information. Particular suppress any exposure, embarrassing information re negative behaviour. Fear managers, Trust, seen in a bad light. Walk-out probably planned. Refusal by Trust Board share findings suggests suppression. ‘Paranoid’ stance, right up, most senior levels. ‘passive bullying’. Exclude people, information from normal discussion relevant to health care. [Why] Root cause fear. Fear by some directors/senior managers own positions, reputation compromised. May been more ‘genuine’ reasons, around ‘bringing Trust into disrepute’. View may have been any actions prevent this happening, regardless of how unfair, is acceptable (R&J). Unsatisfactory behaviour consistent across various levels. Culture fear and arrogance in Trust.

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Int 31 Culture, trying to speak to the truth makes group feel nervous. Retreat into old comfortable ways of being. What happening so bad, hard to take it on board; may become unmanageable. Much of response; unconscious drivers. Study at [organisation], group relations courses. Responses in groups, sometimes takes all by surprise. Act differently in different groups. When something strange happens now, someone gets very upset/angry, stop, reflect why. See regularly when try to speak truth, everyone becomes very anxious.

Int 37 Very similar behaviour patterns apparent when patients challenge poor care. Fear, protectionism, trench mentality, ignorance. Form of collective stupidity, self-preservation.

Int 40 Directors/senior managers feel threatened by findings, potential outcomes.

Int 42 Don’t want clear analysis, critical research, well evidenced work, flags up problem. Causes panic, indicates what doing not correct, feel ‘there is no alternative’ (R&J).

Don’t like challenge to authority, no matter how well intentioned. Scary to them, because it’s exposing a problem. Don’t know how to deal with. Dealing with it mean having to admit flaws in system. Having to abandon things feel can’t abandon.

Theme 13: Selective moral disengagement/ego-defences

Only those sections relating to the concept of fear that are not already documented in the above themes are included in this section.

FG 2 Like is some power wielding person like a Hitler figure going to do something really nasty to them. Under great threat. Something really, really nasty. Why don’t people say no?

FG 4 Anxiety

FG 5 Fear. That’s other side of story. All probability, Christ, if this comes up won’t get this, or that, our star, foundation status, real anxieties, can be replaced, rid of quite easily, taken over. Ethical conflict. Jobs at risk if don’t comply.

Benefits, but in terms of cost sort of deafness goes on. What do is threatening. Not always welcome, changes things. Change what get out of situation. Threaten self-interest/benefit. [Threat?] Talk with CEO, managers; not always comfortable relationship. Dependent on maturity, ability to listen and their anxiety. Trying to make sense why under threat. Don’t understand actions. Rationale is cost savings (R&J). Don’t really buy it to be honest. Think is a red herring. Money could be found; something else going on. Motives unclear. Threatening because hear criticisms about organisation and senior management. Senior position invested in one-sided rhetoric in trust monthly newsletter. May see value of OST, but motivated to silence dissent.
**FG 6** Acceptance, nobody wanting to challenge. Too **frightened**. If are one to put head above the parapet, and then it gets shot off like yours did *(R&J)*. Too risky *(R&J)*. Best way to survive is to **keep your head down**.

**Int 12** Often **worried** if ‘open a can’ [L], ‘the worms will come out’ [L]. Are lots of worms. **Anxiety** at the top was going to open something, unleash something going to be unpleasant.

**Int 18** [Good news factory?] Likely to be true. Function of DOH is to manage **good news stories** for minister, is their job; nothing else. [Scary isn't it?] **Very scary.** Not many people can be honest, straight forward about things. DOH communications raison d'être is to produce **good news story** for minister. Minister said all did what No 10 wanted. Does not want, party political reasons, a **bad news story**.
Appendix 12. Lower and Higher Level Classes for possible rationalisations and justifications

a) Higher level Classes

1) Adoption of R&J mind-set; becomes overarching culture
2) No choice/alternative (helplessness)
3) Claim of obedience to a higher authority
4) Shifting/displacement of responsibility
5) Inability to take action (passive role)
6) Policy and process used to avoid action
7) Money/economic imperative
8) Individual and group rationalisation
9) Data/reports used to provide justifications
10) Redefinition/reframing of language and behaviour/reality
11) R&Js for action and inaction
12) The negative becomes positive
13) Justify actions; deflected onto system/organisation
14) Progression of bad practice/normalisation
15) Multiple rationalisations
16) Make choices/decisions
17) R&Js based upon possible perceived risk
18) Protecting the organisation

b) Lower Level Classes

1) **R&J** – A mind-set; becomes overarching culture; perhaps inevitable consequence of blame culture; difficult to understand
2) **R&J** – Into positions of power through adopting R&J mind-set
3) R&Js is how NHS operates when concerns raised
4) Defence of the indefensible/try to justify what clearly wrong; make excuses
5) Too easily look for reasons/excuses for negative behaviour/excuse criticisms of senior staff/managers
6) End justifies the means/nothing matters except the goal; own agenda
7) Abrogate responsibility; it’s the system
8) **R&J** - Justify it in loyalty to the organisation/it’s all about what’s best for the hospital; CEs protecting themselves
9) **R&J** - A ‘strong NHS’ is their rationalisation; more important than the individual/for the greater good, greater policy, initiatives; don’t rock the boat/protect the institution; all will be well/the powers justify through protecting the organisation
10) **R&J** – Have to have strong untarnished untouchable NHS; otherwise everything will fall apart

11) **R&J** - Rationalise are protecting organisation; protecting themselves/hide behind “THE ORGANISATION”; distancing from personal blame and accountability/can avoid introspection by blaming it onto organisation

12) **R&J** – Hide or spin the bad news to reassure the public, protect the NHS brand

13) That’s the way it is/you can’t do anything about it/that’s how it is/been told to do that

14) Can’t do anything about it; it’s what we have to do/**R&J** - directives; what going to do

15) Haven’t got a choice/we have to do it/ there is no option/there is no alternative

16) Unless person complains cannot do anything about it; forget it

17) Have to have system fair and applies to all; rational for ignoring concerns

18) **R&J** - Money and resources/anything to do with budgets/the bottom line, value for money, economic arguments; increasingly issue in English NHS over best interests of patients, staff

19) **R&J** - Meets needs not wants

20) No time/are busy people/too busy; rationalising, constructing some story about lots of really important things to do/very busy diary

21) Group rationalisation, to convince of rightness of action

22) Busy managers put problems in too difficult box

23) **R&J** – don’t want to get involved; nothing to do with me/never around when this happened

24) **R&J** – busy/got urgent appointment, trains going in 2 minutes

25) Not my job/role/nobodies told me to do that

26) Threat of litigation

27) HR; into ‘talent spotting’, promote people they like/’talent spotting’, that’s where we are, what we are doing

28) Need maverick managers to deal with wicked problems

29) Not lack of staff; bad skill mix

30) Managers switch it round; it’s your duty of care to patients not theirs/you are the staff nurse; it’s your responsibility/no duty of care to staff; it’s the responsibility of the TU

31) Rational for silence; best way to survive is to keep your head down/if things go wrong, not my fault, it’s theirs [senior managers]/**R&J** – too risky/if put head above parapet will get shot off like yours did

32) **R&J** – no point telling management, already know, aren’t doing anything

33) **R&J** - If blow the whistle will be blamed for failings trying to expose/record not unblemished, so just keep head down

34) Acted on the information at the time

35) Looking for own justifications; try to find evidence to justify end goal

36) People labelled as ‘trouble makers’/**R&J** - isolated as trouble makers
37) **Twist and turn**, try to find something to **nail person/twist things round, scraping for crumbs**

38) Bringing hospital into disrepute

39) Is business; should put feelings aside (compartmentalism)

40) Very difficult to prove, lots is hearsay; so never proved/evidence is patchy, easy to dismiss

41) Not allowed to bring anything anecdotal; only act if grievance

42) **R&J** – Justifying bullying and harassing behaviour not big problem; only percentage sent staff survey; not capturing whole organisation

43) **R&J** – Justification for ‘witch hunt’, not performing in manager role

44) When HR/managers make mistake, it’s OK/plausible

45) Protection of CEs; argument use are the accounting officer, **buck stops/modus operandi** for different treatment

46) Claim of ‘one off incidents’; becomes norm/bad apples, exceptions proving the rule of the ‘caring, selfless, dedicated’ NHS staff/**R&J** - rogue surgeon, like rogue trader; not the only one

47) Switch it round to the positive; NHS treat 99% patients very well/of course are some problems time to time

48) Sacking consultants; it makes sure others **toe the line**/have to show who is in charge, excuse

49) Wasn’t bullying, just incompetence not maliciousness; didn’t mean to do it

50) Staff survey figures on B&H high; include mostly non bullying related ‘conflict situations’/ ‘challenging behaviours’/figures not genuine bullying/**R&J** – Good management not bullying/stressed, so much work/it’s personality

51) Outcomes of investigations, ‘difficulties in communication’, ‘genuine distress’, not due to bullying

52) Wait for the staff survey results

53) Senior managers never admit justifications for actions not in best interest of patients; it is all good/talk about ‘working smarter’, ‘sweating the assets’

54) Way presents data, provides R&Js; not lying, truthful/ways of manipulating figures honestly/data is falsified

55) Nobody else is reporting this stuff

56) External reporting ; don’t put head above parapet, need to look ok

57) **R&J** – have to make cuts, cut our cost; economic imperative big one/rationale is cost saving; a **red herring**

58) **R&J** – Don’t have time, to meet or think

59) **R&J** - Got to be competitive; marketisation processes/need to be efficient

60) **R&J** - Got to be flexible; you must accept less pay

61) **R&J** - Lots of rebanding; all kinds of rationalisations

62) **R&J** - Difficult to counter rationalisations; overwhelming

63) **R&J** - It’s obvious we should be doing this/how could anyone complain we want to do it this way

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64) R&J – Claim enforced change works elsewhere (different circumstances, sectors so irrelevant)
65) Mid Staffs, wasn’t a big deal really; were elderly, would die anyway
66) R&J - Non NHS Employment Tribunal case; have come too far to reverse dismissal
67) R&J - Clinical decisions – making the best of a bad job
68) If powerful deep rooted belief, narrative, can present evidence til blue in the face; be denied or re-framed to exclude relevance of new evidence/desire to explain away problems, not confront
69) R&J – Patients unreasonable, unrealistic; blame the patients, first line of defence
70) R&J – Everybody else is doing it/that’s just how things are done around here
71) R&J – A fragile rationality; prey to false memories, cognitive biases, logical leaps/book “You are not so smart”
72) R&J – Slip into bad habits things not in best interest patients/underlings (feelings of guilt), complicit in bad practice, contaminated; slippery slope
73) It’s not the system that makes decisions, people make decisions/R&J - Lack of understanding organisation no power of itself, only entity; people in it
74) R&J – Can choose to behave professionally or badly
75) Begin to believe own rhetoric/propaganda; delude themselves
76) High pressure work environment, fosters culture hard work, commitment
Appendix 13. References to the culture of the NHS

Further to the gathering of the ‘3 word summary’ descriptions of culture a search was conducted on all the specific references in the Categories (Appendix 4) to the word ‘culture’. Some people described a positive culture; many did not. In the list the positive descriptions are detailed first. Many people referred to the fact that the culture needed to change, and change radically in a major way. A major overhaul was required. There needed to be a positive culture. Some expressed the opinion that the culture could change. Another said that to eradicate the endemic culture in NHS was a fantasy and that it would take a generation. One person however was of the view that the culture could actually change quickly if the right people were in place. Repeated exact phrases are not included. The statements represent data from all of the Framework Themes.

One person described culture as a “set of values and beliefs” which are “very, very powerful”.

A few people described a positive culture:

- Culture overwhelmingly concerned with patients and their wellbeing/focus on getting best for patients, sometimes to detriment of staff health and wellbeing
- Culture of continuous improvement and willingness to change
- Strong culture, good interpersonal process, good will, achieving work by developing good relationships with staff
- Strong culture of professionalism, evidence based practice amongst clinical staff.
- Good social support, peer relationships very much part NHS culture.

Many however described a negative culture:

- Horrible culture/plenty nightmare behaviour, bigger concern, culture; very centralised, controlling, hierarchical.
- Organisational culture bullying by top management/bullying culture within management, unlikely to challenge bullying culture within staff/bullying management culture/covert bullying culture from end to end/prevailing culture bullying, command and control leading to fear, insecurity and cover up/dominant, pervasive bullying culture conflicts with need to protect whistle blowers/prevailing culture bullying.
- Harassment and bullying sometimes very subtle; sadly, part of organisational culture.
- Reasons for negative behaviour, ill health to feeling vulnerable to outright bullying cultures in workplaces.
- Horrible centralising culture/culture at the top controlling, not liberating/top down culture/brutal reality of top down culture/nasty culture enforced by Whitehall/’do as I say’ culture/top down target culture/endemic top-down bullying culture in DOH suppresses constructive dissent/very top down driven by macho culture emanating from Whitehall
- Nothing done about negative behaviour, not unusual, because of culture
• Negative behaviour, either/both don’t notice it, so used to it/think it’s normal; never ask a goldfish for its opinion on water!/actively benefit from that culture!

• Good news culture, everything always has to be seen to be working, positive /Good news factory, like Iced cake syndrome, lovely on outside, mouldy on inside, part of culture led by government/culture; it’s how it looks; presentation/want to think everything fine, don’t want to hear anything going wrong; setting culture of organisation/culture: particularly senior managers ‘don’t want bad news’.

Some saw both positive and negative and recognised that the cultures were “enormously variable”: 

• Culture; some supportive, learning orientated, focussed on evidence based progression, sharing knowledge. Others dark, blame orientated, leaders not taking responsibility for poor decisions; blaming others.
• Bullying rife lots [of sectors] but can have good cultures, safe, supportive of new people, excellent bosses.
• Some cultures very hierarchical, some inclusive

Linked to the word of ‘culture’ words that indicate a widespread, engrained and potentially powerful problem with a great impact, were further considered.

1) Several people referred to the “prevailing culture”, also of a culture that filters down from the top:

• Prevailing culture; no accountability/holding people to account not part of current culture
• Sick culture/sick culture at the top filters down/unhealthy culture filters down from senior management to frontline/overall culture unhealthy a lot of organisations/prevailing culture unhealthy/failing organisations unhealthy culture more evident, extreme; few organisations where isn’t widespread/unhealthy general culture, environment in NHS.
• People suffering in organisations due to prevailing culture
• Poor quality of management, long standing issue/lack good quality leadership; reflects prevailing culture of organisation, management of organisation.

2) Fear pervades the NHS:

• Culture of fear/culture of fear pervades NHS and problems whistleblowers; pervades NHS management; managers look up not out/culture of fear of the management/growing fear culture; no longer feel secure/culture of fear, unsafe in hospitals, possibly general practice as well/culture of fear and arrogance in Trust/creating culture of fear; lack of openness.

3) A “common denominator”/*in common":
• Very defensive culture/many cultures; common denominator defensiveness
• In common....Culture; manager always right

4) A “deeply engrained malaise”:
• Lying culture/not culture of honesty/openness discouraged/culture of openness lost/ meant to be open whistle blowing culture, not really like that/deeply engrained malaise, culture of bullying and dishonesty/not open disclosure of problems, or culture of honesty

5) An “endemic top-down bullying culture”
• Endemic top-down bullying culture in DOH suppresses constructive dissent

6) “Overarching mind-set” and culture
• Rationalisations and justifications overarching culture; perhaps inevitable consequence of blame culture

7) “Cronyism is rife”
• Cronyism is rife senior levels, failure dealt with by redeployment or redundancy, seldom by acknowledgement, discipline or dismissal/leads to cynicism lower down ranks; reinforcing culture of not raising concerns.

8) A culture can permeate
• Labour into power; bullying culture began to permeate

Many people referred to the fact that the culture needed to change, and change radically in a major way. A major overhaul was required. There needed to be a positive culture. Some expressed the opinion that the culture could change. Another said that to eradicate the endemic culture in NHS was a fantasy and that it would take a generation. One person however was of the view that the culture could actually change quickly if the right people were in place.

List of references to culture

1. Culture is set of values and beliefs/culture is very, very powerful.
2. Culture overwhelmingly concerned with patients and their wellbeing/focus on getting best for patients, sometimes to detriment of staff health and wellbeing
3. Culture of continuous improvement and willingness to change
4. Strong culture, good interpersonal process, good will, achieving work by developing good relationships with staff
5. Strong culture of professionalism, evidence based practice amongst clinical staff.
6. Good social support, peer relationships very much part NHS culture.
7. High pressure work environment, fosters culture hard work, commitment
8. Achieved more personal, supportive, open organisational culture
9. Culture; enormously variable/mixed/many cultures; all affected by culture at the top/mini sub cultures/group specific/large units different/vary/multiple culture in organisation/different cultures, different organisations/individual pockets, islands, different culture/divergent/differs greatly
10. Want to believe underlying culture caring/supportive
11. Culture; some supportive, learning orientated, focussed on evidence based progression, sharing knowledge
12. Others dark, blame orientated, leaders not taking responsibility for poor decisions; blaming others.
13. Bullying rife lots [sectors] but can have good cultures, safe, supportive of new people, excellent bosses.
14. Some cultures very hierarchical, some inclusive
15. Culture; manager always right
16. Culture reflects dominance of Command and Control culture exhibited by DOH/ministers/effective action inhibited by C&C culture
17. Prevailing culture; no accountability/holding people to account not part of current culture
18. Enclosed; not open whistleblowing culture/very closed/insular, anti-diversity culture/culture of NHS; enclosed, head in sand.
19. Bastard culture; hybrid, parody on the original/turned our back, on original culture born of social solidarity second world war/progressively adopted commercial values, led to bastard culture.
20. Very defensive culture/many cultures, common denominator defensiveness
21. Culture, looking up not out
22. Institutionalised culture; just can’t turn that ship round
23. Horrible culture/plenty nightmare behaviour, bigger concern, culture; very centralised, controlling, hierarchical.
24. Like it or lump it culture
25. NHS relies on inspection culture to function
26. NHS machine bullying; report on culture
27. Organisational culture bullying by top management/bullying culture within management, unlikely to challenge bullying culture within staff/bullying management culture/covert bullying culture from end to end/prevailing culture bullying, command and control leading to fear, insecurity and cover up/dominant, pervasive bullying culture conflicts with need to protect whistleblowers/prevailing culture bullying.
28. Harassment and bullying sometimes very subtle; sadly, part of organisational culture.
29. Reasons for negative behaviour, ill health to feeling vulnerable to outright bullying cultures in workplaces.
30. Nothing done about negative behaviour, not unusual, because of culture
31. Negative behaviour, either/both don’t notice it, so used to it/think it’s normal; never ask a goldfish for its opinion on water! Actively benefit from that culture!
32. Very strong hierarchies in place through/across organisation/often create inappropriate environment more junior staff, unless target broader culture.
33. Horrible centralising culture/culture at the top controlling, not liberating/top down culture/brutal reality of top down culture/nasty culture enforced by Whitehall/’do as I say’ culture/top down target culture/endemic top-down
bullying culture in DOH suppresses constructive dissent/very top down driven by macho culture emanating from Whitehall

34. **Good news culture**, everything always has to be seen to be working, positive /**Good news factory**, like **iced cake syndrome, lovely on outside, mouldy on inside**, part of culture led by government/culture; it’s how it looks; presentation/want to think everything fine, don’t want to hear anything going wrong; setting culture of organisation/culture: particularly senior managers ‘don’t want bad news’.

35. Culture: tendency in large centralised organisational structures towards totalitarianism, way of getting things done.

36. **Sick culture/sick culture** at the top filters down/unhealthy culture filters down from senior management to frontline/overall culture unhealthy a lot of organisations/prevailing culture unhealthy/failing organisations unhealthy culture more evident, extreme; few organisations where isn’t widespread/unhealthy general culture, environment in NHS.

37. Culture of fear/culture of fear pervades NHS and problems whistleblowers; pervades NHS management; managers look up not out/culture of fear of the management/growing fear culture; no longer feel secure/culture of fear, unsafe in hospitals, possibly general practice as well/culture of fear and arrogance in Trust/creating culture of fear; lack of openness.

38. Lying culture/not culture of honesty/openness discouraged/culture of openness lost/ meant to be open whistle blowing culture, not really like that/deeply engrained malaise, culture of bullying and dishonesty/not open disclosure of problems, or culture of honesty.

39. Culture of not learning/culture of learning from mistakes lost

40. Homogenous NHS culture, recreates power bases, works against learning and change

41. Culture; not allowed to admit don’t know

42. Culture of uncertainty; rise in negative behaviours

43. Culture; just have to bury things/culture; mustn’t have bad news/deep culture of cover up bad news, maximum gloss/culture of cover up progresses/culture; keep the lid on/culture of NHS, thou shalt not break the golden rule, the golden rule is keep stum, don’t let it out; way culture, society works/culture of suppressing problems not acknowledging, addressing/organisations not listening, wanting to listen/culture, keep the lid on, don’t expose your dirty linen in public.

44. **Emperors clothes** drives culture of NHS

45. Denial, cover up, air brushed, complete denial, saying the right things; artefacts of culture/culture of trotting out stuff.

46. Culture; anyone speaking truth make group nervous

47. Regulatory authorities ignore culture

48. Goal driven culture; justifies means

49. Poor culture/very negative culture

50. Culture of blame; worst aspect/blame free culture not encouraged/culture of blame evident when something goes wrong/high blame culture/ no longer open communication, avoidance of blame culture/culture of blame immediate response

51. R&Js overarching culture/perhaps inevitable consequence of blame culture

52. Culture accumulative effect over years
53. Inevitable culture; SoS concerned with reputation and suppression of bad news/culture is not to embarrass the minister/NHS so political, failings reflects upon government; culture developed, mustn’t have any bad news.

54. Political nature of NHS results in centralising controlling culture/politically funded since 1948; centralising controlling culture more recent/Labour into power; bullying culture began to permeate

55. Culture of soviet style of political control/culture shift from delegated authority to central control

56. Culture; get on by never making a mistake can be pinned on you

57. Culture influenced heavily by tone and messages set at the top/culture starts at the top/led by culture at the top; comes from the top/culture set by the top table/top people, CEO, Chair, SHA, set tone, culture; responsible/top of organisation definitely culture of corporate bullying; corporate thuggery/culture of bullying starts at the top/senior managers, execs responsible for setting the culture/management set culture within which individuals operate/culture comes from the very top.

58. Management set culture within which individuals operate/way managers deal with or not, negative behaviour, further setting culture/manager has to take initiative, set the culture where everyone else operating/managers decide what is acceptable/message from organisation where just shunted people around, haven’t dealt with issue/allowed such a culture, for so long, very difficult to change/takes long period of time if swimming against that culture; seen as abnormal.

59. Do as I say, not do as I do culture

60. Creatures of habit, creatures of organisational cultures

61. Culture to kick researchers

62. Status and hierarchy important part of culture/culture hierarchical

63. Paternalistic culture

64. Current culture dictatorial, concerned with numbers targets and money, rather than clinical excellence

65. Senior people, lots of power and money, smooth talkers; contribute to culture

66. People suffering in organisations due to prevailing culture

67. Introducing powerful management structure in NHS, allowed tentacles of DOH to reach down into every organisation and control it; where horrible culture comes from.

68. Culture very much target driven, patient care, morale, wellbeing, training or workforce no longer matters/target driven, financial driven culture/top down target culture/targets have impact on organisational feel/current culture driven by financial constraints and targets, not what best for patients/more driven, business model imposed; purchaser and provider split; alien to culture and value system of people in NHS.

69. Culture; need to be efficient, cost effective.

70. Culture changed such a lot/changed last 10 years; target driven.

71. Required outcome/target aligns with culture of organisation; harmonious outcome, good achievement.

72. Where outcome does not align with cultural base; outcome and culture conflict; one tries to bend to meet the other/sometimes cultural norm wins, sometimes cultural norm starts to shift/interim point where clash; leads to turmoil.

73. Need knowledge of culture operate in.
74. *Culture attacked* by nature of relationship between staff side representatives and managers/strong underlying culture, of bullying of managers, where over strong staff side.
75. Elements of immaturity to culture of organisation/leaders.
76. [Scenario] Not outrageous is normal culture, acceptable; busy people
77. Dreadful culture of struggle, isolation and despair.
78. Older women, ethnic minorities excluded ignored; distressed about culture.
79. Poor quality of management, long standing issue/lack good quality leadership; reflects prevailing culture of organisation, management of organisation.
80. Combination of culture, don’t want to cause trouble; not sure, so don’t say anything/culture of not raising concerns reinforced, attitude of why bother; nothing will happen/culture stifles concerns, takes punitive action against those who raise them/culture suppresses raising concerns particularly when involves most senior managers.
81. Culture, if don’t give it a name, if don’t say X happening then it’s not happening.
82. Culture; some organisations might address [neg beh] others won’t.
83. ‘Because know where the bodies are buried’/histories between people, people know people, know stuff, know, got off with someone else’s wife; unofficial culture of organisation.
84. Relationships impact on culture
85. Divisive culture.
86. NHS; civil service culture many ways
87. Unreasonable, unrealistic expectation of delivery; culture have got
88. Don’t enjoy culture, cannot thrive, or break down in that sort of culture, move out/selective pressure, only ones who enjoy or thrive in environment, stay, become managers, move on *up hierarchy/self perpetuating dysfunctional system/survival of un-fittest/only those who like that culture/last four managers, career individuals/sometimes admit career came first/not there to decide, genuinely run things, just there to deliver/look up to tier above, not out to population serve, staff work for/maybe NHS wide phenomenon/people in post, learnt to behave, adapted for own survival purposes, to that culture
89. People, directors of trusts in post learnt to behave, adapted for own survival purposes, to culture; driven by self-preservation.
90. Cronyism is rife senior levels, failure dealt with by redeployment or redundancy, seldom by acknowledgement, discipline or dismissal/leads to cynicism lower down ranks; reinforcing culture of not raising concerns.
91. Can rely on policies/processes and fail to engage in organisation wide discussion about culture.
92. Significant time to effect culture/not to say cultures can’t change, be changed; requires lots of effort, intelligence/need something to *break the culture*; hasn’t always been like this/requires huge change in culture/culture of organisation needs to change/have to speak to people, this is culture, this is behaviour expect in team/need to break culture of denial and sham/exposure of horrible culture/requires cultural change; work place culture difficult to change/need no blame culture
93. Doesn’t take a long time to change cultures
94. Leaders change culture/behaviour change and supporting of positive behaviour/positive culture can only be driven from *the top*; must be role modelled by senior leaders/whilst individual negative behaviours must be
challenged where occur, only happen consistently where such a positive
culture/ manager takes responsibility; setting positive culture.
95. Establish culture early on, hold responsible for behaviour.
96. Now talking about culture, how tackle poor performance
97. To change culture - aims of Lansley's White Paper, not subsequent Bill,
implemented.
Appendix 14. What people don’t want

1) Don’t want clear analysis, critical piece of research; flags up problem, causes panic/don’t want evidence
2) Don’t want to hear/don’t want to hear the truth/hear what I have to say/hear it isn’t a success/hear results/targets; don’t want to hear not good service
3) Don’t want to hear; lack of respect for information going upwards.
4) Don’t want reality/the truth, through NHS, government; don’t want reality/don’t talk to people because don’t want to hear the truth.
5) Managers don’t want to know negative views, deviate from the party line
6) Whatever role, raising different concerns; don’t want to hear it
7) Don’t want to acknowledge are concerns, trying to hide it away; don’t want to hear it/worried negative behaviour in trust, don’t want acknowledgement.
8) Don’t want it in *black and white* behaviour is poor, not being addressed.
9) Don’t want to be responsible
10) Don’t want problems to think about
11) Senior managers, don’t want to deal with junior managers; reflects poorly on organisation
12) Don’t want anything to leak out
13) All conspire; don’t want to know/knowledge and information, tell them; don’t want to know
14) Don’t want to know anything/don’t want to know it goes on; *could snowball/anything untoward happening; like to let sleeping dogs lie*
15) Don’t want to know, not interested, don’t want to make changes or acknowledge results
16) Don’t want to know; then have to change things.
17) Big stigma, senior manager, accused of bullying; don’t want it, reject it, even if know happening, won’t accept it, goes back to de-escalation and how it looks.
18) Don’t want to give the game away
19) Don’t want to admit
20) Don’t want to create fear; losing confidence in NHS
21) Don’t want to listen to creating unsafe structure; don’t want to hear that, that’s *muddying the waters*, so shut it up silence it
22) Don’t want anything unpleasant reported up the line
23) Culture, particularly senior managers; don’t want bad news/don’t want bad press; wanting to block any bad publicity.
24) Don’t want to get involved; nothing to do with me
25) Don’t want to deal with difficult questions
26) Don’t want to show any part of the organisation *in a poor light*, being publicised; *burying the head in the sand*
27) Don’t want to look bad/don’t want any mud sticking to me; just don’t want to know/going to ‘reflect me in a bad light’; don’t want to look bad.
28) Don’t want seeming to be, not knowing what to do.
29) Don’t want to learn.
30) Don’t want to identify issues where need to change; can be improved.
31) Want to think everything fine, don’t want to hear anything going wrong; setting culture of organisation.
32) The ‘head in the sand’, don’t want to believe is happening; rather than bring it out into the open, rather bury it.
33) If listen are acknowledging problem needs investigation; don’t want it public.
34) Don’t want to stick head above parapet/don’t want to be the one raises it
35) Don’t want to spend time, money supporting staff; tight budgets, constantly saving money; lack of good practice.
36) [Reason for resisting action] Lazy, don’t want to do it; can’t be bothered
37) Frightened to stand up be counted. Cuts; don’t want ‘putting head above the parapet’, say ‘shoot me’. Look other way, pretend didn’t happen; don’t want to be tarred with it.
38) If speaking up, problems they flag, relate to policy, often do, don’t want to hear that.
39) If Labour introduced policy, have to show it’s a success because invested political energy demonstrating it to be success; don’t want to hear isn’t.
40) Combination of culture, don’t want to cause trouble; not sure, so don’t say anything.
41) People who get good care, don’t want to look too much, into what happens to other people.
42) No difference whatever role; not saying what want to hear; don’t want to hear it.
43) Don’t report anything negative; so safe. Don’t want to know; implications how seen on organisation.
44) Outsiders/outliers get told off. Don’t want to be seen outsiders. Key; it’s to be seen. Top to bottom; all about being seen.
45) Manager instantly try to de-escalate severity [of risk], too hard to address, or looks bad. Competition. Don’t want to hear it, anyone else to hear it, because looks bad on them.
46) Some SHAs don’t care how make financial balance, meet targets, just want to know are met; don’t want ‘bad news’.
Appendix 15. Underlying assumptions/beliefs in the NHS

Rationalisations and assumptions overlap. Possible assumptions/beliefs were highlighted in the course of the research

1) Managers are always right/tell the truth/know best
2) Staff are liars

These statements imply other assumptions that:

3) Non managers/staff are dishonest and managers are honest
4) Non managers don’t know what is best
5) Non managers are always wrong

Focus group 1

“If you raise a concern they then go and ask the manager and if a manager says it didn’t happen”

“Hasn’t happened”

“It hasn’t happened, so what are you complaining about? So I can only deduce from that, that we as staff are liars, and our managers always tell the truth!”

Interview 12

“That’s not a particularly easy question to answer because I think, though I have worked in 4 NHS organisations, and the cultures have all been different, um, some are very hierarchical, um, some have been more inclusive, um.......um.......but on the whole, if you were to take them all together what they have in common, um, is a culture of um.... If, if, a manager is wrong, or deals with situations badly, um, it takes a lot of work for the individual under that to prove that that’s been the case. Not describing this very well um, that it’s always the culture that the manager is always right. And that when people do raise concerns, they um, and sometimes with HR, they don’t get um, the support, um, often the situation’s investigated, but it’s never um, very rarely, as opposed to never, and it’s only when an individual manager or an individual in an organisation, that there is trend of different people complaining, um...do..um ...does any action take place.

Focus group 3

“And then there are others where they are detached, arrogant, paternalistic. They ‘know best’, um and they, and their work is characterised by failure to engage with staff at all levels. Um, and they drive their personal agenda through the operation of their trust”.
6) A manager serves the purpose/best interests of the organisation

Interview 12

R “Why do think there is the assumption that the manager is always right?”

“Because there is never. I think the evidence in my mind if you look at, remember cases I have witnessed myself. They…it’s always the individual that either leaves the organisation, as opposed to the manager. Um, often what the manager is trying to do, serves the purpose of the organisation…”

“Managers considered right, when I said this I was thinking how difficult it is to challenge a manager's action and get a positive outcome. I believe that this is because managers are seen as having the best interests of the organisation at heart therefore an individual has to prove "beyond reasonable doubt" that the manager is flawed in their thinking/assumptions. One has to be very strong to challenge this. I think in the past if somebody was experiencing problems at work they would move on, in today's climate this isn't always possible.

These statements fit with those that if a manager makes a mistake it is “OK or plausible” therefore justified.

Interview 16

“The disciplinary process has been a bias way of resolving staffing issues! Too much weight is given on punishment and they don't take a balance view! When they make mistakes i.e. HR or Management it's ok or plausible! But if you make a mistake rest assured you will be targeted! It's bullying pure and simple! It's about power, sadly!”

7) Pressure is good and produces hard work and commitment

One of the possible rationalisations implies that pressure is a good thing

Interview 43

“NHS organisations provide a high pressure work environment which fosters a culture of hard work and commitment”

One of the participants was critical of a number of assumptions made by the Ian Kennedy report relating to the Bristol Royal Infirmary deaths.
8) The NHS is there for the patients
9) All NHS staff are dedicated
10) Cultures take a long time to change

Interview 15

"IK is making the assumption that the NHS is for the patients!!!! That the NHS staff are "dedicated" - unconditional. His entire investigation demonstrated the opposite.

That cultures take a long time to change - they don’t; true leaders can change them overnight. Evidence of it every day. He talks about a jumbo jet of avoidable deaths per week - how many jumbo jets since his ignorant and complacent nonsense?

The conflict you cite is exactly the one which any culture change exercise on the front line has to start with. Politicians are scared of it, royal college leaders, GMC etc, etc, etc. The Nicholson machine needs that moral bankruptcy to prevent the train derailing at the points."

11) Public assumption; NHS there “solely to make them better”

Interview 15

“The citadel is a metaphor for the NHS - picking up on AJ Cronin’s title. Its primary purpose is to protect itself even though the public believe it is there solely to make them better.”

12) Increasing number of safety incidents reports is a good thing

Interview 15

“A fundamental misunderstanding by NRLS people and NHS and healthcare people generally of a statement on P.84 [An Organisation with a memory] I think led to ongoing increases in the numbers of incidents reported as a ‘good thing’, wrong!

R “What you said re increases being a 'good thing'. Do you think that was part of the justification/rationalisation process that they did that?

“I think it was just, and remains, a fundamental misunderstanding of safety issues.”
13) Nothing can be done

Interview 22

“Why isn't long standing bad behaviour tackled? I can suggest three reasons:

1) Organisational and managerial inertia and a belief that "nothing can be done". Tackling "bad behaviour" involves having difficult conversations and to some extent getting into subjective discussions about perceptions of behaviour”
Appendix 16. Observations on power and behaviour in the NHS

The following sections of text have been included as they reflect a number of the themes. They also provide interesting more subtle perspectives on behaviour within the NHS.

The first section of text considers two different forms of power in the workplace; legitimate/influence and power and informal power and sabotage. A manager’s “overly authoritative management style is blowing up in their face”, and people don’t want to follow them.

1) Focus group 5:

“I think totalitarianism also rises up in modern organisational life. It’s to do with having the power to define. What can be thought about, what can be talked about, what people can do. Through threats of exclusion, and worse, sacking.”

“Yeh, and I think that’s even the split within that, between the clinical side and the management side and I think it is becoming more that the management side have more power, whereas before it was like, it was more led by clinical thinking whereas I think now, it is more emphasis on the corporate approach and a management style that, and don’t know whether that makes sense. So that there is that, that they hold the power that the more corporate thinking. The management style has more power than the clinical side”

“The whole managerialist thing has a lot to answer for, hasn’t it?”

“Yeh, yeh,”

“I am not in any way disagreeing with -- and what he said, but there is another side to it which is I think, that managers, who are in fact insecure, often tend to act in ways which are over controlling.”

“Yes”

“To their own detriment and to the detriment of their staff. I think particularly inexperienced managers seriously underrate the power that their staff has. So, well I think it was something you said -- once about um, you can’t have followership without leadership. Because you can’t have leadership without followership. So you might think as a manager you hold the cards, and I suppose in terms of what you might call legitimate influence or legitimate power. You know because it is your role. On paper you can say right I want this and these are the targets, but your staff have to go along with it otherwise there are numerous informal ways that staff can stop things from happening every single day. And sometimes managers we end up working with are very distressed because it is their often, their overly authoritative management style is blowing up in their face. People don’t want to follow them”

“Sabotage things in different ways”

“People can go off sick, people can fall out with one another, gossip can be used in very destructive ways. Managers can like, not be invited to a bowling alley. I mean there’s
just, you know, people can leave dirty cups in the sink that need washing up, I mean, there are countless ways that”

“Yes”

“Everything can get disrupted”

“We also had someone photographs being defaced on her desk”

“Stolen

“Stolen”

“There was a manager whose had her photographs of her family members were stolen. It’s an informal way of saying, you are not so much in control of this situation as you think”

“Yeh, yeh, yeh”

The second section of text identifies what happens where the main priority of the senior managers is cutting the budget and how they seemed totally unconcerned about the impact and impervious to the needs of patients. There is an “unsafe madness”, a “dangerous madness”. There is conflict between the clinician and the managers and a sense of battle and of having to fight. The participant expressed much anger, frustration, and sadness. They consider that no one listens. The text also identifies that people can want to get out of clinical work and will perhaps do anything to achieve that ambition.

2) Interview 36

“Patients are...Not a static entity on a production line. They do things unusually, unexpected. They might break down and cry you might need to spend 20 minutes with them, saying how can we help you, what’s the problem?. You know, they might not be getting well, because there is something else they are worried about, that if you have just got the time to sit and talk to them, you might be able to get them out easier. You might be able to get them out of that hospital bed easier, if you have got time to find out what the problem was, and why they don’t want to go home. You know it’s all of those kind of examples really, that you can give, all of those.

I will give you another true story about cost savings. When I was a mid-wife, one night I did the ‘shift from hell’. And this was [date]. That’s how, that was the shift from hell. I was the bleep holder. We had got 15 women in labour. We’d got 4 midwives. 10 of them had epidurals. Do the maths! So I was trying to shut the unit down. It was a tri arrangement thing. The bleep holder, me, the head of midwifery and the consultant. Them two didn’t want to do it. I wanted to do it. Four o’clock in the morning when.. I had 4 women on the go. One delivered. I rushed to the operating theatre with another one. Another one delivered with somebody else. Another lady came out of the room and went --, my waters have just broken, slid down the wall and delivered the baby on the
floor. At that point I went mad, ok. But I managed to get through that shift, and I managed to get through the next shift, but then because I was the lay rep. I, in my possession came a piece... a memo from the finance director that says, and I quote ‘Due to fortuitous vacancies in the maternity we have managed to make a savings of 162,000 pounds this year.

I went ‘ape’. Can you imagine? Ape. And in fact, our chief executive, says, “Oh, this isn’t the place to bring it up” and I went ‘shut up and sit down because I am going to tell you this and you are not going to stop me’. 162,000 pounds, I said ‘somebody’s going to die and litigation costs are going to be a lot higher than that. But, who listens? I jump up and down, scream, I shout, I cry, I write letters, and I have been doing it for 12 years and who listens. I still feel very passionate about maternity services and it’s even worse now than it ever was.”

R “Mm, so coming back to these words um, you said about it’s?”

“Not just efficiency anymore it’s about madness, an unsafe madness. It’s a dangerous madness”.

R “But why have we got this situation? Why are people allowing these situations to happen?”

“I think it is multi factorial. One of the things, I think, is the problem is that clinicians invariably become managers. And one of the reasons clinicians become managers, one of the reasons is, they don’t want to be clinicians anymore. They don’t want to do the shifts. They want to move on and be a manager, so they ain’t going to do all the ‘getting your hands dirty’, and being ordered around by everybody else, and having to do crap shifts like Christmas day and night shifts. Ok, so that’s one of... They are not trained then. They all then, they don’t take ownership of the service and they just want to move on and want some innovative kind of change on their CV, for when they move on. The competitive element, that’s what I am talking about. But the innovative change, is for them, it’s not for the service. It’s to look good on their CV. Or look at us, we save loads of money, doing this. But they left behind ‘a crock’, do you know what I mean?

And I have seen it so many times over the years. I also think, you know, there is a lot of inefficiencies in the NHS, but not where the staffs concerned. It’s stupid things happening with the NHS. Most of it, is because half of it is privatised out, and the right hand don’t know what the left hands doing because there are all these private companies. It’s not run as a hospital anymore.

I think the other thing is, this is just my opinion. It’s too big. All these massive big trusts. You’ve lost it, the minute you get that big, you have lost the personal touch for both the patients and the staff. You have, no doubt about it. And also you are getting into that situation where people do silo work, cause it’s the only way you can deal with the monolith that you are working in. And then the left hand doesn’t know what the right hands doing. So things get duplicated and you know, it’s multi-factorial. I think it’s, there are a lot of problems, it’s not just one thing.”
The third section identifies some of the issues around relationships and how they might affect practice and responses to negative behaviour in the NHS.

3) Focus group 6

R “...there are people who had multiple complaints over multiple years, and nothing is done. You made a particular comment”

“I said, because they know where the bodies are buried”

R “Yeh, and I said what do you mean by that?” [L]

“And I said, because [L] in organisations where there is not a lot of movement there is plenty of histories between people. In somewhere like Scotland or other regions, or whatever, you know, people know people. They went to medical school together, they went to university together. They went to the same church, or whatever. [L] There is a history with people, and they know stuff”

“Yeh”

R “And, um, you are agreeing with this?” [L]

“Yes”

“And so, you know, sometimes they know bad behaviours by other people in the system. They'll know, well you know, they got off with someone else’s wife. Or there’ll be stuff going on, that’s, the unofficial culture of an organisation, um and that means sometimes people don’t have to go, or they are protected, or you know, they are tolerated, until perhaps they do something so outrageous, there is no going back. But, you know it’s still better for the organisation to have that person. There are lots of very opportune marriages between people, you know, that keeps them in quite well positioned, um places” [Much laughter]

“Deals are done.”

“Deals are done, I mean I don’t mean it is quite like the royal families and things, but deals are sort of done” [L]

R “Really?” [L]

“And, and um and people can stay, do stay in positions. You know they may take early retirement, or they might you know, go at some point. But they are not, they are not made an example of, because the view will be they have served ‘the system’”

“Yeh, yeh”

“And they have actually been overall good”
The fourth section covers some of the reasons for the “poor culture”

4) Interview 30

“I think there are probably a number of reasons for the poor culture. In a goal-driven culture, the end (goal) often is considered to justify the means, and that has (sic) part to play...as long as the goal is achieved, then a bit of lies and bullying is fine.

Where there are very senior people who get lots of power and like using it, and if they bring in lots of money, and if they are smooth talkers, then this can contribute to the culture. Often there are rogue doctors who do managers a favour and vice versa, so there is a form of nepotism that goes on.

Having terms such as 'chief executive' and '---' (as they have in --) does not help, as it reminds people that there is a hierarchy.

I have seen lies and bullying, and I have then seen attempts to cover this up with more lies. There is often passive bullying in the form of exclusion from meetings, staff being appointed without any consultation with relevant individuals. Money often talks and is the guiding principle rather than excellence in patient care...

But the whole culture has to change, and when people do whistle blow, and raise concerns, they shouldn’t be suppressed and regarded as troublemakers. The whole culture, the whole, the management system should be completely overhauled, completely overhauled...

On the one hand you get people like me who are trying to stand up and speak out, and get the sack and one thing and the other... Then the other side of it you have got managers who you know who behave obnoxiously and one or two doctors, and you get this balance. And in between there is this sea, and there is ‘a sea of silence’, right...

Edmond Burke, the only thing necessary for the triumph of evil

R “Yeh”

“Is for good men to do nothing”

R “Yeh”

“And so that is something which I think is probably arguably is just as important, is that why do these people stay silent? And obviously the very good reason is that they um they don’t want to get into trouble. They don’t..., they are looking after themselves. Oh well actually I like you and support you. And I got lots of support from people, but there was a limit to that. And nobody was going to, you know, go all the way to appear in an employment tribunal. One doctor was courageous to. And so there is this silence which is driven by fear largely, of their own jobs. In my own case the managers I know went to my staff and said on no account are you allowed to talk to --. But it was more of the senior consultants. One or two of them did write letters etc but with that ‘body of silence’ there.”

R “Yeh”
“Which is largely driven by fear”

R “Yeh”

“And that’s what does disappoint you is that uh that those people didn’t stand up and speak out. And in a sense they are the moral majority”

R “Yeh”

“They are decent hard working, doing a fantastic job at work and yet when it comes to the crunch they say well hold on. You know well, obviously everyone says what’s in it for me, but they also say well hold on, do I really want to risk the trouble? I know often the wives will say you don’t want to get involved, you know you don’t want to put yourself in the firing line, you just stay clear of it, you just stay quiet. And, and, obviously it’s difficult to make any [L] grand moral statement about that, but that’s something which obviously upset me from time to time.

And um, and you thought, um, what moral courage do people have when they don’t stand up and speak out? Now, chances are if they had stood up, spoken out it wouldn’t have made any difference. I mean whenever Kim Holt was sacked from Great Ormond Street. So I think, were there 1 or 2 thousand people wrote to the Department of Health saying that she should be reinstated at Great Ormond street, and the Department of Health ignored that.

So in fact [perhaps] 300 doctors wrote to the BMJ asking for her to be reinstated, and they ignored that too. So in fact, whether it made a difference I don’t know, but, but, you certainly, you certainly... I was, I found it quite upsetting that, especially the people in power, who could have... There were one of two senior doctors whom I think could have changed things. Even, in my case there was a chief executive and, who I got on quite well with, and they refused to come to my support. Which, I expected that, they are part of management really.”

R “Yeh”

“Got to expect that, but I actually did quite a bit of work for her, to help her. I met up with her several times and I actually supported her in quite a few things, but it was more the senior doctors that I had worked with, and um, etc, and um, in fact it was the boss of the bully, who bullied me, and he didn’t do anything. And I just felt you so, you feel a bit let down so. I think that’s, that’s the sort of silent negative force. You get the obvious aggression from the managers. You get very good support from one or two people. And I had a few people who were wonderful, came to my employment tribunals and gave me all the support and some would shed tears for me, which upset me more than anything else I think. But it’s that in the sense the silent aggression, silent, were these doctors, who should have had more courage and should speak out...

Well, that’s, the question of morality doesn’t come into it. There is no moral, ethical stand. That is what, that’s what upset me, probably more than anything else. I mean these are people who are supposed to be caring, supposed to have taken a sort of Hippocratic oath of sorts, and they are supposed to be, uh you know, supposed to be having the highest... supposed to be highly educated professional people. And where is their moral standards? And it was just ‘the end justifies the means”....

R “Mm”
“And don’t and um, and that’s something was... how do address that? I think that has to be addressed as well actually. You see I think those doctors have to be, those managers and doctors and what have you, have to be told look. At times like this we expect you to stand up and speak out. We don’t want you to be this silent majority, and obviously that requires a huge change of culture”

R “Mm, yeh”

“For that to happen. That’s the other thing is this silent majority who by their nature will often stay silent and won’t march and jump up and down and such, they’ve got a responsibility. And they have got to take a stand, especially when they see injustice you know. I look at it if you see somebody dying across the other side of the road, got knocked down by a car, do you say just hold on I’m just actually I’m busy going to the station, I’ve got a train to catch? I’m sorry I can’t. And that’s what, that’s the sort of attitude I got. Well actually, I don’t want to get involved, it’s nothing to do with me. This is actually, I was never around when this happened. And I am sorry you are bleeding to death, but I’ve got this very urgent appointment, and the trains going in 2 minutes”

R “Yeh”

“Um, sort of thing. So there is that sort of attitude which um, you know, it’s only when these situations arise do you see [L] people can behave in this way. God, if I was dying in the street would you walk past me? [L]”

This person also provided some explanation of why there is a good news factory operating in many trusts.

“I entirely agree that there is a 'good news factory' that operates in many Trusts.

My own explanation is a complex psychological one. As individuals, we are constantly - often unconsciously - obsessed with our self-image, not only how we look (lipstick on please), but how we are as a person to others, and what we think of ourselves. It is part of our survival instincts. A large part of our self is not only about eating and drinking to survive, but having a self that we are happy with. We will never admit to some things - poor sense of humour, bad driving, bad at assessing candidates in interviews or sexually inept. An intact, flourishing, praised-by-others self is more likely to survive, not only physically but also psychologically. So self matters, and by corollary, self-image also matters, and by corollary the image that others see of us also matters. So it is not a large jump to see that an organization also has a 'self' that has many of the parameters of the individual self, and so the image of that self matters. I suspect some psychotherapists have speculated on this...one called Maslow had a whole movement around the concept of self. There are probably other factors...importance of media these days, league tables, honours/awards for coming out on top, etc...”

“I think that I mentioned about this concept of self that you always, that you unconsciously carry around this self-image, and we do everything to portray it as being, as being good, and anything which harms this self-image, we automatically, uh, try to avoid or, or, or, a, a, oppose...
So we have got this self-image that we like to convince ourselves and portray to the outside world, and, and we, and if somebody comes along and tries to damage our self-image, or at least what we think is our self-image, and say things against us, then we would try to protect it. And we try to say, well, hold on, look, I am kind and honest etc., etc., and you are saying otherwise. And I think that then applies to an organisation that they have this self-image, and especially when you know you have got something as, as [...] especially when they have got, when by definition it is a high profile organisation”

R “Yeh”

“They have got this self-image and the way you...and they have got this wonderful slogan in [...]... at [...]...[slogan]..... As if, this is our way, sort of thing, here. Our way is the right way, and everybody else’s is the wrong way, so they have got this image, that we are the best and uh, we. And so if someone dents that image and says well actually you have [...] times more never events, these are serious reportable events, that should never, like operating on the wrong part of the body or leaving a swab behind”

R “Yeh”

“If something then happens, then they begin to go into a paranoid defensive state, oh that’s No, that can’t be... and then what they’ll do is everything possible to protect, so, I think....... They’re getting all these criticisms practically in the news every day. Another never event at [...] they were [...] times the national average, I think it was, and then so what they said was well. We will have to show we are actually very strict and very, and uh we don’t tolerate any.

So what they did, actually, they sacked... consultants,... over a minor clinical matter. As if to say that, these things were about in the news about us being an unsafe hospital. We are actually not an unsafe hospital, but actually ‘we are whiter than white’. And to show that this consultant who just [...]... we will give him the sack.

This shows you how good we are. And so there is this sort of thing that partly revolves around the self-image, but as you say, they should, they don’t think about basics. Hold on the basics is what is important for patient care? What is important for staff wellbeing, how can we be truthful and compassionate in our behaviour? And forget about our reputation. You know, cause, after that, the reputation will look after itself

R “Yeh”

“And, and, yet, no, no, and then there is this whole thing that I emphasise. If a clinical error takes place, there is a huge inquiry if there is a major error, there is apologies, compensation, and meetings. What lessons can be learned? When a management error takes place, it is just buried. It is totally ignored. No inquiry, nothing what so ever. No apology. The management error may be an unfair dismissal. We sacked this person by mistake, we shouldn’t have done that, but will they admit that? Or have they done wrong?

Never in a million years, even though the harm to patient care, they are spending hundreds of thousands of tax payer’s money, the stress to staff and their families. Even though that’s an error, let’s ignore that, and the people who did the management error, they get promoted. They... nothing happens to them. No accountability, no apology, no go on a training course or something like that. And so you have that huge double standards, but, but, as I say, going back to reputation, I think that is...
Largely around image and I say, we all carry an image of ourselves and organisations are sometimes as concerned. That’s why they have got a huge PR department. .. And they try to show what a wonderful thing they are. And they always have these high profile events where they proclaim themselves as being kind and generous and wonderful. They’re all concerned about this stuff because they know that to some extent the public, they are partly dependent on the public and the local MPS and people like that. Uh, so I think they try to manipulate the local media as well, I think, Obviously, I don’t have any proof of that. There is probably some of that going on as well indirectly”

R “Mm”

“So, but I think it is all to do with ‘the self’ and then it goes back to what, ‘the end justifies the means’. The end is that we have a good self-image and that we have come across well. If the means to getting that means that we break the law or we cause somebody to commit suicide, then well... what’s the problem?”

“Well, that’s, the question of morality doesn’t come into it. There is no moral, ethical stand. That is what, that’s what upset me, probably more than anything else. I mean these are people who are supposed to be caring, supposed to have taken a sort of Hippocratic Oath of sorts, and they are supposed to be, uh you know, supposed to be having the highest... supposed to be highly educated professional people. And where is their moral standards? And it was just ‘the end justifies the means’.”

In the fifth section of text the person described the different view of the organisation at the bottom compared to the view at the top; described as Orwell’s 1984 situation. Of the “...constant fabrication about how things are”, “...played out right across the system”.

People protect themselves from cognitive dissonance and behaviour can alter and adapt, maybe to survive. People resolve dissonance “...either by denying it”, “Or by leaving the job, or by having a nervous breakdown”.

There is a loss of values within the NHS, and dependency “...on being groomed by the ones above them”. A person achieved promotion. “...one minute she came in a cardigan and the next day she came in, in a cocktail dress”; a chameleon and “...almost value free”. “...they just take on the next thing that is required”.

5) Interview 21

R “One of my participants described the NHS in England as a ’good news factory”

“Yeh, I mean, I can understand that analysis, but I think it’s, I think there is a systemic dynamic going on. Um, occasionally it’s really interesting because obviously I have a very skewed picture of the organisation. There is no doubt about that. My job is not to hear good news, my job is to hear bad news I am --

R “Yes”
“And, but what that means is that people bring problems to talk about”

R “Yes”

“So I freely admit that I have a skewed picture of the organisation. How skewed I don’t know, um, but some of these stories are very pervasive. Um, but, but, so this is what I do every day is listen to these sort of stories. And then I hear like an announcement on the, on, you know, the internal internet saying something like, you know, I don’t know. Here’s the marvellous news about something or another in the organisation, and here’s how great it all is in down in ’so and so’ bit of the organisation. And it feels a bit like um, it is a long time since I have read it, but it feels a bit like, um is it 1984?”

R “Yes”

“Where, you know, no-one has got any bread to eat, and it’s all absolutely ghastly and they are drinking horrible you know, cheap you know spirits and God knows what, to keep, to keep their hopes up, and there is an announcement saying you know, it’s fantastic news the grain yields are up by a million percent this year. And it feels a bit like that sometimes. And you think well, you know, that isn’t how it feels to me and it doesn’t feel like that to lots of people that I am listening to everyday.

So it is quite interesting, but you know, you look at our politicians...um, so this is played out right across the system, if you look at our politicians. It’s sort of a fabrication isn’t it? A constant fabrication about how things are because that is, that’s how they are going to get elected again. And I think that gets played out. You know a politician who is honest is um...well if they can be honest and survive they have done bloody well. I think that people like -- and -- for example are unusual examples of that, and I think it is interesting when it happens”

R “Do you think it used to be like that?”

“I don’t know I mean, I cannot say, I, I, I, am doing a job now which has put me in this sort of situation in the organisation. One thing I would say, is that I, um, encourage people to take care of themselves, um, and one of, obviously that is my job. And one of the things which, um, I say also, to protect them, is to separate themselves out a little bit from the organisation. I think that there has been a long history in the NHS of staff feeling that the organisation will look after them, that they are, you know, that they wouldn’t call themselves corporate people, but they were certainly in the ‘NHS family’ and that they would be looked after.

And I see, sort of, in the last 10 years, that that has definitely changed and I consistently encourage people to take care of their own careers, take care of themselves. To separate out a little bit from the organisation. It’s a bit like in terms of a metaphor for me, it’s a bit like, if you are with a partner who has, um, betrayed you in some way, um, and ok you forgive them and you take them back, but it is never quite the same. And to protect yourself you just disengage emotionally from them a little bit. And I feel that’s what people have to do now.
And I think that is a loss to the organisation because the ‘good will’ which let’s face it, in people services, the ‘good will’ of staff, is what makes it all work. I think that is eroded now, because people won’t be prepared to give that extra bit anymore, because of how they are being treated. And I think that is normal behaviour? “

R “Mm”

“But it means that it actually costs the organisation, although they are trying to save money all over the place this erosion of ‘good will’ means that actually it is costing them, but you cannot measure it. And if you cannot measure it, and you cannot count it, it doesn’t count. And, you know, this soft stuff is very hard to, you know, very hard to track the actual pathway. Well, it is virtually impossible to do that. To track the pathway between, here’s the outcome, here’s what you did to cause the outcome, it is so complicated. That is my opinion” [L]

R “Mm, so I mean I know this is just guessing isn’t it? But how do they view the staff? You know, I sort of consider myself as an ordinary member of staff as a clinician. How do you think the senior management view us or people like us?”

“I think I am sure you are familiar with the term of cognitive dissonance”

R “Yeh”

“And I think in order to cope in these jobs they have to resolve that dissonance somehow, and each senior manager will have a different way of doing that. Some, some people will um, dismiss staff and lose respect for them because you know, that is the only way they can cope with it. Some people talk, some people have perhaps never been clinicians, so they don’t understand anyway, and so you almost have to have these layers, because if you do understand what the clinical work is like, it is very hard to do these senior management jobs because you know what the impact is going to be. You have to resolve that dissonance somehow. Either by denying it”

R “Yeh”

“Or by leaving the job [laughter] or by having a nervous breakdown” [L]

R “Yeh”

“And some people find it very hard to sustain. Some people say they put on a mask in order to cope with it. Um, some people um, have the sorts of personalities which it means that it doesn’t particularly affect them. They can just move on to the next thing. And you get an occasional senior manager or executive who understands fully, and who is also able to survive at a senior level.

And they are unusual, and I have complete respect for them. I am sure you have come across people like that yourself, and who really get it, and yet are able to, you know, survive at a senior level, and implement what is required with some integrity, and, but I do think it is very hard to do. And I think some people struggle with that dissonance. I think it is very, very, draining for some people.”
R “I mean, one of the things that I saw just in the, really in the year before I left. Suddenly one day, a colleague across the other side of the organisation described the managers as robots, and that they changed personality? And I actually saw that with, in our little community hospital. Because that was where I was based and it was almost, as if, because I had known her for years, as if the person I once had known, wasn’t there.”

“Mm mm”

R “And it was almost that as if she, this...she, sort of like... automat... wrong words, sorry."

[Laughter] “An automaton”

R “Yes” [Laughter]

“Yes I think that, if you view it as a change of behaviour. I mean this is another extreme metaphor, but if you think about people who had to do all sorts of things to survive in the, in the um, in the concentration camps during the war. I know it is an incredibly extreme example, um, but it is that type of thing. It is what do I have to do to survive around here? You know, I have got a mortgage, I have got a family. How do I do this?

The other thing that I, I, I know it is another extreme metaphor I know, but you understand what I am saying, but it is about reducing that dissonance. Whether they begin to believe what they are doing, I don’t know. I think that afterwards people really suffer because they recognise what they have had to do, if you see what I mean.

The other thing that we have noticed here which has been quite hilarious. There are people who are, because they don’t have any currency, they don’t have qualifications particularly, they don’t have, certainly not professional qualifications. They are totally dependent on being groomed by the ones above them, and being looked after by the ones above them. And we have had a local example of a young woman who came to the organisation. I don’t think she is a graduate, I think she may have A levels I don’t know, if that.

And somebody obviously was advising her and one day she came in, and we joke about it she came in, in a sort of cocktail dress, in heels, and this jacket and sort of all this.. and the next thing we knew she had been um, um, promoted. And I think that’s the sort of person that will be prepared to shed the previous life because, because there is a vested interest for her and she has got nothing else. Do you see what I mean?”

R “Yes”

“And I think those people are the most dangerous, those people are the ones who are most chameleon like, because they just take on the next thing that is required, and they’re almost, um, they are not bad people I’m sure, they are kind to their families and so on, but they are almost, at work, almost value free, and that is quite hard. Whereas for somebody, for example, you know, in my position who has had years of training and values and principles and all that kind of stuff, then everything that comes across my desk is viewed through that filter.
And I have the, you know, privilege, or the, I don’t know the, you know the responsibility to say actually, I won’t be doing that, because that doesn’t fit with my professional training and my standards. Um, and a lot of people don’t have that, so it is interesting watching it playing out. I will be interested to see how this young woman gets on, but it was hilarious watching because one minute she came in a cardigan and the next day she came in, in a cocktail dress [L of L] and I thought, ‘Oh hello, [L of L] what is going on here, kind of thing?’

R  "Interesting isn’t it?"

"Mm, it is, yes"

R  "I mean when I actually left I mean, well, getting like you watching with horror actually, as I saw various things being played out in the organisation. And the biggest concern I have, that it was like it had become a moral vacuum"

"Yes, yes, I think that it is one way of understanding it. I think, I think my, my sort of discourse or narrative on this is, is always, these aren’t by and large bad people, um, however, sometimes it does look like, they don’t get it. And I think for my, for my own, to be able to do my job, I totally focus on people’s behaviour, rather than personality. Of course you get one or two people who are, you know are [L] borderline, um, but mostly...I have to ask myself how would I be in that position? I don’t know. I don’t know the answer to that"

R  "Mm"

"There are some decent people out there, I know one or two people who are in very senior positions who have good values. And try to do their best in a nightmare situation really”

The sixth section considers the nature of bureaucracy where you are “…rewarded for taking good news to your boss”.

6) Interview 38

R  “One of my research participants described the NHS as a “good news factory”. I shared this with another participant who had described the NHS as wanting to hide bad news. He responded that he would call it a ‘stopping bad news factory’. Any thoughts around this you could add from your experience/thinking?”

“Well, this is the nature of bureaucracy. You are rewarded for taking good news to your boss. If you take bad news to your boss you get seen as “negative”, “not a go-getter” etc, etc. Now, of course, the best way not to have to take bad news to your boss is to make sure your underlings don’t bring you bad news. And you do that by not dealing with their problems, or dealing with them slowly, in a cack-handed manner (effortless for many
people, truth be told). And you personalise it (“well, no-one else has ever complained about the person you’re complaining about. Are you sure it isn’t just a personality clash that YOU have?”). And you lose the paperwork, and you cancel and reschedule meetings until people just give up, and learn not to bother bringing you problems. And you can then say to your boss “no-one seems unhappy.” Then, even if it does all come out at a later date, you can act all injured, “well, no-one came to me. If they had, I would certainly have acted on it...” This is just the way bureaucracies work, hierarchies work.

I would suggest having a look at the causes of the Challenger (1986) disaster for evidence of how the people trying to raise problems at the coalface are over-ridden and ignored. Also, the work of Atul Gawande on organisational behaviour (Better, Complications). The “human factors” literature is kinda interesting too (a lot of it around cockpit communication).

The seventh section of text describes the person’s lack of respect for management and again how behaviour can change. Managers if they want to prosper have to “...join the corporate line”. “...they sometimes begin to believe their own rhetoric” and the propaganda. They believe “...there is no alternative” so they actually delude themselves. Management did not want to listen to clinical concerns and patients are not their first priority.”

7) Interview 42

“But, in the last 10 years I was basically doing [-] and I found it riddled throughout. It was quite clear that you know not all clinical staff are goodies, some of them were at the root of some of the problems, but by and large, the problems were that management did not want to listen to clinical concerns and for all the rhetoric, actually, as you said their primary concern was not patients. I mean, I have since I am on my soap box a view that every chief exec, or senior manager who stands in front of the television cameras and says patient safety is our first concern should be put in the stocks and paulted with rotten eggs [L] because it is a lie”

R [L] “Yes”

“It is a lie [L] and I’m afraid that I, I do not have overall much respect for managers in the health service. As I say I’m afraid to say that I think that whatever they came into the service with, most of them, um, either give up and get out because they can’t cope with it or perhaps try and move sideways into some area where they are less exposed to the worst of it. But otherwise if they want to prosper, they just join the corporate line. And they repeat endlessly about patients being their first priority, whereas in huge swathes of what they do, it is quite apparent that it is not right”

R “How do they live with themselves?”

“Uh, well, I’m afraid I think like, uh, a lot of people, they sometimes begin to believe their own rhetoric. That was one of the things that we quite often found in chief execs of trusts where appalling things have happened. That they would say when you interviewed them some extraordinary thing about what they had done and so on, and then we,
because we would by then, have been in and out of the trust for 6 months and had done loads of analysis would flatly contradict what they would say, and they would stare at us in horror, because they are used to not being questioned.

Their word is accepted and I think some of them, maybe a lot of them, begin to believe the, the propaganda really. I think they, you know, I think they ‘there is no alternative’, so they actually delude themselves. Some of them aren’t very clever in the first place so, you know. Maybe they genuinely don’t understand the effects of it, others I think, know perfectly well, but as I say, carry on regardless really”

R “Yes”

“Um, it’s depressing isn’t it?”