Meeting title:	Public Trust Board Meeting				**Public Trust Board paper L**	
Date of the meeting:	9 February 2023					
Title:	BAPIO Collaboration					
Report presented by:	Clare Teeney – Chief People Officer					
Report written by:	Clare Teeney – Chief People Officer					
Action – this paper is for:	Decision/Approval	x	Assurance	x	Update	

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The proposals in this paper will have a positive impact on the strategic objective for People and Culture. This objective describes that we aim to; look after our people, develop workforce capacity and capability and a compassionate and inclusive culture. The lack of workforce capacity and capability is a significant risk for the NHS and UHL is no different. The proposals in this paper will help to mitigate the impact of the following risks: - Failure to attract a diverse workforce - Failure to implement an agile workforce - Failure to build a compassionate culture - Failure to recruit, retain redesign and transform the workforce

What is the impact on:	
Patients	Improved staff engagement leads to better patient care
Workforce	Improved morale, staff engagement and staff experience
Equality and Diversity	An improvement in the inclusivity of culture. Improved WRES and WDES compliance and compliance with the EDS.
Services	Improved People Services that directly impact on operational services and effective partnership working
Finance	Improved workforce efficiency and effectiveness
Regulation/Legal	Improved statutory compliance

Acronyms used: These will be explained throughout the report.

Purpose of the report:
The report describes and recommends that UHL works in partnership with BAPIO (British Association of Physicians of Indian Origin) to: - Support workforce transformation and contribute towards building a sustainable workforce for the future - Support strategically building UHL as an exemplar organisation for international colleagues - Build an effective partnership with BAPIO and its associated organisations - Improve the culture and inclusivity at UHL - Enhance the experience of overseas colleagues working at UHL and to ensure that this is equitable - Support our overall objectives of being a great place to work and to receive care -
Summary:
We are a significant employer within our local economy with responsibilities for social and economic growth, population health and environmental and cultural issues. We aim to consistently provide safe effective patient care and to be an inclusive employer of choice, and we know that our civic responsibilities associated with this have wider meaning and impact on the communities we serve. To fulfil these aims we know we have to achieve many things and promoting good inclusive employment is significant in this. In terms of our current position we know that we have caring and compassionate colleagues who are committed to the patients they serve. The majority of our 18,000 workforce live locally. We have a diverse workforce and a diverse community. We have a number of international colleagues working with us who often relocate with their families. We have a risk in terms of workforce capacity capability, with too many vacancies and in some areas high turnover. This affects patient experience, staff experience and health and wellbeing. The experience of our colleagues is variable and inequitable both in terms of conditions of employment and experience. This is reinforced by the feedback from the national staff survey and the WRES and WDES indicators. Levelling up is something we owe to our colleagues and communities and we believe that working in partnership we can and will do better. This paper sets out proposals to work in partnership with the British Association of Physicians for Indian Origin (BAPIO). We believe that this partnership will help us address some of the issues identified above.
Main report detail:
BAPIO was established in 1996 with the initial aim of supporting international medical graduates. Since that time it has grown in membership, focus and influence. BAPIO work in conjunction with a number of healthcare organisations. It has 13 regional divisions and a number of associated organisations including a training academy and an institute for

health research. BAPIO is an organisation that actively promotes the diversity equality and inclusion of all healthcare professionals.

Within UHL we know that we need to improve the capacity and capability of our workforce, the inclusivity and equity of experience and level up terms and conditions. To do this well we will need to work in partnership with a number of other organisations and we would recommend BAPIO as one of these. The organisation has a shared set of values and commitments. It also has experience and expertise that will support us in some of the work that we need to do.

This report sets out three recommendations to take forward.

1. Memorandum of Understanding

To underpin our commitment to working in partnership we recommend that we commit to a Memorandum of Understanding. This is non legally binding agreement. It does demonstrate a commitment to working together. The Executive Team and People and Culture Sub Committee are supportive of a commitment to an MoU.

2. Dignity at Work Standards

These standards have been developed in response to some of the experiences of incivility, discrimination, bullying and harassment that we know exist in our workplaces. The standards provide a framework for organisations to work to. The standards will give more visibility and transparency to the experiences of colleagues at work and provide a framework for improvement and oversight of impact. Following a summit hosted by the Royal College of Surgeons in October 2022 we have the opportunity to participate in a pilot of the standards. The other organisations included in the pilot are: Kings College Hospital NHS Foundation Trust and St Georges and Epson and St Helier University Hospitals. The pilot is supported by other organisations including Health Education England. We believe that participating in the pilot is timely for us, that we will learn a lot and it will provide us with a framework for the work that know we need to do. The opportunity to work with other organisations and learn will be of significant benefit to us. The pilot is due to commence in April 2023 and to run for one year.
The Executive Team and People and Culture Sub Committee are supportive of UHL participating in the Dignity at Work Standards Pilot.

3. Charter for Locally Employed Doctors

Locally employed doctors (LED) are a diverse and heterogenous group of doctors whose core function is to deliver health care (often described as service provision) in partnership with consultants, doctors in training, specialty doctors and other healthcare professionals. The majority of LED's undertake their primary training overseas. LED's cover many contracts and job titles. Within UHL our data and understanding of this needs to improve.

The work that LED's undertake is vital in supporting patient care. We know however that our employment offer isn't consistent with that of other doctors in training and other employees. Developing a support programme for the SAS and LED groups will enhance their professional development, allow for talent recognition and level the playing field.

We need to significantly improve in this area. Recent reports including those from the GMC have highlighted that if current trends continue Staff, Associate and Specialist (SAS) and LED's will be the largest medical workforce group on the register by 2030. If we do not improve the training and experience of our colleagues this will have a significant impact on patient care, social and economic growth, population health and environmental and cultural issues. It will also mean we have ongoing employment issues, capacity and capability risks and inequality of experience.
BAPIO have developed an LED Charter which outlines how improvements can be made in the experience of LED's.
The GMC also have a charter for LED's. The BAPIO charter is ambitious, and some parts we will find difficult and challenging. We do not believe this should prevent us working towards the charter and we believe we should be ambitious for our LED workforce. We will also benchmark ourselves against the GMC Charter.
The Executive Team and People and Culture sub committee recommend that we work towards the BAPIO Charter.

Recommendation/s:

The Board of Directors are recommended to support the:

- Collaboration with BAPIO
- Participation of UHL in the pilot of the Dignity and Work Standards
- Work required in adopting LED Charter

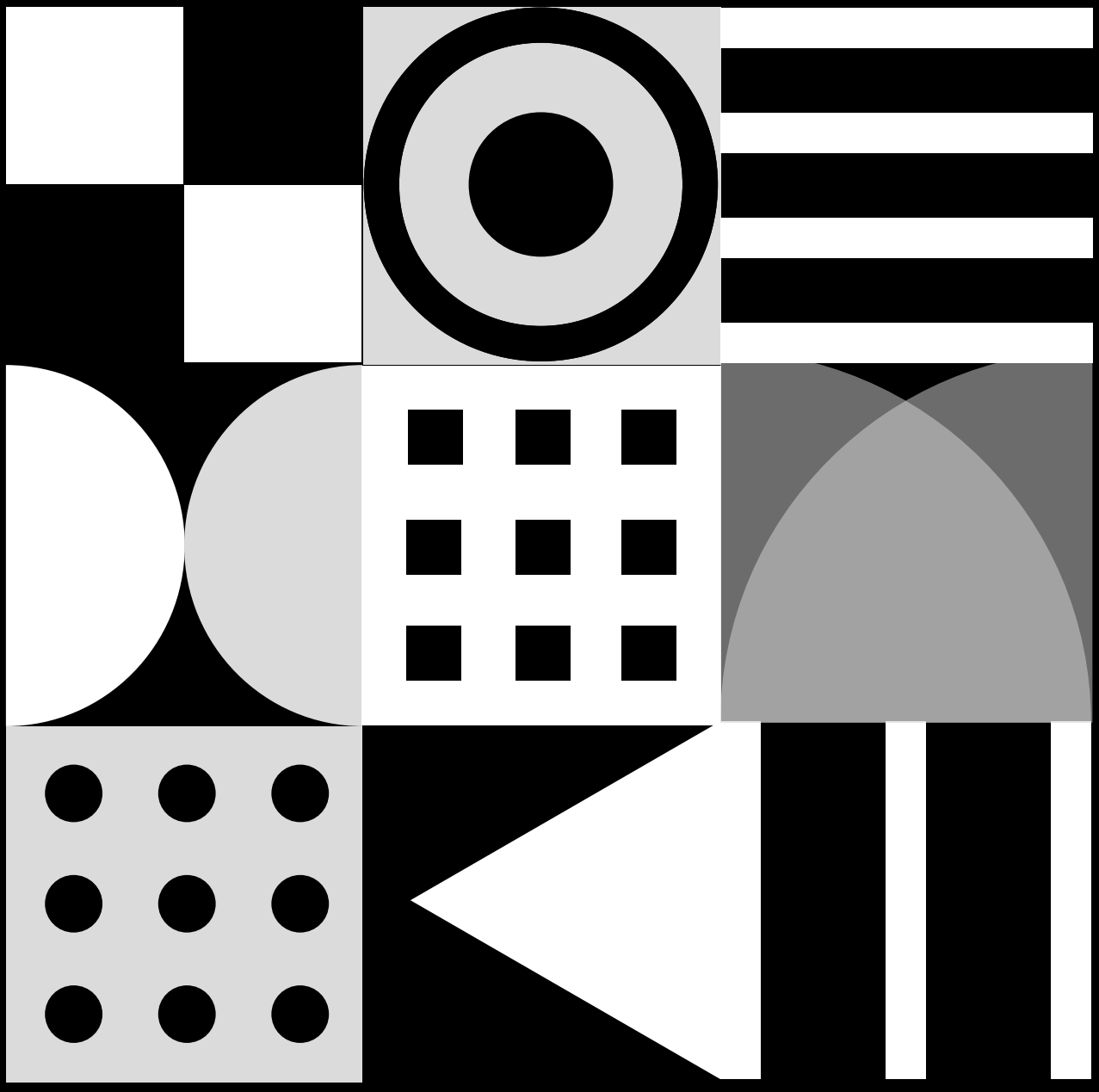
Supporting documentation:

Dignity at Work Standards (both documents are available in the BI reading room for Trust Board members)
LED Charter

A BAPIO BIHR NATIONAL CONFERENCE

DIGNITY at work consensus STANDARDS

15 January 2022



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Dignity@Work Standards

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March | 2022

BAPIO Institute for Health Research

It comes down to the way you treat people.
When you treat people with dignity and respect,
you can work through anything.

John Bacon

From the President

'I am delighted that we are producing another constructive piece of work to improve the work environment and organisational culture that leads in turn to efficient and safe care. We know the implementation of the standards will require genuine commitment from all of you.'

In 2021, BAPIO celebrated its silver jubilee and we are proud to have contributed to excellence in patient care, supported our members in being inspirational leaders as well as creating a supportive environment for health and wellbeing. Throughout our history we have stood for our values of equality, diversity and inclusion of not only black and minority ethnic professionals but for all groups who have faced differential outcomes in society. Our membership are accessible to all who wish to be part of the mission. We have always fostered collaborative relationships with the NHS, Medical Royal Colleges, academic partners and all voluntary organisations such as Medical Womens Federation. We formed the **Alliance for Equality in Healthcare Professions** in 2020, with over 50 voluntary healthcare organisations. With our regional chapters, forums, arms-length bodies we support excellence in education, leadership, research and publication in science and healthcare policy across the UK and globally.

Listening to our members, we are acutely aware of the widespread issue of structural inequalities, bias and discrimination that exists in society. The issue of bullying and harassment faced by many healthcare staff stems from such inequalities, which have been compounded during the last 2 years of the pandemic. We are concerned that although all the organisations have policies for dignity at work, most of the time it stays on paper, and a large proportion of staff suffer incivility in silence and fear. A recent survey conducted by BAPIO showed the scale of bullying and harassment to be much larger in staff with certain protected characteristics (based on their gender, race, ethnicity, religion and disability). Such toxic workplaces have a significant negative impact on the productivity, health of staff, and an estimated cost to the UK economy of up to £14 billion per year.

It is interesting that there are no nationally accepted standards to evaluate the efficacy of policies for dignity at work. Therefore we decided to review the literature and work on developing consensus standards for dignity at work. Following our experience of working with all the stakeholders while we developed the "Bridging the Gap" report, we engaged with the members of the Alliance and relevant stakeholders to this conference to build consensus for Dignity@Work Standards.

I am grateful to our team at the BAPIO Institute for Health Research (BIHR), very efficiently led by Prof Indranil Chakravorty for the incredible hard work they have put in to develop the draft standards. Thanks also to Dr. Cherian George, who has been a star organiser of the conference. I am delighted that we are producing another constructive piece of work to improve the work environment and organisational culture that leads in turn to efficient and safe care. We know the implementation of the standards will require commitment from all of you.

Ramesh Mehta OBE
Jan 2022


senior leadership position
chief executive
many doctor
little bit
nh employer
role of regulator
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important things
culture
compassionate leadership
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second point
everybody
questions
professional regulator
many people
good morning
mental illness
staff engagement
great pleasure
ethnic minority doctor

Executive Summary

BAPIO (British Association of Physicians of Indian Origin) as an organisation actively promotes the diversity, equality and inclusion of all healthcare professionals. As an organisation which encompasses a majority of ethnic minority members, we hear the unfortunate experiences of bullying, harassment and discrimination that takes place in numerous healthcare settings within the UK. In response to these lived experiences, a committee was appointed to establish a set of standards, to foster dignity within the workplace, using the large body of literature documents available.

The ambition of this project is to advocate and advertise for an environment that is free from bullying and harassment and to adopt a zero tolerance policy towards bullying or harassment. We aim to do this by developing, implementing, and evaluating our **Dignity@Work Standards.**
The Standards constitutes of 8 different domains for all healthcare professionals including managerial members to adopt in clinical practice. These domains include:

1. **Environment & Culture** - ensuring the workplace environment remains a safe place for professionals to raise concerns, be treated fairly and one with dignity for all.
2. **Cultural Intelligence** - acknowledging and raising awareness of the impacts of culture and diversity on dignity and accounting for intersectionality in the workplace.
3. **Organisational Interventions** - highlighting the role of the organisation in accommodating the appropriate resources to eradicate behaviours of bullying and harassment.
4. **Communication & Interactions** - encouraging respectful interactions between staff and creating a safe workplace to communicate any workplace issues.
5. **Monitoring & Accountability** - adopting a collaborative approach to routinely monitor the standards of behaviour in the workplace and being held accountable for any failures
6. **Metrics** - collection of data from the workforce to be able to understand the lived experiences of the workplace.
7. **Concerns & Grievances** - having a transparent process to raise concerns and ensuring the same process is applied to all members of staff.
8. **Support** - provision of the appropriate support for all staff that are a victim of bullying and harassment.

Our preliminary vision of the Standards is to create a document that defines the gold standard for dignity in the workplace. The Standards incorporates the diversity of the workforce and ensures consideration is given to the intersectionality of already known determinants of bullying and harassment within the workplace.

The COVID-19 pandemic has created increased pressure on the workforce of the National Health Service and with this pressure has come unacceptable working standards, inappropriate behaviour within staff, increasing reports of bullying and harassment and more staff leaving the NHS than ever before. It is therefore crucial to act now in order to eradicate bullying and harassment within the healthcare setting.

We know and appreciate that collaboration is the cornerstone to progress and we encourage working with core leaders within the UK healthcare system to create this change. Together we will deliver.

INTRODUCTION

There is a high level of incivility prevalent in healthcare organisations. These organisations should theoretically be run by empathic, caring, high achieving, highly trained staff working in scientific and technologically advanced - complex systems. Most healthcare environments are high stakes, high risk, emotionally challenging workplaces. This highly charged environment, when combined with high workload and the imbalance between resources and demand, creates a toxic soup, where incivility prevails. Predictors of incivility also include challenges in communication or coordination, safety concerns, lack of support and ineffective leadership.[1]

Incivility is manifested and perceived in various acts and interactions from the covert to overt. It affects all, but some more than others.[2] Year after year, staff surveys report high levels of disrespect, microaggressions, bullying and harassment.[3] The experiences of minority ethnic groups (especially migrant workers) and those with protected characteristics [4] are much worse.

The phenomenon of intersectionality [5] determines how interrelated systems of social, economic and political imbalance manifest to uniquely and differentially shape the lived experiences of people in intersectional social positions of race, ethnicity, gender, age, disability etc. The differential impact of intersectionality is poorly measured, and hence the compound damage to individuals with multiple protected characteristics are grossly under-recognised. [6]

In healthcare, individuals with varying levels of autonomy, experience, expertise and behaviours interact at several levels to deliver outcomes for patients and the community. However, despite volumes of policies, standard operating procedures and guidelines, there is significant variability in practice at all levels, in large organisations, as demonstrated in staff surveys.

One of the earliest determinants of outcomes in healthcare settings is the 'human factor'. Healthcare brings together high achieving, ambitious individuals who are naturally protective of their autonomy, territory and self-governance, therefore increasing the chances of conflict. Imposition of extrinsic standardisation of 'practice' also leads to stress.

Regulators are often responsible for inadvertently introducing a culture of blame and via punitive measures which prevent open admission of human errors and learning from them. Wheras associating quality of work with dignity, job satisfaction, career progression offers a better model and vision of a fair, just and mutually constitutive society.[7]

Over the last two decades there have been several initiatives to tackle incivility. The cost to both the affected workforce and the public at the receiving end of healthcare, is also high [8]. Recruitment and retention of a happy, contented [9] and engaged workforce remains one of the most important rate-limiting steps in achieving health for all. Although the funding models of healthcare are very different in systems which are either fully or partially state-funded versus those that are funded by private enterprise (often major corporations), the challenges of human error and adverse human interactions are quite similar.

It is the aspiration of system thinkers that healthcare organisations can be transformed to high reliability organisations (HRO) which are responsive, safe, and caring - with patients at their centre. HROs that are run by staff who are fully aware of their roles and responsibilities, who interact with mutual respect, have transparency of process and decisions, and are empowered to learn with a shared vision of excellence, as well as an ambition for continual improvement.

HROs minimise errors through a just culture, mindful and inclusive leadership, teamwork, awareness of potential risk, anticipatory thinking, a blameless learning environment and a cycle of constant improvement.[10]

It is widely accepted that healthcare is complex, with the potential to fail in new and unexpected ways. However, to view near misses as opportunities to improve, to value insights from frontline staff with the most pertinent safety knowledge over those with greater seniority, and prioritising training for possible system failures are critical for success. [11] There are no extrinsic processes or guidelines that can create such an organisation- HROs are best developed by internally managed evolution.

Interventions aimed at promoting civility and respect in the workplace help to prevent co-worker incivility, work-related exhaustion, and enhance organisational efficiency. [12]

Co-creating a culture of respect with frontline staff is an essential step in a health care organisation's journey to becoming an HRO. A culture which provides a supportive and nurturing environment and a workplace that enables staff to engage wholeheartedly in their work. Institutions require to develop effective methods for responding to disrespectful behaviour while also initiating the cultural changes needed to prevent them from occurring. Leaders must create the preconditions for change, establish and enforce balanced policies, enable worker engagement, and facilitate the creation of a safe learning environment.[13]

The price of incivility is huge and manifests in adverse outcomes for patients, staff and for the organisation.[2]

Staff perceiving equal access to opportunities are strongly motivated, while aggression and discrimination leads to demoralisation and poor performance.

Better workplace environments were positively linked to lower levels of absenteeism and greater patient/ client satisfaction. [14] A study in 2018, conservatively estimated incivility to cost the UK taxpayer £2.281 billion pounds per annum. [15] This did not include the cost to the healthcare service user or society. The societal cost of incivility in the UK is estimated to be around £14 billion per annum.

Policy vs Standards

Every organisation has policies as part of its regulatory obligations. [16] While the scope of a policy tends to be broad, high-level statement of intent, guidelines [17], are used as a framework for action.

- A policy outlines the requirements or rules that must be met, refers to standards or guidelines as the basis for their existence.
- A standard is a set of requirements, typically system specific, that must be adhered to by everyone.
- A guideline is similar to a standard, but it differs in that unlike a standard, a guideline is merely a recommendation or suggestion that should probably be followed but is not necessarily required.
- A procedure defines the process that is followed to meet the requirements of a policy, standard, or guideline. The scope of a procedure is the specific step-by-step processes and procedures that should be followed for implementing a given standard or guideline. [18]

Tackling bullying & harassment in the NHS

19% of staff experienced bullying or harassment in the last year from colleagues.[1]

13% of staff experienced bullying or harassment in the last year from their manager.[1]

98% of staff experienced incivility in the workplace.[4]

Staff who see incivility have a **20%** decrease in their performance and a **50%** decrease in wanting to help others.[5]

Disproportionate impact

- BME staff are more likely to experience bullying or harassment.[1]
- 26.6% of disabled staff reported bullying or harassment in the last year.[1]
- Bisexual and gay staff are more likely to experience bullying or harassment than heterosexual staff.[1]

Costs to the NHS

- Toxic behaviour costs the NHS more than £2bn a year.[3]
- If bullied NHS workers left their jobs, it would mean a loss of 42,681 staff.[3]
- The cost of replacing those staff would be £231.9m.[3]
- Sickness presenteeism due to bullying costs £604.4m a year.[3]

What is the impact?

On the organisation

- Greater risk of human error[2]
- Poorer patient care
- Reduced productivity
- Low morale
- Increased absenteeism
- Reduced teamwork[4]

On the individual

- Anxiety and depression
- Disengagement and isolation
- Reduced confidence[4]
- Take the feelings home with you[4]

What can my organisation do?

- Create policies to develop and promote a positive culture.
- Appoint a leader to work with your freedom to speak up guardian.
- Monitor organisational data to identify patterns to target interventions.[6]

What can my manager do?

- Identify early warning signs and challenge inappropriate behaviours.
- Respond quickly to complaints and issues.
- Engage and involve trade unions colleagues.[7]
- Provide training on inappropriate behaviour and its impact.[6]

What can I do?

- Ask the individual to stop.
- Speak to your manager, senior colleague and/or union rep.
- Keep a record of the incidents.
- Speak up when you see staff treated unkindly.
- Report the incident to your freedom to speak up guardian.

1. NHS Staff Survey, 2018
2. Workplace bullying in emergency nursing: Development of a grounded theory using situational analysis. [Wolf et al, 2017] Bullying in the Healthcare Industry [Dalton, 2016]
3. The price of fear: Estimating the financial cost of bullying and harassment to the NHS in England [Kline and Lewis, 2018]
4. Make or Break: Incivility in the workplace ESTH 2019, https://www.youtube.com/watch?v=S1EDatTYMkE
6. Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision-making in the NHS, Illing et al, [February 2013].
7. Creating a culture of civility, compassion and respect in the NHS, 2018, Social Partnership Forum

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HEALTH, SAFETY AND WELLBEING PARTNERSHIP GROUP

NHS Employers
Part of the NHS Confederation

INCIVILITY

Determinants

There is a broad agreement among the various existing policies on incivility or bullying and harassment (B&H) in the NHS (and other organisations), setting out an escalating set of steps. These include

- an initial exploration of concerns,
- a fair attempt to resolve issues at an informal stage,
- utilise principles of mediation and then
- to use the formality of human resources led investigation
- followed by disciplinary or punitive measures to correct a breach of such guidance.

While there is nothing wrong with this approach and there is a need for uniformity of a framework or policy to provide for recourse when dignity is compromised, it does nothing to foster a culture of respect or a safe, healthy and stress-free workplace environment.

The level of bullying and harassment that persists in the NHS and similar high stakes organisations remains unabated.[19,20]

Existence of Structural Inequalities

- Minority groups

There are substantial differences in the experience of minority ethnic groups and those with protected characteristics which are currently not recognised nor addressed by the existing dignity at work policies. [21–24] Incivility both builds on existing embodied, classed, raced, gendered and sexualised social inequalities and prepares people to accept such inequalities as a "normal" part of living in the world. [25] Disproportionate intergroup bullying or the mistreatment of members of low socio-economic status groups, often exists due to structural subordination of such groups in society. [26] Objective measures of inequalities and workplace incivility correlate closely with the health impact on the workforce. [27]

- Gender & Sexual Orientation

The impact of gender related inequalities on incivility is complex. Multivariate analyses show that among women, perceptions of workplace gender discrimination are associated with poor mental health, and perceptions of sexual harassment with poor physical health.[28] There is a higher tendency for women to self-label as 'bullied', while a higher proportion of men are labelled as 'bullies'.

The mental health impact of incivility is also disproportionate.[29] Data for the LGBTQ+ and transgender communities is stark. A government survey showed that 78% of respondents attributed incivility experienced to colleagues and seniors, while the Stonewall report showed awareness of bullying based on being of trans-gender.

- Socio-economic status

Lower educational achievement and socio-economic status is a determinant of incivility. [30]

- Immigrant status

More than a third of doctors and a fifth of healthcare staff in the NHS were either born or trained abroad or are descendents of those who were. Factors such as challenges in communication, cultural differences in the workplace, daily life, relationships with family and colleagues, financial problems as well as social inequality contribute to acculturation and occupational stress.[31] Immigrant health workers experience a disproportionately higher level of incivility, stress and inequalities [32]. They tend to under-report due to fear. [33]

In the UK NHS higher educational and socio-economic cohorts (such as senior doctors) almost 50% of incidents of incivility may go unreported in toxic environments, due to fear and minority status. [34]

- Age, Physical attributes & Disability

The prevalence of incivility can be higher for older workers, those with physical attributes such as obesity [35] and upto 3-5 times higher for workers with a recognised disability even after adjusting for all confounding characteristics [36] This impacts negatively on employee retention. [37] It is recognised that 1:5 people in the UK have a disability and that 80% of disabilities are hidden. The NHS Workforce Disability Equality Standard was implemented to help better understanding of discrimination felt by disabled NHS staff and action measures for prevention.

Rationale for the Standards

More needs to be done. A one size fits all approach is unlikely to lead to a balance of the multiple structural inequalities.

- Parallel antiharassment and antidiscrimination policies do exist that target unprofessional behaviour specifically targeting a person's race, colour, religion, sex, nationality, disabilities, or age and this is enforced by the Equality Act (2010).
- But much more needs to be done to combine the impact of equality, diversity and inclusion (EDI) dynamic, currently missing in existing policies.
- Every organisation needs to develop and adopt a unified approach to a set of EDI balanced, consensus standards of Dignity@Work.
- This should be used to self-assess its progress towards achieving a universally accepted benchmark and demonstrate its commitment to a safe environment, a happy workplace and an engaged workforce.

AIM

- This paper explores the currently published policies for dignity in the NHS, draws evidence-based interventions which have been shown to be effective across high-risk organisations and develops standards for organisations to aspire to and benchmark their performance across the spectrum.
- This paper addresses the equality, diversity and inclusion domain that is missing in the majority of existing policies and co-creates with stakeholder organisations - a balanced policy to mitigate the inherent inequalities that exist in the NHS.
- These standards will stand as a framework for NHS organisations to deonstrate their willingness and achievement of an exemplar status.
- The Standards presented here are desigend for adoption across all healthcare organisations and beyond to other high-risk, high reliability organisations

DIGNITY

Dignity is a personal sense of worth, value, respect, or esteem that is derived from one's humanity and individual social position; as well as being treated respectfully and fairly by others.[17]

COMPONENTS

of Dignity

1.1 Valued
The NHS Constitution [38] provides the framework for principles and values, while the NHS People Plan [39] the aspiration for its staff. Within this every NHS organisation has a stated commitment creating mutual respect, a compassionate environment, an inclusive culture which fosters staff health, wellbeing, engagement and ultimately patient care.

Organisations must ensure staff feel valued, supported, and empowered to carry out their work. These values should be role-modelled throughout teams and organisations. Leaders at all levels, have an integral role to play in exhibiting behaviours and demonstrating the values of civility and respect. The NHS: People Plan 2020/21 – recognised the need to tackle incivility providing a Civility and Respect toolkit [40]

1.2 **Respect**
Respect is the act of showing appreciation for someone's traits or qualities or treating people with dignity and gratitude. An attitude of respect should come as standard in the workplace regardless of any personal feelings. A culture of respect requires that the institution develop effective methods for responding to episodes of disrespectful behaviour, while also initiating preventive cultural interventions.

Responsibilities for organisational leaders include;

- to establish and enforce policies,
- to enable frontline engagement, and
- to facilitate the creation of a safe learning environment.

1.3 Culture
Culture is defined as ideas, customs, and social behaviour of people in a organisation. Cultural characteristics for safe organisations include shared core values of;

- transparency,
- systems thinking,
- accountability,
- respect,
- being learning organisations (responding to untoward events as opportunities for improvement)

1.4 **Engagement**
Collaboration and teamwork - are at the heart of successful implementation of safe practices. Without mutual respect and a sense of common purpose, people cannot work effectively together. Creating a culture of respect requires action on supporting transparency and collaboration.

1.5 **Collective Mindfulness**
Provides teams with a cognitive infrastructure that facilitates the adaptation of work processes[41] and behaviours. [42]

1.6 **Fairness**
Healthcare organisations should deliver fairness consistently and transparently. Central to an effective response is a code of conduct that establishes unequivocally the expectation that everyone is entitled to be treated with courtesy, honesty, respect, and dignity. The code must be enforced fairly through a clear and explicit process and applied consistently regardless of rank or station.

1.7 Personal & Collective Accountability
Leaders and every member of a team or organisation carry a responsibility not only for their own behaviour, but a collective accountability for the whole team. This includes ensuring that the workplace is safe, that all staff are treated with respect and kindness and there is overall kindness in the environment. Standing up for fairness or speaking out when witnessing unacceptable behaviours is also a critical step in the right direction.

Peers and bystanders are people who observe or learn (about unacceptable behaviour by others) – but who are not the relevant supervisors, or knowingly engaged in planning or executing that behaviour.

The interests of bystanders may or may not coincide with the interests of an organisation or team. Bystanders often have multiple, idiosyncratic, and conflicting interests, experience painful dilemmas and their contexts – often differ greatly from each other.[43] Appraisals of severity, a sense of 'victim deservingness' and efficacy often influence bystanders to enact a range of possible divergent behaviours including moral disengagement in response to future bullying. [44]

1.8 **Active Constructive Bystander**
A shared vision of a respectful environment as well as active bystander training is essential. Passive bystanders (of acts of incivility), add to the overall burden of disengagement, reduced efficiency and an indirect impact on their own mental health. On the contrary, active constructive bystanders can act as positive resources, mitigating the impact of incivility. [45]

1.9 Culture
Culture is defined as a configuration of belief, custom, language, social, ritual, values and behaviour, which is held in common by a group of people who identify themselves as distinct from other groups.

1.9.1 Cultural Intelligence denotes an individual's ability to operate in culturally diverse settings. It draws from a general set of capabilities that facilitate the individual's effectiveness in multi-cultural environments.

1.9.2 Cultural Awareness, by definition, is an insight into mechanisms that interplay in our grasp of cultural diversity and individual differences.

1.9.3 Cultural Competence on the other hand takes that awareness a step further where it incorporates knowledge and understanding of intercultural effectiveness, with some models relying heavily on personality traits, attitudes, and capabilities while others focus on unique domains of characteristics.

Essentially, Cultural Intelligence has a narrower scope of intercultural capabilities, while cultural competence incorporates the individual's experience, knowledge, personality traits, mindset, and other characteristics.

Furthermore, in the context of BAME culture and history, cultural Intelligence has connotations of white supremacy with an author suggesting that people of African or Asian descent have been assumed to be less intelligent than white people - Orientalism

1.10 Respectful Feedback
The difference between a manager who is firm but fair and a manager who bullies and harasses is often difficult to distinguish. As part of the everyday management, line managers are required to provide staff with feedback concerning their performance, e.g. conduct, punctuality etc. If any of these areas have been unsatisfactory the feedback may be critical of the worker concerned. If criticism is delivered in a constructive way it can be beneficial, providing an opportunity to reflect and make any necessary improvements. Destructive criticism is likely to have a detrimental effect.

- Constructive criticism focuses on: specific actions and behaviours, including facts, with specific examples of behaviour that has been inappropriate, and an explanation of why it was not appropriate. It also includes suggestions or recommendations for future improvement.

- Destructive criticism may involve: aggressive behaviour, such as shouting or yelling, personal insults or put downs and allocating blame rather than responsibility.

1.11 **Bullying**
Bullying is the systematic abuse of power and is defined as aggressive behaviour or intentional harm-doing by peers that is carried out repeatedly and involves an imbalance of power, either actual or perceived, between the victim and the bully. [46]

According to the Workplace Bullying Institute, [47] bullying is the repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. It is abusive conduct akin to psychological violence and is characterised by threatening, humiliating, or intimidating actions or words. This can be unacceptable behaviour as perceived by the employee, which subjects the individual or group to unwelcome attention, intimidation, humiliation or ridicule or violation of an individual's dignity.

Bullying can also include offensive, abusive, or insulting behaviour, abuse of power or unfair sanctions which makes the recipient feel upset, threatened or vulnerable. Bullying can also be in the form of deliberately undermining a competent employee by imposing unreasonable workloads or frequent unjustified criticism.

Instances of Bullying Behaviour

- Intrusion by pestering, spying, stalking;
- Unnecessary or unwanted physical contact or invasion of personal space;
- Sexually suggestive behaviour, or compromising sexual invitation or demands;
- Racial harassment- including racist jokes or graffiti;
- Displaying offensive material;
- Unwarranted or suggestive remarks;
- Verbal or written abuse including non-communication and deliberate and/or inappropriate exclusion from social events;
- Derogatory name-calling and insults;
- Threats of a physical or psychological nature;
- Victimisation because of someone's gender, race, disability, sexual orientation, age, religion or other beliefs;
- Overbearing behaviour or language that causes fear or distress to others;
- Abuse of power by someone in authority, or intimidation by junior staff towards a member of senior staff;
- Incitement of others to commit harassment;
- Abuse of power of Trust staff over agency/ temporary staff;
- Electronic messages or electronic displays of sexually suggestive pictures or literature (including email and text message);
- Inappropriate or derogatory remarks in connection with performance or appraisal;
- Inappropriate literature, pictures, books, tapes etc.

1.12 Victimisation
This can be where an employee is subjected to a detriment because they have, in good faith, raised a concern or complained, be it formally or informally. This concern or complaint may be because they have been bullied or harassed, they may have supported someone else to raise a concern or complaint or given evidence in relation to a complaint.

Cyber abuse is becoming a common form of harassment, This can be defined as bullying, vitriol, discrimination, intolerance or hate expressed online or digitally that embarrasses, hurts or intimidates another person. This abuse can be posted via websites, social networking sites, chat rooms, message boards, webcams, smartphone apps, instant messaging, emails and text messages.

1.13 I**mpact of B&H**
The impact of bullying and harassment may include the following[48]:

- Emotional - make someone feel anxious, humiliated, angry, frustrated, frightened and being unable to cope with the job. May experience stress, loss of self-confidence and self-esteem. Increased mental distress, sleep disturbances, fatigue, lack of vigor, depression, anxiety, adjustment disorders, and even work-related suicide.
- Interactions - some may not disclose workplace maltreatment due to embarrassment or fears of retribution, while other may try to retaliate in some way thus deteriorate interactions and workplace relations
- Performance - become unmotivated or disengaged/ resigned- certainly impair job performance and impact on retention.
- Health - lead to illness (such as neck pain, musculoskeletal complaints, acute pain, fibromyalgia, and cardiovascular symptoms) and frequent absence from work.
- Socio-economic - this impact may impair social interactions, becoming a recluse and adversely affect members of family or friends. Financial insecurity - fear of job loss and even being forced to resign.
- Employer penalties- The NHS has often faced claims of bullying, harassment and discrimination. One of the largest awards was in the case of Michalak vs Mid Yorkshire Hospitals NHS Trust where Dr Eva Michalak was awarded compensation exceeding £4.5 million by the Tribunal for racial and sexual harassment.

1.14 Effective Interventions
Much of the literature on bullying and incivility reveals that employees who experience it are frustrated by the poor response by their organisation, and the inability or unwillingness of organisations to devise or implement appropriate practises to prevent it. Where there are interventions, they are focused primarily on individuals.

- Individual Behaviour Change

A systematic review [49] revealed a commonly held notion that workplace bullying and incivility are principally problems of interpersonal behaviour, therefore many of the interventions are based on targeted educational programmes, increasing awareness of and recognition of negative behaviours, or coaching "better" responses to negative behaviours for errant individuals.

This is based on the assumption that workplace mistreatment will be lessened if more people know about it, know how to recognise it and be more assertive in their responses to it. While the majority of healthcare organisations have anti-bullying policies, very few tend to offer training in identification of bullying and almost none have systems for monitoring of the culture of incivility. [50] This indicates a poor organisational response to bullying, contributing to the lack of improvement in dignity over the years.

Emotional self-efficacy - via encouraging reflection and cognitive restructuring may lead to an improved ability to recognise and ward off incivility in the workplace, and also reduce the likelihood of communication with others in an uncivil manner.[51]

- Organisational Development Approach

Bullying and incivility are complex organisational problems that manifest at the level of individual behaviours. An integrated approach incorporating the individual, their diversity, their background and characteristics with the impact of the job, the workplace pressures, organisational systems and broader societal inequalities is required to tackle workplace culture. Theoretical advances in the area indicate that interventions will be best placed at the level of the organisations, rather than individual perpetrators, and this may be why organisations find it so challenging to address the problem.

Monitoring is based on a wide range of outcome measures and instruments including behavioural checklists for negative acts and/or incivility, knowledge about bullying, perceived prevalence of bullying, perceived confidence in recognition of bullying or confidence in tackling bullies, witnessing of bullying, staff turnover rates, job satisfaction or intention to quit.

- CREW - a multi-component, six-month intervention CREW (Civility, Respect, and Engagement in the Workplace), is a facilitator-led series of group-based exercises, designed to allow participants to explore social relationships in their work group and in particular civil and uncivil communication. The intervention commences with preparatory work engaging organisation leaders and management, building a learning community of leaders and facilitators, training facilitators and communicating management buy-in to employees.

While a structured programme guides the weekly workshops, the experiences and needs of individual groups also dictates choice of exercise thus responding to the unique situations of work groups. The focus is on building positive, civil behaviours, respect, cooperation and conflict resolution, and is delivered at a number of levels; it focuses on individual behaviours, in a group context, and includes actions to ensure visible management commitment. [52]

- The Change Laboratory® - facilitates both intensive, deep transformations and continuous incremental improvement. The idea is to arrange on the shopfloor a room or space in which there is a rich set of instruments for analysing disturbances and for constructing new models for the work practice. The Change Laboratory is used by a natural team or work unit, initially with the help of an interventionist. [53,54]

Essential criteria for development of the Dignity@Work Standards?

1. Define the values - The standards must define what exactly the gold standard for dignity in the workplace looks like. It should also take into account the diversity of the workforce and ensure consideration is given to the intersectionality of already known determinants of incivility.
2. Representative and acknowledge diversity - The standards should ensure that all parties who are commonly affected are represented in the development of the code of conduct. It is essential that the fundamental principles of EDI are adhered to and all standards are tested against the diversity of the workforce. The policy must apply to all, regardless of seniority or position.
3. Refer to existing (or update) the law, policies and guidelines - There must be a robust reference to and alignment with policies and universality of standards across the organisations (and the NHS).
4. Fairness - The process for responding to breaches of the code of conduct must be perceived by all parties to be fair. The workforce must be treated equally regardless of protected characteristics or seniority.
5. Transparency - The organisation's process for responding to any violations should be illustrated clearly and explicitly. This should be disseminated to all. There should be well defined criteria for escalation of concerns or progression when concerns are raised.
6. Consistency: The program of enforcement must be responsive to all complaints, large or small. Serious complaints must be investigated, and the subject must be informed of the complaint.
7. Leadership commitment is required to overcome natural tendencies not to report or take action against a high-status individual or one whose departure, if necessary, would be damaging to the institution's reputation or income.
8. Graded response: The response to a complaint must be proportional to the nature of the incident. For a single, relatively minor infraction, an informal conversation initiated by a trusted peer may suffice. More egregious episodes or patterns of offensive conduct require a more formal approach. The policy must clearly define the process including: the responsible officer for a contingency of actions at each level of staff,the circumstances when an investigation indicated.
9. Restorative process: The goal of the process should be to enable the individual to change his or her behaviour and continue as a member of the health care community. Plans for remediation must be explicit, with clear markers, deadlines, and methods of monitoring. Disciplinary action should be reserved for those who are refractory to improvement or whose behaviour is so outrageous as to constitute a threat to patient or worker safety.
10. Active surveillance and data: Without effective mechanisms for identifying individuals with problems, policies are meaningless. In addition to safe reporting of inappropriate behaviour, surveillance should be proactive, such as the use of "360-degree" evaluations, to identify problems early.

Dignity@Work Standards

There are 8 Domains and x standards

01 | Environment & Culture

02 | Cultural Intelligence

03 | Organisational Interventions

04 | Communication & Interactions

05 | Monitoring & Accountability

06 | Metrics

07 | Concerns & Grievances

08 | Support

1: Environment & Culture

1.1 | Environment & Culture Committee

- Every organisation should establish a workplace environment and culture committee with proportionate representation from all professional groups, divisions and departments.
- There should be appropriate representation from EDI champions and minority or under-represented groups.
- The committee should be chaired by a non-executive member of the Trust board and must include the HR Director, CEO, CNO and CMO/MD.

1.2 | Appoint Culture Champions

- The Environment & Culture committee must appoint culture champions.
- Their purpose is to be role models, act as catalysts for change, encourage staff to be active constructive bystander and be the visible person for staff to approach when required to escalate concerns.
- The Culture champion must be job planned, be given access to adequate resources, feel empowered to take on their role monitored by 360 feedback reporting to the EC committee.

1.3 | A shared vision of dignity for all

- The EC committee will undertake the co-creation of a workplace code of conduct/ standards of behaviour ensuring dignity and respect for all.
- The code of conduct of behaviours should be championed, prominently visible in all forms of communication in the workplace and reinforced at every interaction / meeting.
- This vision should be a living document, reviewed at regular intervals and updated through engagement with all staff.

1.4 | A culture of openness

- Culture Champions will have the responsibility to develop active interventions to encourage and monitor adherence to the agreed code of conduct
- Undertake regular surveys of all staff and facilitate reflective conversations on psychological safety and culture;
- Encourage raising concerns without fear and confidentially both within the department/ team/ care group and through the ‘Freedom to Speak up Guardian’

1.5 | A learning environment

- CCs to facilitate acknowledgment, reflection, open discussion of findings from surveys and escalated incivility incidents. [55][56]
- Encourage team to find collective solutions to restore and enhance a just culture.

2 | Cultural Awareness & Competence

2.1 | Acknowledge diversity and PROMOTE cultural awareness

- Organisations must understand that each individual is a sum-total of their many characteristics, each carrying a very different past, their own legacies and various experiences.
- **ACKNOWLEDGE** - socio-economic and cultural diversity of staff in interactions. An awareness of such cultural and social interactions and interrelatedness helps to understand how each person may view an event differently influenced by their own unique context and be aware of the variable impact of differences between people and their experience of the organisation.
- Understanding how shared roles and responsibilities bring staff together.
- **PROMOTE emotional intelligence and cultural awareness in teams.** [57] Organisational leaders must proactively encourage inclusion of members from varied backgrounds, while focussing on shared vision and synergies [58]
- **TRAIN & APPRAISE** - The skill of inclusive leadership should be trained for, supported and appraised through 360 degree feedback for all staff.

2.2 | Examine & monitor diversity & intersectionality

Existing research on employee rights, discrimination, and harassment does not use an intersectional lens to examine the power structures that create a disenfranchised experience for marginalised individuals.

- **Intersectionality** - Design and implement policies that openly account for the impact of the interrelatedness of the multiple identities embodied by individuals, instead of dissecting their identities into specific categories. Thus better reflecting how policies are experienced by individuals living at the intersection of different forms of behaviours.
- **Monitoring** - Organisations must undertake annual audits of events, escalations and outcomes based on multiple identities for each individual. The results of such audits need to be monitored by the EC committee and reported to the Trust Board.
- **Accountability** - Leaders must be accountable to the EC committee for providing realistic action plans, seeking appropriate expertise in organisational development, and agreed timelines for eradication of differential outcomes.
- **Affirmative actions & Social Justice** - Organisations must encourage enactment of affirmative actions and social justice for disproportionately affected groups (i.e based on gender, ethnicity or any other protected characteristics) and facilitate reflective conversations on safety and culture;
- **Foster a culture for raising concerns** - confidentially both within the department/ team/ care group and through the ‘Freedom to Speak up Guardian’

3 | Organisational Interventions

3.1 | Awareness of rights and responsibilities (Setting the right tone)

Staff inductions should make new employees aware of the organisation's commitment to dignity at work and to introduce the policies and support services at an early stage of their employment. At induction, all employees must be made aware of their rights:

- to be in a workplace free from bullying, intimidation, harassment, or victimisation
- to be treated with dignity, respect, and courtesy
- to experience no form of unfair and or unlawful discrimination
- to be valued for their skills and abilities
- to be provided equal opportunities for career progression and leadership positions

3.2 | Developing & training for excellence in behaviours

- **Develop standards of excellence** - Proactively identify incivility with regular monitoring - Leaders can work to avoid this behaviour within their teams, identify it early, challenge it, and deal with it appropriately should it arise.
- **Prevention by training** - It is well known that prevention is always better. An ongoing comprehensive training programme that not only prevents issues, but saves time and resources later, by addressing the learning needs of all stakeholders concerned, must be created. Ensure active constructive bystander training for all.
- **Leaders first** - Ongoing dignity at work training should be first and foremost undertaken by key leaders and then later conducted by supervisors, managers, and other staff. Training parameters will help key leaders identify behaviour that may be construed as bullying and/or harassment.

3.3 | Communicating the principles through regular workshops and role play

- **Role modeling** - The policies that support dignity at work need to be understood at a practical level by all stakeholders. There should be effective communication of relevant information for all staff on what is and what is not an acceptable standard of behaviour. This is best delivered as interactive, educational workshops with examples of behaviour role played or modelled.

4 | Communication & Interactions

4.1 | Promoting effective and respectful interactions

- **Standards of communication** - Organisations must promote effective working relations including set minimum standards for all forms of communications within and in between leaders as well as team members. Inappropriate communication or interactions between managers and staff, leads to stress, overwork, micromanagement, sometimes being ignored or even excluded. Organisations should clearly define acceptable and unacceptable standards, appropriateness of timing and forms of communication in their policies and ensure this is dispersed to all.
- **Train for informal mediation** - Personal workplace conflicts can have a negative influence in the workplace and they need to be addressed at an early stage to prevent any adverse events arising from them. As effective first steps in resolving workplace relationships, conversations and mediation (trained formal and informal) should be encouraged to review interpersonal differences.
- **Showcase & reinforce** dignity in regular communications with staff - Key messages should be highlighted and encouraged using electronic communication, staff meetings, roadshows, posters, leaflets, internal bulletins, and any other form of regular communication used in the workplace.

4.2 | An open and safe environment- ensuring psychological safety

- **Psychological safety** is a shared belief that the team is safe for interpersonal risk-taking;, a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes. A workplace environment that values dignity and respect, is where people feel safe to speak up (including to their manager), give feedback, offer a different perspective, and report an actual or perceived dignity violation without fear of being ignored, judged, or punished. It is important to identify and tackle a number of factors which lead to a fear of speaking up. These include;
  - a fear of being blamed or made a scapegoat,
  - being disbelieved,
  - being disrespected in a hierarchical system,
  - being discriminated against, or
  - suffering an adverse impact on career progression.
- **Provide and Support forums;**
  - Multiple forums providing freedom to speak up, both openly, in one-to-one sessions and in confidence- including outside of the organisational hierarchy.
  - Data on the content and frequency of such reporting must be monitored, discussed and reported as a marker of a psychologically safe, learning organisation.
  - An agreed value system that rewards the courage of staff reporting concerns and
  - A system to listen and act on suggestions for improvement/ safety including behavioural ones.

5 | Monitoring & Accountability

Leaders have a responsibility for developing and adopting workplace culture. This includes working collaboratively with their staff. Leaders and managers are responsible for setting the expectations for the standards of behaviour and ensuring these are fostered, maintained and monitored.

5.1 | Ensure routine monitoring of organisational culture

Using established tools of team behaviours encouraging continuous quality improvement for culture and behaviours with clear publication and discussion of results and developing consensus on specific actions needed to improve. The regular use of tools such as the Workplace dignity scale[59] should feed into appraisals of managers and leaders.

5.2 | Individual accountability and role modelling

- Leaders should demonstrate exemplary standards of behaviour, acting as role models to ensure that all staff in leadership positions act as champions of dignity.
- Employees have a responsibility to familiarise themselves and act in accordance with this Policy. Individual appraisals and feedback for all staff, should highlight excellence and areas for improvement proactively, instead of merely relying on peers or complaints to identify those in need of help.
- Routine evaluation for professional behaviour should form part of an annual, formal process (e.g., “360-degree” evaluations).
- Managers and leaders should be independently scored on the workplace dignity scale as part of their annual appraisals.

5.3 | Ensure board level accountability

- The executive board should be **responsible for nurturing an environmental culture that empowers individuals to speak up** if they experience or witness unacceptable behaviours. Boards should also recognise that an imbalance in leadership positions within organisations creates power hierarchies.
- The Board must **own the responsibility to oversee the implementation of organisational culture through design and implementation of policy** and to ensure that managers take action to meet the obligations to maintain equity and consistency.
- Managers have a responsibility to follow this Policy and **to act swiftly upon concerns or issues raised** in an empathetic, sensitive and supportive manner.
- HR is responsible for the provision of advice and/or support to managers and employees in relation to the application of this Policy.
- The Board **must model a culture of visibility** by acknowledging when standards are breached and demonstrable accountability with employers apologising and taking responsibility when an employee’s dignity has been violated.

6 | Metrics

6.1 | Organisations must develop specific metrics collaboratively with all staff

Currently there are no metrics solely attributed to collecting useful data on respect or dignity for comparing institutions. A lot of thought needs to be given to ongoing monitoring and evaluation of dignity at work initiatives. If surveys are used, it is important to involve all stakeholders in the design and implementation.

6.2 | Organisations must establish a qualitative & quantitative baseline and understand the context to people via lived experiences

- **Collect meaningful data at organisational level** which acts as a baseline including both quantitative and qualitative information. Statistics from quantitative data are easier to generate, collect, collate, and compare the spread of the problem but give little understanding or meaning to the data.
- **Qualitative data** is essential to understand subjective information about why someone had a poor experience or holds a particular opinion, giving in-depth idea of the recalcitrance of a particular source and can also point to obvious sources that can otherwise remain hidden. Qualitative data may take longer to analyse but is essential in obtaining genuine feedback that can help improve services. A mixed-methods approach is therefore essential.
- The **power of story-telling** (i.e. lived experiences): demonstrate the direct connection between cause and effect therefore needs to be listened to and acted upon. Vignettes of lived experiences and stories should be acknowledged and shared widely within organisations.

6.3 | Benchmarking of patterns of organisational culture & resources

- **Broad based monitoring is essential** to identify patterns in improper behaviour, bullying and harassment across teams and the organisation.
- Organisations must determine robustness of data collection and direct the allocation of appropriate attention and **ensure the reallocation of resources specifically towards the targeted areas**.
- Organisations must encourage early identification of bullying behaviours (e.g. through staff surveys, exit interviews) and **act on risk factors like poor management practices and excessive workloads.**

7 | Concerns & Grievances

Organisations must provide the tools and mechanisms for safety and confidential raising of concerns. All employees should receive appropriate guidance on the process for raising concerns including the relevant protection for raising concerns and whistleblowing. Following a complaint from an employee, the employer has a responsibility to act. This may take the form of an informal exploration or a formal investigation.

7 | When raising a concern or grievance a uniform, transparent step-by-step process should be followed;

- **1 - raising a complaint:**

Every organisation must have a 'Grievance Policy' outlining the procedure. The employee with the grievance should write to their line manager, HR manager, or employer, and clarify pathways for escalation processes in order to deal with violations.

- **2 - Handling the situation informally:**

some situations may be able to be resolved informally. In some situations, the person may not understand the effect of their actions, or a line manager superior may not realise the disadvantage a rule has to certain individuals. In this case, you may have an informal chat/send an email explaining the effect of their actions on the individual concerned,and propose a solution.

- **3 - Dealing with a concern formally:**

If an individual feels as if they have been harassed, bullied, or discriminated against, and the situation cannot be handled informally, employees should seek help and support. This can be sought from the following:

  - The line manager
  - Anti-bullying aAdvisor
  - Human Resources (HR) dDepartment
  - Occupational hHealth dDepartment
  - Chaplaincy Service
  - The Trust's' employee aAssistance pProgramme
  - Trade Union representatives
  - ACAS - Advisory, Conciliation, and Arbitration Service

- Minimum datasets for any formal investigation should include:
  - what the grievance is
  - any evidence or details of witnesses
  - what their expectations are for the complaint
  - Individuals receiving the complaint should keep all personal information confidential.

7 | Concerns & Grievances

7 | When raising a concern or grievance a uniform, transparent step-by-step process should be followed; continued

- **4 - responding to a formal grievance:**
  - The employer and anyone investigating the grievance should keep written records of what happens throughout the process. Any claims should be investigated fully before a decision on any actions are made. This will include a grievance meeting. By law, any employee or worker can bring a relevant person (‘companion’) to a grievance meeting.
  - If there are concerns about employees in a grievance case working together while the grievance is looked into, the employer should consider the best course of action to take short-term to help all parties.
  - Looking after employees’ wellbeing and mental health: going through a grievance procedure can be very stressful, so it’s important that employers consider the wellbeing and mental health of any employees involved to help prevent any negative impact on mental health.
- **5 - deciding the outcome:**

after the claim has been investigated in a fair manner, a decision should be taken based on:

  - evidence and findings from the investigation
  - what is deemed as fair and reasonable
  - what has been done in previous similar cases
  - The employer should offer the employee the right of appeal if the employee feels:
  - the outcome didn’t resolve the problem
  - the grievance procedure was wrong or unfair
  - Further help and support should be offered to anyone involved in the grievance procedure.
- **6 Appeals**
  - Appeals against decisions taken under this Policy shall be dealt with as follows:-
  - Appeals against a disciplinary sanction will be dealt with in accordance with the
  - appeals process in policy Disciplinary Procedure; Appeals by a complainant about the outcome of the initial inquiry will be dealt with in accordance with the grievance process outlined in the Grievance Policy.
- **7. Records**
  - Where the complaint is informal and resolved at this stage, a file note will be kept on the complainant’s personal file only. Following a formal investigation, where the complaint is not substantiated, a file note will be kept on the complaint’s personal file only.
  - Where a complaint is substantiated, or partially substantiated, but does not proceed to a formal disciplinary hearing, a letter confirming the outcome will be retained on both parties’ personal file and supporting documentation will be retained by HR in an confidential file.
  - Where the matter proceeds to a formal disciplinary hearing, then associated records will be kept in accordance with the Disciplinary Policy.

8 | Support

8.1 | A trained, supported and resourced facility for mediation

Mediation is usually the initial informal step before the formal grievance procedure. Mediation is not suitable for use in all cases, but can be a very useful facility, particularly when dealing with issues between peers and when early intervention is possible but unlikely to succeed where there is a serious power imbalance.

8.2 | A trained and resourced facility for counselling (In- house and external)

Counselling might often be seen as an expensive option, but not only would such provision have a beneficial impact upon the psychological well-being of a significant number of employees, it would also improve efficiency and productivity by reducing sickness and absenteeism.

8.3 | A robust and resourced Employee Assistance Programme

- **8.3.1 Support networks:** Institutions should establish support networks for specific groups that have often faced inequality including women, BAME staff, LGBT staff, trainee doctors, etc.
- **8.3.2 Trade unions**: Trade unions are often the first point of contact for staff who have issues at work. Employers should encourage all union members who are concerned about difficulties in their workplace to speak to their representatives as soon as possible. Institutions should also undertake joint working with union representatives to develop strategies for tackling work-related stress and other relevant issues to promote dignity at work, including the possible provision of joint training programmes.
- **8.3.3 Trained dignity at work advisers/champions:** These champions must be trained facilitators who have a variety of skills, including trauma recognition, pastoral care, and other counselling and complaint handling skills. The role of harassment advisers should be clearly defined. Training should be provided for advisors and there should also be a selection process for advisors to ensure only suitable people are used in the role. Advisors should have regular meetings and refresher training, as well as and have access to an external counselling service for supervision purposes.
- **8.3.4 Wellbeing teams:** The wellbeing of individuals adversely affected by incivility, bullying and harassment may often be better looked after by someone who is not aligned to organisational objectives, but facilitated by Occupational Health or external resources.
- **8.3.5 Buddying, Coaching & Mentoring** for all staff is essential in providing support, informal advice, guidance, role models and informal support to improve. All staff must have access to such support resources.

Consensus Conference

15 January 2022 | Virtual
Multi-organisational, multiprofessional approach to consensus

01 | Review

This conference will bring stakeholders to review the evidence that Policies are ineffective in tackling incivility;
Consider the impact of diversity and intersectionality

02 | Discuss

Consider the evidence for interventions that are likely to make a difference; Discuss the collaborative modalities for setting organisational standards and demonstrating excellence

03 | Commit

Acknowledge the need for culture change, leadership commitment, transparency of data collection, review of progress and benchmarking against the consensus standards

Conference Programme

Consensus Building (6 CPD points RCP Code 138775)

Time	Session	Topic - Speakers
09:15	**Platform open**	BAPIO song
09:30	**Welcome**	Apurna Jegannathen & Cherian George
09:40	**Setting the Scene**	Ramesh Mehta & Indranil Chakravorty
10:00	**Keynote Speech**	Moderators: Renu Jainer & Chandra Kanneganti Roger Kline, Workforce Culture, Midlx Univ Bus Sch & Keele University
10:20	**Session I**	**Managers play a central role** Moderators: JS Bamrah CBE & C Marimouttou Chair: Nick Ross CBE, Broadcaster & Journalist • Stephen Powis, National Medical Director, NHS England • Jagtar Singh Basi OBE, Chair, Coventry & Warwicks Partn Trust • Makani Purva, CMO, Hull University Teaching Hospitals NHS Trust • Sanjay Arya, MD, Wrightington Wigan & Leigh NHS Trust
11:10	**Session II**	**Role of Regulators & Oversight Organisations** Moderators: Bhavna Chawda & Satheesh Mathew Chair: Sir Terence Stephenson, Chair of Health Research Authority • GMC - Tista Chakravarty-Gannon, Head of Outreach Operations • BMA - Chaand Nagpaul CBE, Chair, BMA Council • Royal Colleges - Jeanette Dickson, President, RCR • CQC - Nigel Acheson, Deputy Chief Inspector of Hospitals • NMC - Andrea Sutcliffe CBE, CEO, NMC
12:00	Break	
12:10	**Workshops**	**Stream 1: Compassionate Leadership – Walking the talk** Facilitators: Apurna Jegannathen & Rajanee Bhana • Clare Gearon, Organisational Development, St George's • Habib Naqvi MBE, Director NHS Race & Health Observatory • Jenny Vaughan, Chair, Doctors Association, UK **Stream 2: Culture change – how can we make it happen?** Facilitators: Sanjeev Nayak & Coumar Marimouttou • Clare Morris, Medical Education, University of Cambridge • Partha Kar OBE, Director, Equality, Medical Workforce, NHSE • Amit Gupta, Lead for IMG, University of Oxford **Stream 3 - Health & Wellbeing Impact** Facilitators: Sapna Agrawal & Tara Al-Rubyee • Nandini Chakraborty, Psychiatrist, University of Leicester • Ananta Dave, MD, Lincolnshire Partnership NHS Trust • Saraswati Hosdurga, Chair, BAPIO Wellbeing Forum 12:50 Workshop Round-up - Prasanna Sooriakumaran
13:10	LUNCH BREAK	

Conference Programme

Consensus Building (6 CPD points RCP Code 138775)

Time	Session	Topic - Speakers
14:00	Session III	**Ground reality** Moderators: Geeta Menon & Hemadri M Chair: Iqbal Singh CBE, Healthcare Commission • Whistle Blowing - Raj Mattu, Consultant Cardiologist • Support systems - Joydeep Grover, MD, MDS • Lived experiences – Dame Clare Gerada DBE, President, RCGP
14:50	Session IV	**EDI: The Essential Ingredient** Moderators: Subarna Chakravorty & Suresh Rao Co-Chairs: Irfan Akhtar, APPNE & Ibrahim Bolaji, MANSAG • Race Equality Charter - Alison Johns, CEO, AdvanceHE • Workforce Equality Standards - Mala Rao OBE, Medical Advisor, WRES • Improving the Minority Experience - Hina Shahid, Chair, MDA
15:40	Break	
15:50	Workshops	**Stream 1: EDI Leads in Practice** Facilitators: Rajanee Bhana & Apurna Jegannathen • Priya George, Clinical Lead for EDI, STW CCG • Tara Hewitt, Head of EDI, Northern Care Alliance NHS Group • Joseph Orosun, Chair, BAME Network & CLDP, UHNM NHS Trust **Stream 2: Organisational Support** Facilitators: Roshelle Ramkisson & Sanjeev Nayak • Sabir Giga, Organisational Health & Wellbeing, Univ of Lancaster • Shivani Sharma, Executive Lead for EDI, Univ of Hertfordshire • Sakkaf Ahmed Aftab, LNC Chair and Governor NLAG NHS Trust **Stream 3: Interventions for Nurses & Allied Health Professionals** Facilitators: Suresh Packiam & Coumar Marimouttou • Asha Day BEM, International Recruitment Matron, LP NHS Trust • Giridhar Ravi, Physiotherapist, Scotland • Sue Tranka, CNO Welsh Government, & Nurse Director NHS Wales • Mahendra Patel OBE, Professor of Pharmacy, University of Bolton 16:30 Workshop Round-up - Moderator: Kamal Mahawar
16:50	Big Room Discussion	**Implementing the Standards** Facilitation - Martin Fischer Nigel Acheson, Irfan Akhtar, Sanjay Arya, Jagtar Singh Basi, Ibrahim Bolaji, Tista Chakravarty-Gannon, Clare Gerada, Alison Johns, Roger Kline, Ramesh Mehta, Chaand Nagpaul, Habib Naqvi, Makani Purva, Nick Ross, Hina Shahid, Iqbal Singh, Parag Singhal, Terence Stephenson, Sue Tranka, & Jenny Vaughn
17:30	Sum up & Vote of thanks	Ramesh Mehta & Chandra Cheruvu

Next Steps | Implementing the Standards

A Cochrane Systematic Review in 2017, concluded that there is very low quality evidence that organisational and individual interventions may prevent bullying behaviours in the workplace. Interventions such as communication skills training, complaint procedures, and workplace policies have limited chances of eliminating harassment in the workplace. [60] For interventions to effectively reduce workplace harassment, the mechanisms of change must be activated to create new meanings, norms, and social identities. When activated, the mechanisms enable workers to establish mutual agreements on the very definitions of harassment and constitute new norms and identities. [60]

A multilevel model of bullying [61], suggests that conflict can transmit its impact from the individual up to the group and organisational level. The interaction between the three levels needs to be taken into consideration when developing effective multilevel approach of interventions in workplace bullying.[62] In a Delphi exercise, a core set of 11 intervention types (investigation, codes of conduct, policy; EAP and counselling, bullying awareness training, coaching, system-wide intervention, skills training and development, values statements, local resolution, organisational redesign) were endorsed for inclusion in the taxonomy. Six intervention types (mediation, conferencing, monitoring, support officer programs, emotional intelligence training, and resilience training) failed to reach consensus.[63] Accordingly, this can assist organisations to audit and amend their current practises and intervention strategies and adopt a holistic approach that includes both preventive and responsive interventions for everyone.

A: Benchmarking

A.1 Develop a holistic toolkit for assessing organisational dignity and respect

A.2 Benchmark and accreditation by self-assessment

B: Research & Quality Improvement

Large well-designed controlled trials are needed for bullying prevention interventions operating on the levels of society/policy, organisation/employer, job/task and individual/job interface. Future studies should employ validated and reliable outcome measures of bullying and a minimum of 6 months follow-up.[49,64]

B.1 Evaluation of the effectiveness of policies

B.2 Mixed-methods analyses of organisational interventions exploring environment and culture change

Conference Proceedings

Summary of the Conference and Workshop Discussion on the implementation and delivery of standards

Introduction

1.1 Listening to our members, we are acutely aware of widespread issues of structural inequality, bias, and discrimination in society. The issues of bullying, harassment, and victimisation faced by many healthcare staff stem from these inequalities.

1.2 Although organisations have policies for dignity at work, it is rarely implemented, and many staff suffer incivility in silence and fear.

1.3 A recent survey conducted by the British Association of Physicians of Indian Origin (BAPIO) showed that healthcare staff with specific protected characteristics, including gender, race, ethnicity, religion, and disability, were much more likely to experience bullying and harassment.

1.4 Toxic workplaces have a significant negative impact on the quality of care staff health and carry an estimated cost to healthcare from absenteeism of £3 billion and in the society of up to £14 billion per year.

1.5 There are no nationally accepted standards to evaluate the efficacy of policies for dignity at work.

1.6 Therefore, we decided to review the literature and work on developing standards for dignity at work in consultation with other stakeholders. We have invited members of the alliance and relevant stakeholders to this conference to ensure we reach a consensus for our 'dignity at work' standards.

1.7 The overarching aim of our exercise was to improve the workplace, organisational structure, and culture to lead to efficient and safe care for patients.

1.8 We hope all stakeholders will support the implementation of the standards.

PURPOSE OF DIGNITY@WORK STANDARDS

2.1 Dignity is a concept that philosophers, scholars and psychologists have been delving into and deciphering. The literature is fascinating.

2.2 When one deconstructs and understands the concept of dignity, certain concepts take shape.

- Values. Society needs to define values, and these values are what we live by, how we do things.
- How do these values come about, and how are they produced? It is multidimensional, influenced by education, culture, and humanity's assimilation.
- Dignity is a transactional or interactive concept. Having dignity, preserving dignity, and taking away dignity are all about interactions and impacted by individual perception or judgment.
- Dignity directly impacts how productive we are and our contribution to society.

2.3 **How is workplace dignity defined?**

It is all an individual's perception into respect, equality, self-esteem, sense of self-worth, freedom of expression and being able to make their own decisions.

2.4 **Four key areas worth focussing on are:**

1. Trust and respect
2. Fairness
3. Right to live with self-esteem and self-worth
4. Autonomy to make decisions

Defining Dignity

2.5 The cost to UK businesses of incivility totals up to £14 billion annually, which is likely a considerable underestimate. From the literature and feedback collected across organisations, we know that 15% of people report bullying and harassment.

2.6 **In healthcare, the prevalence of incivility is much higher**. There are different grades of incivility, and an estimated 90% report feeling disrespected or undervalued in society.

2.7 Incivility or bullying and harassment is **experienced disproportionately** by groups of people with specific **protected characteristics**. Most importantly, it gender, Black and minority ethnic groups, and people with any form of disability.

2.8 There is significant **under-reporting**, and the greater the element of bullying and harassment, the greater level of underreporting.

2.9 **Intersectionality** highlights that the experience of people with specific characteristics multiplies their experience of harassment. At present, we do not have enough methods to estimate the impact of intersectionality.

2.10 **Bystander effect** - A bystander in an environment of incivility experiences a deterioration of their ability and performance. It also reduces their ability to help others, and this is crucial in healthcare, where the profession is dependent on empathy and compassion and being able to help others.

2.11 **What are the contributors**?

- **Inequality stems from bias, discrimination and not having the same privileges.**
- Being overworked, understaffed, under-resourced, ineffective management and poor leadership can create a toxic atmosphere.
- Being undervalued
- Lacking autonomy or being unable to be true to one's actual identity leads to internal conflict.

2.12 **Policies** - Every organisation must have a policy by law, and some are well designed but ineffective. We know that, at present, most organisations can only reactively implement the policies by enforcing them when dignity standards are compromised.

2.13 **Co-design** – We need to work with all members to **define cultural standards**, which are inclusive. We must capture the impact of intersectionality whilst being fair convey cultural awareness and cultural competency at the organisation level where our policies and implementation take notice of someone's **diversity.**

2.14 **Responsive leadership** - to understand what is responsive and compassionate leadership.

2.15 **Data and benchmarking** - We also want to know how we can successfully use tools through education and training to build that supportive environment. We want to benchmark, measure and share good practise whilst also making ourselves accountable.

Introduction

3. Evidence for Dignity

3.1 Bullying in the NHS adversely impacts staff health and well-being, organisational effectiveness, and patient care and safety. A 2015 case study looking at the impact of incivility on staff performance and infant care highlighted that teams exposed to disrespectful leadership displayed lower capabilities in all diagnostic and procedural performance metrics, markedly diminishing the infant's chances of survival. The teams exposed to this disrespectful leadership displayed behaviours of non-disclosure of information as readily and a lack of seeking help from teammates.

3.2 The causes of bullying and incivility are poor job design, increased work intensity, job stress, workplace conflict, job insecurity, self-interest, and institutional power imbalances.

3.3 The NHS has developed a widespread culture of fear and compliance than learning, innovation and enthusiastic participation in improvement.

3.4 In recent years, the NHS staff survey data has consistently shown that a quarter of staff report being bullied by colleagues and managers. The proportion of Black or minority ethnic (BAME) staff reporting such bullying is significantly higher than for white colleagues. This proportion is even higher for staff who are disabled or who identify as LGBT+. Regrettably, only half of the bullied staff reported it. The data is even worse for junior doctors.

3.5 The reasons to restore dignity at work are:

- **bullying damages staff health and well-being;** disrespect causes recipients to experience fear, anger, shame, confusion, uncertainty, isolation, self-doubt, depression, and a whole range of physical ailments, including insomnia, fatigue, nausea and hypertension. These emotions diminish a person's ability to make sound judgments highlight questions or concerns, and are worse for BAME staff. Harassed staff have a 50% greater chance of reporting fear and poor health. Racial discrimination is associated with many conditions, including coronary artery calcification, high blood pressure, low birth weight, and increased mortality. Like other stressors, it can affect health through both actual exposure and the threat of exposure. A combination of bullying and race discrimination is thus genuinely toxic.

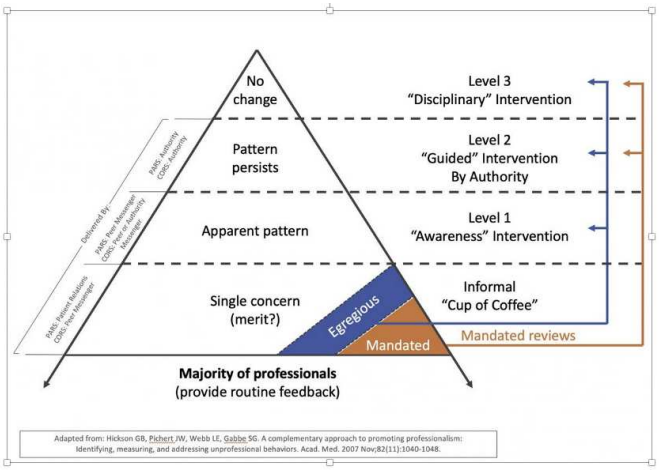
- **Bullying and harassment adversely affect organisational effectiveness** through increased sickness absence, reduced productivity, increased presenteeism, employee turnover, litigation costs, and costs of delivering unsafe care. In 2018 Kline et al. conservatively estimated the likely costs of bullying to the NHS in England to be £2.28 billion per year. This figure did not include the cost of increased presenteeism, the impact on staff bystanders, the emotional impact of incivility or the costs in primary, inpatient care or legal costs.

Evidence

- **Bullying and harassment negatively impacts on patient care and safety.**

A study by West and Dawson in 2012 found a robust negative correlation between staff reporting bullying and harassment and dignity in patient interactions. Dixon-woods found that managing staff with respect and compassion correlates with improved patient satisfaction, reduced infection, mortality rates, better CQC ratings and better financial performance. West found that bullying, discrimination, and overworking are likely to deprive staff of the emotional resources to deliver compassionate care. Disrespect is a threat to patient safety because it inhibits collegiality, cooperation, teamwork, effective communication, undermines morale, and inhibits compliance with implementing new practices.

3.6 **Bullied staff are less likely to raise concerns, admit mistakes, and work in effective teams.**
In 2015, Robert Francis highlighted how BAME staff who raised concerns were more likely to be victimised. He showed that BAME staff are more likely to be ignored, dissatisfied with the response to their concerns, less likely to report a concern again. The final Bristol Royal Infirmary report shows that bullying and a reluctance to raise concerns are intimately linked. Kennedy wrote that there is a real fear amongst junior staff, particularly junior doctors and nurses, as 'to comment on colleagues, particularly consultants, endanger their future work prospects.



4. **Why haven't NHS strategies been effective?**

4.1 NHS employers all have policies. The emphasis is overwhelmingly on fitting policies, procedures, and training.

4.2 Research shows this approach does not work, with one in four NHS staff consistently reporting being bullied and harassed at work. However, only a few staff ever raise a concern using these policies.

4.3 Staff have no confidence in the organisational processes or culture. A reactive approach relies on individuals to report incidents formally. Research has generated no evidence that, in isolation, this approach can work to reduce the overall incidence of bullying. The failure to provide a safe environment to raise concerns has been a driver of repeated system failures.

4.4 **Actions needed**?

- **An inclusive and compassionate learning environment with psychological safety is crucial for care.** Leaders have a central role in tackling bullying-harassment-incivility, and this should not be left to the victims of poor behaviours to challenge those behaviours.
- Leaders need to be aware of and understand the perspectives and experiences of staff who wish to raise concerns but fear doing so.
- Leaders need to use interventions with an evidence base and exhibit behaviours they expect of others.
- Leaders need to be proactive and preventative. Challenging by practice without waiting for individual staff to raise concerns and show accountability is essential.
- Staff at all levels must account for their acts and direct change in their divisions which will find ways to build trust and psychological safety.
- Emphasise informal early interventions wherever possible, learning, just culture and adopting an incremental approach (see fig)

Evidence

- Discuss unprofessional behaviour as soon as it surfaces by escalating it. **Make it safe for bystanders to intervene as allies.** We need allies around bullying, signifying to perpetrators that their behaviour is unacceptable, helping to break the silence, forced tolerance and isolation that victims suffer.
- **Staff want bullying and harassment to stop.** They should not have to demonstrate motive on the perpetrator's part, but just the impact on them as victims. Long, drawn-out formal proceedings lead to toxic relationships even in the rare event of them being successful.
- **Intersectionality is important.** Where bullying overlaps with a disability, gender, or ethnicity, its impact is likely to be much more significant.

5 Role of Managers

5.1 Everybody is at risk of bullying and harassment. However, we must specifically address the risk of increased disproportionality amongst our ethnic workforce and women.

5.2 Healthcare professionals are leaders in whatever role they undertake and act as role models in everything they do. The behaviours that leaders exhibit legitimise the behaviour of others sets the tone and culture of an organisation.

5.3 The Organisations must support managers and doctors in management positions to do their jobs, fostering a culture of mutual respect. There must be schemes and opportunities that will allow the medical managers of the future to be much better prepared, making them more effective and their roles less stressful.

5.4 Appoint medical managers on a values-based approach and those who have the values of compassion.

5.5 Doctors and others in leadership positions need to have the dedicated time and support to do the job effectively, which may mean other deputies or administrative staff help them.

5.6 Doctors in management roles play a crucial role in setting the culture of the organisation, in particular medical directors, but also other leaders, including clinical directors. They have a responsibility in dealing with the medical workforce and ensuring that the workforce shows the characteristics of compassion, transparency of fairness, and in particular, kindness to each other.

5.7 **Data to Action** – There is no shortage of data; however, the NHS has a deficiency in turning the data into actions.

Example

A Trust in the Midlands took a partnership approach with cultural champions, and they saved £2.5 million. If the fundamental human factors cannot be appreciated, then the financial drain of bullying and harassment should be enough reason. If an intervention is not working, we should be brave enough to abandon it swiftly.

01

Participant

'If you say our policy is this, you have to follow it through and be seen as a champion.'

02

Participant

'We do not need any more research. The research has already been done. Pull the research out, pull the recommendations out and comply with the recommendations. We have plenty of tools and methods to reduce bullying and harassment at work.'

03

Participant

'We have confused these words several times already: leadership and management... Management does what the policies say, and leadership is everybody's responsibility.'

Effectiveness

5.8 **What is good leadership?**

- During the COVID19, many inherent societal inequalities contributed to disproportionate mortality among BAME groups. There was no time for equality and diversity. When fighting for dignity, there is a role for NHS England, leadership academies, and the CQC need to consider actions, metrics, and whether organisations are improving or condoning such behaviours
- HR Directors often do not see a lot of bullying, harassment complaints, or grievances due to a lack of an open culture where people feel they can come to managers.

5.9 **The Anti-bullying Toolkit,** highlights early recognition. We should focus on identifying and tackling unprofessionalism in the organisation using a transformational cultural approach.

5.10 **The ability to tackle bystander apathy** - Teams should confront incivility themselves. Leadership should not be the only position where we can tackle unprofessionalism and bullying; it should stem from the whole team. We should not only be empowering our team to speak up but also giving them the tools to tackle issues as they arise.

We must endeavour to:

1. Educate and train staff
2. Support individuals who decide to raise a concern
3. Support individuals to take a concern to its logical end.

04

Participant

'Leaders can either stop bullying and harassment by their actions, authenticity, kindness, and respect for others or ignore it and be part of the problem.'

5.11 **Informal resolution** - Current systems are sound in tackling high profile cases, but we must develop processes to address the informal methods to resolve issues.

5.12 **Importance of a positive perspective** – We must approach dignity with a positive perspective and highlight what negativity can do to staff and patients.

5.13 **The CQC does not focus adequately on metrics.** What gets measured gets done, so we should consider how the CQC assesses organisations.

05

Participant

'Let us tackle racism, sexism, and ageism in the NHS. Our population is ageing, and is our NHS fit for purpose for our ageing population?'

06

Participant

'We need a systemic change, and not one individual can make that change. It is not just about medical leadership, but it is about leadership and is about boards per se. We do not have representation at senior management level.'

Effectiveness

6 Regulators

6.1 **Regulators have a vital role in promoting and maintaining professional standards.**
Our work falls in a continuum of crucial behaviours, from standards and guidance to put this into practice at the other end. There are several areas within standards, good medical practice, or leadership guidance, relating to dignity at work.
However, these standards do not go far enough to tackle incivility at work.
6:3 The GMC introduced new standards to promote compassion, civility, inclusivity, fairness.
6.4 **A compassionate leader can take risks**. If, as a leader, one is not a compassionate risk-taker and unable to encourage, then one should reconsider their suitability for the role. It is essential to encourage and value staff.
6.5 **Disproportionate treatment** – There is an increased workload increased ask of presenteeism. Staff are often anxious about employer behaviour expectations. However, members from ethnic minority backgrounds are in a vulnerable position, and they often worry about being blamed for the consequences of the increased workload.

07

Participant

What is needed now is not just the standards but the implementation so that these can lever change.

08

Participant

'they are often not judged on a level playing field.'

6.6 During the Francis inquiry into the atrocities at Mid Staffs, Don Berwick stated that NHS staff were not the problem, but the environment, systems and constraints they were working in were the key issues.
6.7 **The need for a culture of learning fear is toxic to safety and improvement, and regulators have a significant role in creating a positive culture.** Data from the BMA showed that seven years from the Francis inquiry, we live in an NHS ridden with fear that is toxic to patient safety.

- 9 in 10 Doctors going to work are afraid that they will make a mistake because of systemic pressures.
- Over half of healthcare professionals feel unfairly blamed for problems and mistakes not of their own doing. This data is even worse for staff from ethnic minority backgrounds.
- About half of doctors practice defensively.
- Only 40% of staff feel able to report errors, and ethnic minority doctors are twice as less likely to report errors or concerns because of the fear of being blamed.
- 40% say they believe they work in a culture of learning.
- 40% of doctors suffer bullying and harassment, and twice as likely if they are from an ethnic minority background,
- A doctor is twice as likely to be referred to the GMC if they are from an ethnic minority background three times as likely if they are an international medical graduate.
- The MHPS internal trust disciplinary process has a more significant disparity weighted against ethnic minority doctors.

Effectiveness

- If you are a GP partner leading a GP practice, you are more likely to be rated inadequate by CQC.
- A hostile workplace culture results in a 45 to 63% higher risk of a significant medical error, whereas civility saves lives. There is also a 51% reduction in cognitive ability when a doctor performs in a hostile environment. We know that certain groups, like ethnic minority doctors, are treated worse than others, and patient safety suffers due to a lack of dignity at work.

09

Participant

'The GMC regulates individuals, and I do believe this is a problem. Don Berwick shows, that the majority of acts and omissions of doctors work is a result of systemic factors and yet the GMC is focused because of its role to look at the individual.'

6.8 **Racial bias** - We know about racial bias, that employers are disproportionate at referring doctors, but we must not forget the OMA carrying out a landmark ruling last year. The tribunal ruled that the GMC's processes may be racially biased. We believe the GMC should conduct a proper external review of the GMC's processes.

6.9 **The dignity of work is made worse because GMC referrals are weaponised,** with referrals being made often in a vindictive or rather vexatious manner between colleagues. The added double jeopardy in the BMA of parallel disciplinary processes within the employer itself.

10

Participant

So doctors are being hit twice. As a result, we have a culture where doctors do not speak out, and they are afraid of their regulators because they are not sure they will be treated fairly.

Dr Bawa Garba is a rather tragic case because of a system where the Trust itself found 79 actions in its internal review of what went wrong or the night a boy unfortunately died. However, the GMC could not speak about these numerous systemic omissions because its focus is on the individual.

6.10 **The CQC is a regulator in England, but doctors feel the CQC takes time away from looking after patients.** The most worrying statistic is that 86% of GPs and 71% of doctors say the CQC adds worry and fear in the workplace. According to doctors, this does not motivate improvement and does not consider context, such as workforce shortages.

6.11 **Regulators have a fundamental role in improving workplace dignity.** However, regulators can also exacerbate problems of workplace dignity through their processes. We need significant regulatory reform, a new paradigm in which every doctor is regulated within a system that the GMC should rule and only look at doctors when they also look at the entire system. When systemic factors are at fault, accountability needs to be part of judgments. The CQC process is also just a snapshot of a moment in time, and it does not regulate cultural change, which should be ongoing.

Reform is needed to ensure that regulations support dignity at work.

11

Participant

'I think we need a reform of our regulatory system that looks only at individuals while ignoring systemic factors.'

Effectiveness

- A “just culture” - health providers should investigate patient safety episodes in a no blame / ‘safe space’ environment (HSSIB* / aviation industry)
- **Any GMC investigation must always consider wider cultural and systemic factors or pressures from the outset**
- Where any act or omission has been caused fully or partly by systemic factors, any judgement by the GMC should also hold the healthcare provider/system to account
- GMC and CQC must be focused on a preventative strategy of regulating for a positive and open learning culture
- Aggregate CQC judgements should be abandoned in favour of identifying more granular shortcomings with support & improvement outcomes.

12 **Participant**

‘I think that the Medical Royal Colleges have a unique professional standing to promote and showcase role modelling of excellence in behaviours and support workplace dignity'

13 **Participant**

‘I think if you promote a just learning culture, you also promote a dignified culture. We need to be looking at those standards through the prism of dignity at work and making sure that that is crucial when developing those standards.'

14 **Participant**

‘I think we need to think about simple things like our panels, respectful of diversity, are they respectful of the dignity within the workplace?’

6.12 **Medical Royal Colleges** - The Royal Colleges need to have policies about how their members behave and HR capability to implement them. It needs to lead by example and call out destructive behaviours. As a college, we need to recognise disrespectful behaviours, those who do not promote dignity at work, and acknowledge that there are difficulties in calling out poor behaviours.

6.13 **Leading on solutions** - All curricula include professionalism and leadership, yet they do not cover the virtues of followership- which is the need to engage in team behaviours. Curricula are designed to train people in the knowledge and technical aspects of the job. However, they should also include training in behaviour and skills for working in a safe, supportive environment, management and leadership. We produce resources for trainers to highlight issues and help them deliver their job, but we need to implement the solutions. We should provide opportunities across the career structure to junior colleagues to promote the development of leadership roles.

6.14 **Tackling historical wrongs** - Should we be acknowledging previous behaviour.

15 **Participant**

None of us is perfect, and I do not think anyone can sit there hand on heart and say I have never been poorly behaved to somebody. It is about acknowledging that we have the structures in place that poor behaviours cannot happen again. We use these behaviours as learning rather than vilifying those in the past, and we need to move forward.

Effectiveness

6.15 Why do we need more than just professional standards?

- The Nursing & Midwifery Council, expects staff to prioritise people, practice effectively, preserve safety and promote professionalism and trust.
- Moreover, the first area under prioritising people requires our professionals to treat people as individuals and uphold their dignity. To achieve that, **they must treat people with kindness, respect and compassion, recognise diversity and respect and uphold people's human rights.**
- To practice effectively, we expect professionals to work cooperatively, recognising and respecting their colleagues' skills, expertise, and contributions.
- One of the aspects of preserving safety is protecting anyone who has management responsibility for any harm, detriment, victimisation after a concern is raised.
- Promoting professionalism and trust is centred on a personal commitment to the standards and behaviour set out in the code, being a model of integrity, treating people fairly and without discrimination.

16

Participant

We must empower and involve all staff in driving improvement through leadership. It is through effective management, openness and good governance.
It is not just kindness to patients, but it is about kindness, respect and dignity for each other. It is a curiosity about how we can all be better tomorrow than we are today.

6.16 **The Team, Organisation and System** -

Our focus is necessarily on the individual as a professional regulator. However, staff do not operate in a vacuum. They are part of a multidisciplinary team, working within large and small organisations and in complex and interdependent systems. **The team, organisation and system play a critical role in creating an environment where our professionals comply with their code.** That is why these standards for dignity at work can come in and guide teams, organisations and the system to do the right thing.
Regulators must:

- Have that shared vision for excellence and dignity at work with all staff.
- Be culturally intelligent leaders,
- Provide training and support and
- Promote effective and respectful interactions.

6.16 **Regulators set the tone and have an essential system leadership role.**
Regulators do that by setting a tone through how we do our work. Regulators must be very clear about their values, be fair, be kind, be ambitious and be collaborative. In being fair, regulators must ensure that they respect and value diversity and promote equality and inclusion in everything. Regulators must act with kindness and in a way that values people, their insights, situations, and experiences, and to be ambitious. That is about taking pride in their work, learning from when things go wrong and improving specific areas that are relevant for today.

Effectiveness

6.17 What can the regulators do to prevent disproportionate referrals from happening?

- One of our (Regulators) key concerns is that early intervention is required all too often, as it is usually too late by the time someone is referred. Early intervention and collaboration will make a difference in this space.
- We (Regulators) need to provide guidance for employers about what makes a reasonable investigation at a local level.

6.18 Economic benefit of the engaged workforce - We found very clearly that for every two standard deviation increases in staff engagement, a hospital trust can save on average £1.6 million per annum.

17 **Participant**

'I am convinced that we do not get safe care if 745,000 people are scared of their regulator.
We need to make sure that we have an essential role in promoting a just culture, understanding the context when issues happen and referring to us by focusing on showing that people are fit to practice and not punishing them.

18 **Participant**

'The way an organisation treats its minority staff is a good barometer for the overall culture of care within the organisation. That is why we must focus on compassionate culture and compassionate leadership. in order to get compassionate leadership, we need to be comfortable with the uncomfortable.'

19 **Participant**

'If respect is one of our values, do we need to define it? If this is something we value or expect, we recognise those behaviours and define them.'

6.19 Mentorship and support- are about empowerment and compassion towards others in the workplace. When there is compassion, you get to know your team, and you can predict trouble or see someone is in trouble and be alongside them.

6.20 **We must build on a standard of excellence within an organisation and set a standard of cultural awareness.** The priorities for addressing culture change are well understood. We know the culture we are aiming for, we have set values, and we are reaffirming those values.

The dismissing attitude towards millennial behaviours or woke culture is wrong when people are standing up to toxic behaviours. There are many aspects of what the younger generation stands for, typically coming up through the organisation with higher expectations, that we could adopt.

19 **Participant**

'It takes courage, defining what we expect, rewarding when we see it and compassionately challenging when we do not because that is what causes change.'

Effectiveness

20

Participant

'Who regulates the regulators? We need an external body.'

21

Participant

'In many people's minds, informal appear unprofessional and formal is professional.'

22

Participant

'Blame does not have to be apportioned for justice to be done.'

23

Participant

'We do not want to get rid of all of these people that perhaps do not have the best behaviour, but we do want to change that behaviour, and we can do it, but it tends to be person by person. We need to be tenacious, with energy and absolute determination.'

Leadership

7. Compassionate Leadership

7.1 Compassionate Leadership can improve patient outcomes, and we must encourage compassionate people to become leaders. We must support, mentor, and coach leaders into specific Compassionate Leadership roles.

7.2 The silent bystander is someone who sees something going on and does not attempt to do anything about it; such inaction needs to be eradicated.

7.3 The bullies within the system are obstructive to a cultural change. These bullies are sometimes also supported by people at higher management levels and create fear in individuals so that they cannot achieve anything positive for the organisation.

8. Dignity and Health

8.1 The impact on health and well-being when someone suffers a lack of dignity at work, whether bullying, harassment, discrimination, violence, aggression, or others, we look at how wide-ranging the impacts can be.

Bullying and harassment can worsen severe mental health problems, physical health problems, and in fact, on immunity.

8.2 Interventions at an organisational level

- Junior staff often do not feel safe enough to raise concerns. We have to find interventions for them to feel safe enough to raise concerns.
- **We need to define the role of dignity champions** and establish how to make a difference and if it will work.
- We must enable victims of bullying and harassment to become part of the solution.
- **We must help victims as well as perpetrators. There must be an emphasis on rehabilitation and recovery if we want to create dignity at work.**

24

Participant

'We have doctors whose careers are destroyed because they raised their voices and often can never get back to work. They lose their confidence and cannot function as doctors without constantly looking over the shoulder, which is unfortunate.'

9. **Consequences of raising concerns – Whistleblowing**

9.1 **Reform and regulation of Managers**

- Senior managers must be encouraged to be brave.
- Reform the processes and the structures.
- Develop regulation for managers and leaders, which does not presently exist.
- Be more preventative rather than reactive.
- In times of conflict provide fair representation. Usually, the power balance prevents organisations from providing relevant advice to the doctor with less power, which tends to be junior members increasingly from ethnic minority backgrounds.
- Tackle cultural insensitivity and blindness to the impact of diversity
- During complicated investigations or allegations, the lack of empathy can be added stress to staff, and **organisational leaders must display empathy to support them through these episodes.**

Leadership

25

Participant

'It is one of their identities, as opposed to being at work, but even in their personal lives. Being a doctor is an identity for them. Furthermore, when all of that is at stake, the emotional disturbance that doctors go through and the lack of support and lack of understanding leads many doctors to either break down or lose confidence in the regulators or, in very tragic circumstances, take their own lives.'

26

Participant

'Far too many international medical graduates, Black or minority ethnic professionals who end up in disciplinary or regulatory curtailment of their licence to practice are victims of racism either through their colleagues, employers, or patients. There needs to be full-scale reform, but we need to make it a significant issue.'

9.3 **A significant precipitator of mental illness is getting a severe complaint in an organisation or one that goes up to the regulator.**

Sometimes, mental illness may have led to the complaint, for example, in cases of substance addiction. We know that doctors often have mental health issues misinterpreted as performance issues, particularly from varying backgrounds.

If a doctor does receive a complaint, It is not just about the complaint and the complainant, but we must be looking for systemic problems and see what might have led to the issue.

9.4 **Data and Benchmarking** - we need to start collecting comparative data on organisations that use disciplinary processes at a national level.

This data set should not just be referrals to regulators or complaints, but how organisations respond to the escalation of concerns and grievances.
We need to start collecting this data like we do at a national level and examine whether we can see trends to intervene.

9.5 **Disproportionate handling when errors occur -** There is a big difference between BAME people being disciplined and white people. White individuals will get an informal warning or a conversation or even get overlooked.

The disproportionality is not because BAME doctors are worse than white colleagues that are probably making the same mistakes, and it is what managers do with individuals.

9.6 **Disproportionality affecting IMGs** - If a doctor or nurse from abroad receives a complaint, the support network is weak, families are distant, and the regulator often overlooks the social context (behind a complaint).

9.7 **Need for enhanced induction -** The NHS and DoHSc should provide a mandatory induction and mentorship programme as an introduction to the UK for foreign doctors.

9.8 **Setting Standards by the Regulator** – The regulator must set their expectations for organisations and demonstrate that the environment they foster induces good practice of support.

- Providing feedback to organisations -
- Every system needs a feedback loop. The regulators need to develop this feedback loop and ask organisations to demonstrate their learning from referrals
- Through an annual report and an action plan, demonstrating their accountability.
- **Independent grievance panel for the NHS** – There is a need for a specialist group of independent people to be nothing more than a disciplinary grievance panel for the entire NHS, independent of the employment tribunals.

Regulation

10 **Implementing the Standards**

10.1 Investment in good practice -

- Organisations must invest in good practice so that the sector itself can develop a framework for action and change.
- It should be data-driven,
- co-created based on a local level self-assessment, action-oriented with intelligent objectives.
- It should measure the outcomes, and the final result should be peer-reviewed. Small interventions and actions can add up because we do the things that change the culture of organisations, and these actions need to be addressed.
- Role of leadership - creating an environment for people to be honest and managers feel confident to address issues of race-related grievances.
- Introduce reverse mentoring and specialised training.
- Promote awareness about what microaggressions are and their impact on people.
- Close the race pay gap, it may not seem to impact bullying and harassment, but it is about rewarding appropriately.

27

Participant

'Bullying is endemic. Just being a doctor is a risk. Furthermore, doctors from overseas, who are fleeing war, leaving their families, their culture, need to learn a new language. All these risk factors put them at higher risk of mental health problems.'

28

Participant

'Regulators have to be very careful not to undermine the autonomy of the professions they are there to serve. Because that can also be unhelpful and hinder success.

29

Participant

'we have to rethink what we do. We have to rethink what we know. Nevertheless, most importantly, we have to rethink what and who we are in terms of our values, our behaviours, and how we can tackle this issue.'

Empowerment

10.2 Workforce Race Equality Standards - The workforce race equality standard emboldened those with negative experiences and gave them a voice to show positive change has begun. **Intersectionality is crucial because these are some of the most vulnerable staff with the lowest voices.**

10.3 **Empowerment and life-expectancy -** The WHO reports on the impact of not being empowered and valued at work impaired their life expectancy.

Gender empowerment measure (GEM), a composite index measuring gender inequality in economic participation and decision making, political participation and decision making, and power over economic resources, analysis of data from 75 countries with GEM values in the 2006. The Human Development Report (HDR) showed evidence of association with measures of health and mortality. [2] Analysis of data from 1970 to 2013 across 149 countries suggest, quite strongly, that higher levels of empowerment have a significant positive association with life expectancy, particularly for females, and lower rates of infant and under-five mortality. [3]

10.4 **Improving metrics for all** - The NHS staff surveys demonstrate that the extent to which an organisation values its minority staff is a good barometer of the quality of care provided to their patients. If we take that method into looking at gender or other protected characteristics, it will probably work similarly. It is a compelling incentive for the whole workforce to implement workforce equality standards to achieve dignity at work.

10.5 **Improving the minority experience and what this means for organisations**

- We know that minorities and minority groups do not form a monolithic group. However, very diverse and profound experiences occur on a spectrum from biases and prejudices, including discrimination, bullying, harassment, and marginalisation exclusion that occur across their career.
- Colleagues feel that they cannot bring their whole authentic selves to work, do not feel included, or do not feel that they belong where they are working.
- It is difficult for BAME colleagues to tease out which part of their identity may lead to invisible barriers, e.g. when wearing the headscarf. They perceive the need to exert that extra effort to prove themselves because of the assumption of being somewhat incompetent or intellectually inferior.
- Foreign doctors, in particular, face many difficulties with accents being made fun of. Whether it is because of your ethnicity, race, religion, sexual orientation, whatever it is, you have not to allow a part of yourself to be, and you distance yourself from it. It does not make you whole, and therefore, it did not make me happy.
- We need an intersectional approach, not just at the individual level, looking at one of these multiple characteristics, but also across the level in the NHS.

Organisational culture

- At the structural level, we need to be thinking about how government policies like immigration health surcharge, adult dependent relative prevention policy, the mandatory vaccination policy that's coming into effect impacts particular groups within our organisations and the media.

- **Intersectionality must be centred at all dignity and EDI policies within governance structures and processes that are clear, transparent and consistent.** Metrics to capture all protected characteristics and go beyond metrics, look at the lived experiences, and have benchmarks of an exemplary process.

- **Organisations must promote cultural humility where we make space for honest and reflective conversations or communications and respectful, non-judgemental interactions.** We need training that goes beyond standalone unconscious bias training. We need to include empathy-based training around really helping people at an individual level. We need to include personalised job plans and risk assessments and support the diverse and multicultural backgrounds. Supervisors and mentors should be relatable and approachable. There must be psychological safety within the organisation around processes such as whistleblowing and freedom to speak up for guardians.

- We need a whole system, a whole-person integrated approach that's coherent and that centres around people and values.

- **Organisations must protect people with multiple characteristics and work to implement an intersectional approach.**

- A humility model allows you to have greater understanding and insight.

11. Organisational Culture

11.1 Shifting organisational culture to equality, diversity and inclusivity. The structure for accountability and delivery vehicles are not well established.

An EDI Lead should be appointed at a senior level as part of the executive committee, but such an appointment should not take away from the fact that there is shared responsibility and accountability for all leaders. However, the EDI lead is usually a single person tasked with quite a significant FTE contribution to bringing all of this activity together. This role should include a period of training to learn about broader diversity characteristics that affect colleagues, staff, and students within the university and involve external training development programmes.

- There is a need for resetting strategy and linking with organisational key performance indicators. Once agreed, this vision, strategy and targets were about the proportion of staff at particular levels followed by a programme of activity including workload and well-being.
- Develop cultural collaboration and allyship
- Empower diversity at the senior management board level to improve professionalism and outcome measures of an organisation.
- Establish cultural ambassadors- who understand and have expertise in discrimination
- Invest in well-being initiatives.
- Empower a Safe to speak up forum where they can raise concerns and issues, proactive development instead of waiting for staff to manage their career trajectories.

Implementation to Delivery

- **Monitor, publish and address the ethnicity pay gap and the proportion of women and minorities stops at senior levels**
- Increase awareness of organisational objectives, staff feedback and information about the range of available opportunities through website and newsletters that talk about engaging and thought-provoking themes.
- Incentivise people to move towards a culture of diversity intelligence, so organisations do not just have leaders, managers but also individual staff who are aware of the imperative around equality, diversity.

11.2 Leadership

An organisation needs authentically inclusive leadership and creates a culture that embraces diversity at its core. However, within the NHS, we still have a long way to go achieve this. There is a need to get more compassionate people to be leaders and ways to get leaders to become compassionate. Leaders create the climate of the team. Leaders take responsibility and remain mindful of the temperature particularly in response to the external shocks and forces.

11.3 **Organisational culture**
The organisational environment that is not ready to accept diversity or representation is what we need to tackle as a focus of our interventions. Individuals should not feel forced to change themselves to fit a particular job or seek support.

We need organisations to adopt an atmosphere or a culture in which individuals who have the right attitude and the proper thinking progress and not only those with certain privileges or characteristics. Organisations should prioritise the right person with the right skills for the right job. Organisations should the impact of institutional hierarchy, understand culture and power difference and adopt a bottom up approach.

11.4 Wider Multi-Professional Leadership

It is everybody's responsibility, and that goes much within the organisation but to society as well.

12. Implementation to Delivery

12.1 Education

Education has a role. Education is not just about educating others but educating ourselves as well. We need training and education packages for managers, including clinical and non-clinical managers, but this is not enough to address the problem.

We want employers to be required to provide early support interventions when there are mistakes and show accountability for giving a proper induction where we finally have elimination of disproportionality.

We want colleagues to receive a comprehensive welcoming, supportive induction and improved supervisors understanding.

12.2 **Accountability**

Accountability comes from the system or leaders. Currently, we work in a system where clinicians are accountable for everything they do or do not do. However, managers are not. There is a system of accountability, and there is a learning system for offenders. It is human to make mistakes, but we need to be held accountable for our actions or inaction.

An independent review mechanism at the organisational level is needed to create accountability for any action taken by the manager or lack of action in addressing the concerns raised by an individual

Implementation to Delivery

12.4 **Focus on Delivery**

The focus is around delivery, not implementation but delivery. The question is, 'have the policies delivered on dignity in the workplace?'

- Policies, Procedures and Standards on their own will not work. One needs a new paradigm.
- How does one create cultures where this never comes up as an issue?
- **There is very little evidence that personal or systemic interventions prevent bullying.** So, whatever we decide to do today and take forward, we need to evaluate it. We do need evidence of what worked and if it does not work, let us disinvest in these.
- **We do not need evidence of a problem, but we desperately need evidence about the impact and what works and what does not.**
- Reform is needed. The medical act does not confer the power to do what we [regulators] want with employers.
- Shared leadership means leadership flows depending on the situation, and it is not tied to the individual but the situation.
- Much of the emphasis of NHS policies and processes that the NHS operates on is unconscious bias training.
- One of the things that we must do is look at the causes of inequalities that we see and focus on fundamental issues to get a better outcome.

In real-time, what can we do quickly?

- **Be polite to each other.**
- **Listen to people – hear their experiences and give space to validate them.**

System regulation
CQC have a long way to go before their inspections can become meaningful and bring accountability. Even if they become meaningful, they will never bring real-time accountability for feedback.

Accountability by Non-Executives.
Non-executives who are supposed to hold executives to account are not doing the job. There is a disconnect between the executive, non-executive, and frontline staff. The frontline staff hardly sees the non-executives, and Non-executives do not even know what is happening at the ground level.

30 **Participant**

If you could harness your energy to build whatever is suitable for you in terms of the delivery framework, which will probably take two years, then you test it and pilot and evaluate it. You show that it works, and you get people wanting to buy into it. I think that is how you move forward with this agenda. It is self-evident if you got all the stuff that's needed to do that, and you have got the leadership.

Setting the Standards

12.5 **Setting the Standards at each level**

- Government – The Department of Health & Social Care has to set out their employees' overarching support and value. We have not focused on them, we focus more on the management level at individual organisations, but Trusts have a spectrum of managers, some very good, some not so. The responsible government departments have made some fundamental changes centrally.

- Managers - Middle managers need support training, and they are, in fact, culpable for much of the day to day cold faced experiences of people. There is a lack of caring for staff well-being when concerns are raised rather than the assessments by regulators.

- We must hold those who ultimately carry authority for incivility and hold them to account.

- It is time to have an accountable platform for management and manager decisions, whether they are leaders or not leaders.

- **We propose the idea of a national whistleblowing office where people can go outside their workplace to raise concerns without worrying about repercussions.** This office should be an independent panel under no pressure from the Trust and the NHS, who can look at whether there is a genuine whistleblowing concern.

- There are guiding principles, rules of thumb that people operate and then work out locally, how to apply them, and I am very intrigued by the degree to which it gets shifted up onto either managers or the regulators to people outside this group's control well.

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Epilogue

The purpose of writing these Standards was to raise awareness of the impacts of bullying and harassment within the healthcare setting, highlight the reticent nature of intersectionality, establish effective methods to eradicate bullying and harassment and discuss these methods in order to adopt a zero tolerance policy. We will work with the various stakeholders to make the standards attainable by 2025.

Interventions & Awareness

All healthcare settings will adopt interventions mentioned in these standards to work towards dignity in the workplace.

- Freedom to speak up with no consequences
- Transparent guidance on complaints process
- Organisational awareness of rights and policies

Collaboration & Culture

All staff including clinicians, nursing staff, managers, executive board and more, will work together to create change.

- Effective and respectful interactions
- Culture of openness and raising concerns
- Cultural conciousness and diversity

Eradication & Accountability

Organisations will work towards creating an environment where the dignity of staff is paramount and any breach in this will be reflected appropriately.

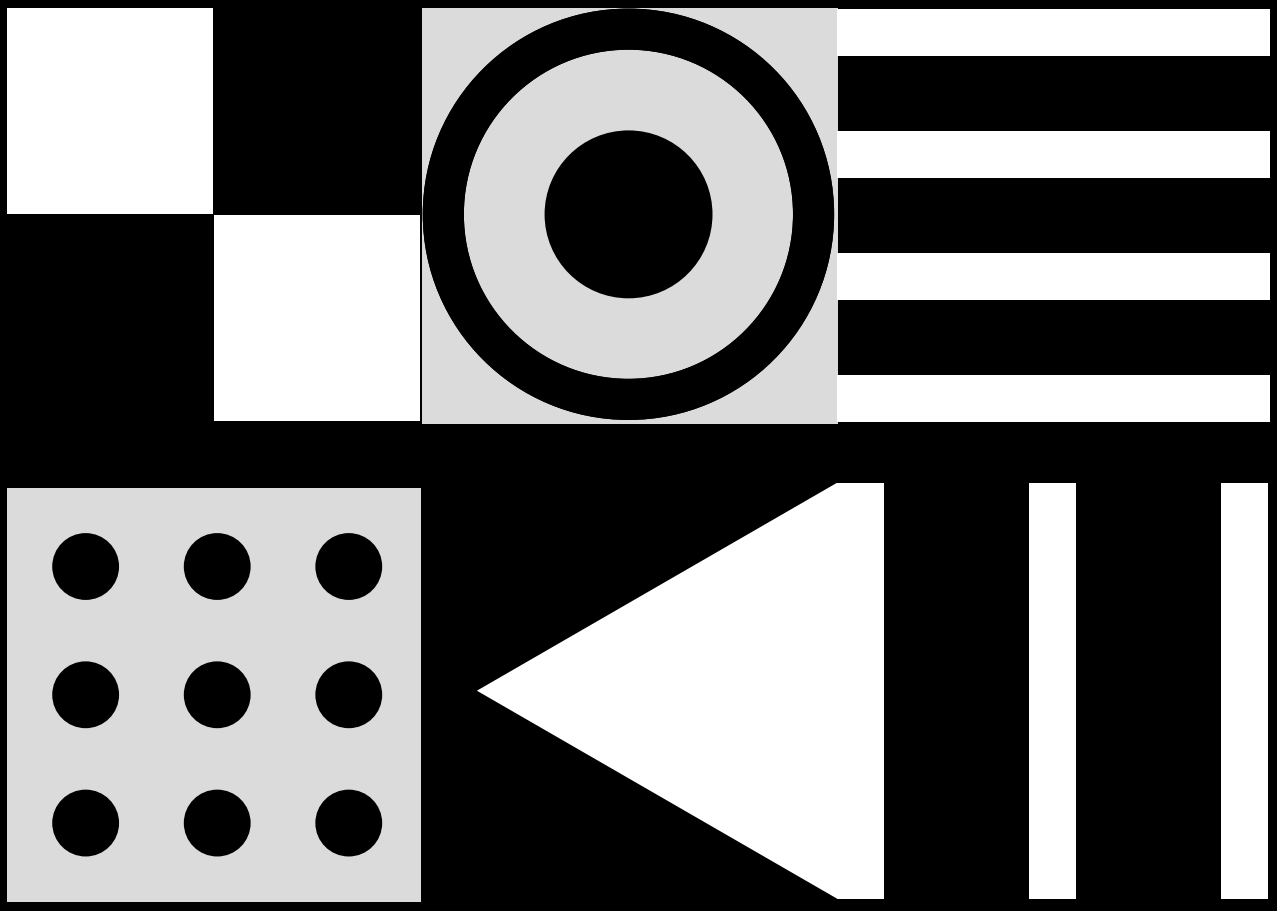
- Zero tolerance policy for bullying and harassment
- Regular monitoring of complaints
- Organisational accountability when issues occur.

Alliance for Equality of Health Professionals

- British Association of Physicians of Indian Origin
- British Egyptian Medical Association
- Association of Pakistani Physicians of Northern Europe
- Medical Association of Nigerians Across Great Britain
- British Indian Doctors Association
- British Indian Psychiatrists Association
- Medical Women's Federation
- Royal College of Physicians of London
- Royal College of Physicians of Edinburgh
- Melanin Medics
- Doctors Association UK

BIHR-BAPIO CONSENSUS

2022



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BAPIO SAS &
LED FORUM

SEPTEMBER 2022

CHARTER

FOR LOCALLY EMPLOYED DOCTORS IN THE UK NHS

PRESENTED AT THE

NATIONAL LED CONFERENCE

LEICESTER

24 SEPTEMBER 2022

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SAS-LED FORUM

CONTRIBUTORS

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FOREWORD

Kantappa Gajanan, Chair

The British Association of Physicians of Indian Origin (BAPIO) is a well-known national organization for its support of International medical graduates and its stand on inequalities. The BAPIO SAS & LED forum has worked hard to increase the profile of Locally employed doctors (LEDs) in the last three years. The forum Committee has doctors from a multinational, multicultural, multireligious and inclusive group and is led by more than 65% women. The forum aims to increase the profile of SAS & LED doctors and is open to any doctor who comes to work in NHS.

Its four pillars are,

- Improve the profile of the role
- Support for career progression
- Engage in education, teaching and research.
- Mentorship and pastoral care.

To improve the LED profile and raise awareness, we planned the first National LED conference to create a platform for these doctors to showcase their talent and exemplary work and learn from peers through presentation, networking and knowledge sharing. These doctors need more support in improving the working environment so they can thrive and get trained to treat patients safely. We want to bring all the stakeholders on this platform to work harmoniously to improve the life of LED. To make this happen, we have worked hard as a team with lots of input from various team members and devised the LED Charter with the first edition. This will be discussed, and further worked with diverse stakeholders to make it beneficial for LED doctors.

I welcome you all to this conference and thank you for helping and being part of this document to improve the working conditions of LEDs.

EXECUTIVE SUMMARY

Charter for Locally Employed Doctors in the UK NHS

Indranil Chakravorty MBE

Locally employed doctors have been described along with their compatriots as 'the lost tribe' compared to their peers who are either in formal training or consultant or general practitioner posts. Over the last decade, considerable progress has been made in improving the recognition, value, and respect given to doctors in Specialty, Staff Grade or Associate Specialist (SAS) roles with harmonised contracts, working conditions and support available. The vast majority of the cohort of over 127,000 doctors in the SAS-LED category as per the UK medical register (GMC 2022 dataset) continue to be lumped with their SAS historical counterparts, yet have a very different experience. These LEDs are unsung, unheard and remain voiceless members in the UK NHS medical staff, yet continue to provide service in delivering high-quality healthcare to the nation.

Most human resource departments, rota managers and consultants or GP Principals responsible for running safe services may consider them as 'rota fillers', where the employing organisations, education and training boards (i.e. Health Education England or Health Authorities), the regulator and even their trade unions do not demonstrate any consistent responsibility to providing them with the essential tools for delivering safe, effective service or support to pursue their career aspirations and have fulfilling working lives.

The NHS is not immune to the bias and discrimination rife in wider UK society; this phenomenon was better recognised during the COVID-19 pandemic. Nearly 60% of LEDs have a minority ethnic background, and most obtained their medical training and primary qualifications overseas. It has been shown consistently that these characteristics usually lead to a poorer experience while at work, a higher risk of burnout and for receiving a harsher outcome from investigations for breaches of professional standards.

The BAPIO SAS-LED forum was established to support, represent and improve the working lives of SAS and LEDs in the UK. In September 2022, the forum is organising the maiden conference for LEDs at Leicester. This is the first initiative of its kind. This conference also provides the perfect backdrop to launch the LED Charter, which aims to harmonise the whole spectrum from recruitment, employment contracts, working conditions, support, education, training, career support and wellbeing for the over 100,000 doctors in this category working in the UK health service.

This Charter is ambitious in its aspiration and aims to deliver the 'Gold Standard' for all LEDs. It was developed following a prolonged exercise of listening to the experiences of many LEDs both within the membership of BAPIO, across its affiliated organisations and social networks. It is unique in being developed and written by LEDs and IMGs early in their careers or by those that have transitioned to more established senior and autonomous roles. So it is grounded in the reality of lived experiences and ambitious in setting the bar at an equal level with other doctors in the UK NHS.

The LED Charter offers ten practical recommendations for implementation by all NHS employing organisations. Most of the principles of equality and inclusion described in this Charter should be embraced by the medical royal colleges, education and training agencies (i.e. Health Education England) in their committees and processes to provide a voice to this 'lost tribe'.

By implementing and supporting the uptake of the LED Charter, NHS organisations, education and training agencies, royal medical colleges, the regulator and trade unions can help to break the perpetual cycle of inequality, differential outcomes, poorer working experiences and consequences on health and wellbeing for these doctors. BAPIO SAS-LED forum will work closely with our partners and all stakeholders to undertake annual surveys of LED experiences from 2023, provide a national benchmark and assist NHS Employers in achieving compliance. If we need our NHS to survive and flourish, we must respect and value all our staff - remembering the NHS People Plan.

BAPIO TRAINING ACADEMY

BAPIO FACULTY OF LEADERSHIP

BAPIO INSTITUTE FOR HEALTH RESEARCH

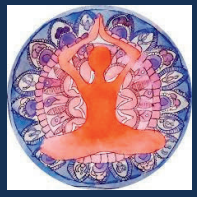
BINA British Indian Nurses Association

MDS MEDICAL DEFENCE SHIELD

BAPIO HEALTH & WELLBEING

BAPIO BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN 25 YEARS SILVER JUBILEE 1996-2021

The Physician
Journal of The British Association of Physicians of Indian Origin



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SAS & LED Forum
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CONTENTS

INTRODUCTION

Overseas doctors have been working in the UK even before the inception of the national health service (NHS) and continue to play a crucial role in successfully delivering healthcare. They represent one-third of the total number of UK doctors, including doctors from the European Economic Area and international medical graduates (IMGs).

Overseas doctors gain their primary medical qualification from about 150 diverse countries, with the inherent variability of medical regulations between the country of origin and the UK. In addition, the frequently inadequate information about the NHS and its structure makes the reality often differs from expectations.[1]

In 1972, following several concerns from the public and healthcare providers regarding the variability of the knowledge, skills, competencies and communication of a significant proportion of IMGs, the Merrison Inquiry was set up.

Dr AW Merrison concluded in his report published in 1975 that there was a need for a new regulatory authority responsible for registering the medical practitioner, quality assurance of education and training and assessing fitness to practice. [2]

The Temporary Registration and Assessment Board (TRAB) was set up to check that any IMGs could meet the requirements for practice in the UK before being granted registration. The formalisation of differential attainment perhaps commenced with only a third of applicants being successful in this assessment. [3]

IMGs usually do not have adequate information on individual posts, particularly for competitive specialities. They may not be made aware of the new regulations, e.g. requiring them to obtain medico-legal insurance during clinical practice in the UK, hence may miss this important support when most needed.

As the acceptable practice of medicine requires knowledge of language and culture, overseas graduates need time to become familiar with practice in the UK, mainly when their training in medical school is not in English. Even when English is the medium of instruction, the language learnt may vary in its day-to-day use for grammar, phrases and idioms. There are also the subtleties of language and dialect to misunderstandings of the nuances of non-verbal communication and social and behavioural norms.

- Lack of information about the UK health system;
- language and communication challenges;
- clinical, educational and
- work-culture challenges; and
- discrimination challenges are some of the difficulties that overseas doctors might experience.

The Merrison report recommended a national induction program for all IMGs and uniform support to be provided; it has taken till 2022 for this to be finally implemented. Understanding these challenges and providing support is essential in helping overseas doctors make a smooth transition. [1]

A lack of work-life balance in medical training negatively impacts doctors' learning and well-being. Women with children and International Medical Graduates (IMGs) are particularly affected.[4] There are additional challenges for IMGs and UK doctors who have either a protected characteristic and commonly face bias, discrimination and sometimes overt racism from colleagues and patients/ members of the public. [5–7]

1.1 Who are Locally Employed Doctors?

Locally employed doctors (LED) are a diverse group of doctors employed by organisations such as National Health Service (NHS) Trusts, private hospitals, and the community and primary care sector. Their core function is to deliver health care (often described as service provision) in partnership with consultants, doctors in training, Specialty doctors & associate specialists, and other health professionals.

They are distinct from the Specialty Doctors and Associate Specialists (SAS) grade and comprise doctors who are not in formal, designated training posts.

The General Medical Council register and NHS Digital data indicate that one-fifth of all the licensed practitioners working as Locally Employed Doctors obtained their primary medical qualifications (PMQ) abroad, therefore, are referred to as international medical graduates (IMG).

LEDs are known as 'Trust Grade' doctors and cover many contracts and job titles, often of fixed term duration.

1.2 Inferior experience

Locally employed doctors are a cohort of doctors with a wide range of clinical experience at different stages of their careers. They choose this role for a host of diverse career or life aspirations. A sizable proportion starting their career in the NHS fall under this group. They may have completed Foundation or Core training and choose to take a gap in their formal training.

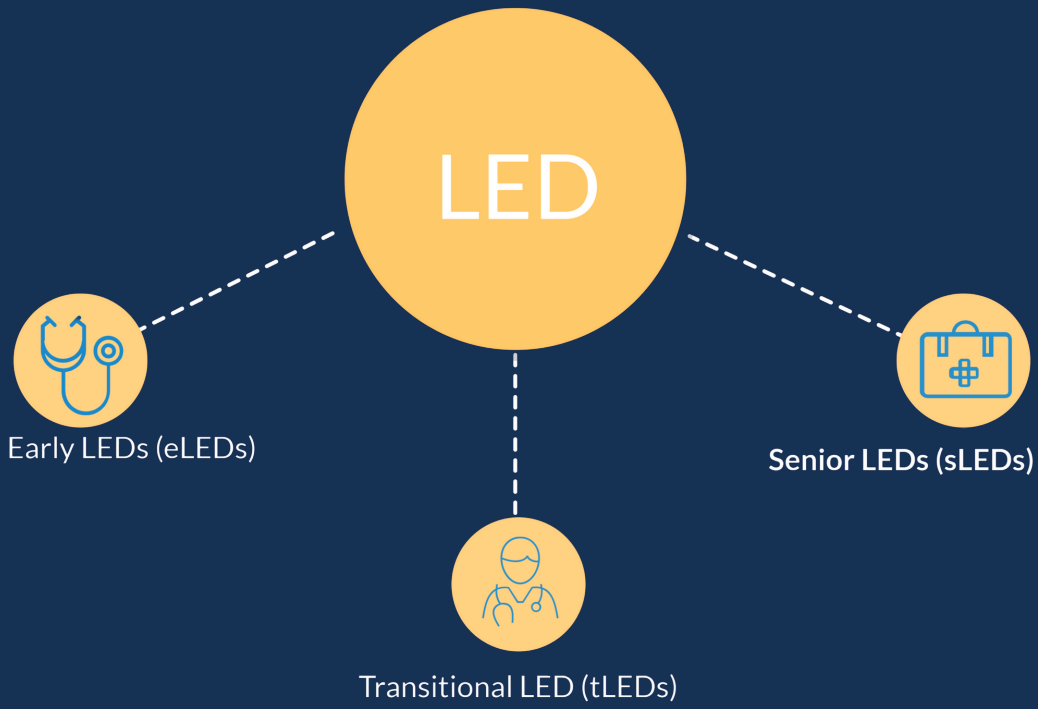
Many LEDs are IMGs, some on a Medical Training Initiative (MTI) programme, European Union doctors undertaking fellowship or overseas doctors looking for employment and experience in a different health system.

Despite their variable backgrounds, clinical experience and aspirations, they have a unity of having challenging and often substantially inferior employment support, workplace experience, differential opportunities for career progression and a higher likelihood of being investigated, blamed for errors and reported to the regulator.

This manifests mainly due to a lack of access to structured educational or learning opportunities and professional support and adversely impacts their wellbeing. Despite the absence of a national agreement, there are pockets of good practice.

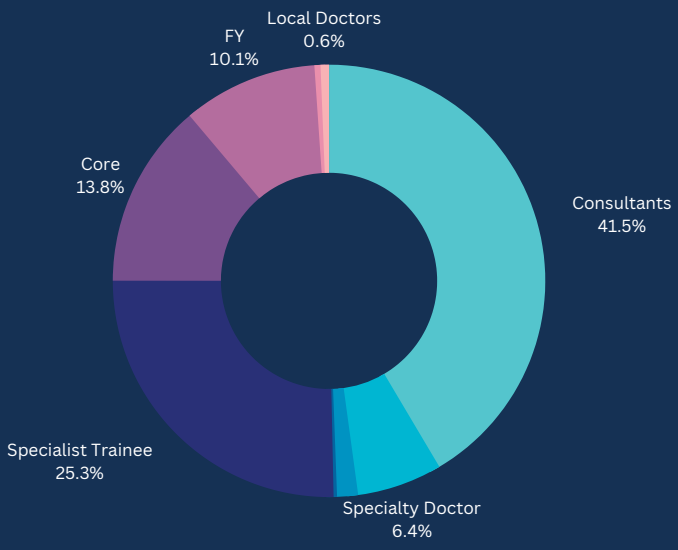
However, it is widely recognised that there is an urgent need for improved employment contracts, equality in induction, structured education-training opportunities, a supportive workplace environment, and career progression.

In addition, recognition of the diversity of backgrounds, career or life aspirations, and inclusion as valued members of the employing organisations and their respective professional bodies (i.e. Medical Royal Colleges and Specialist Societies).

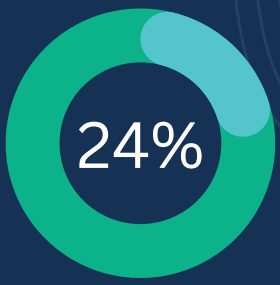


DATASETS

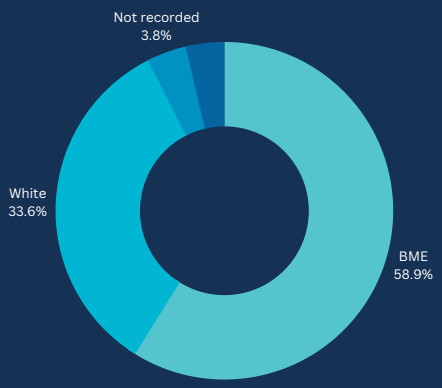
UK NHS WORKFORCE



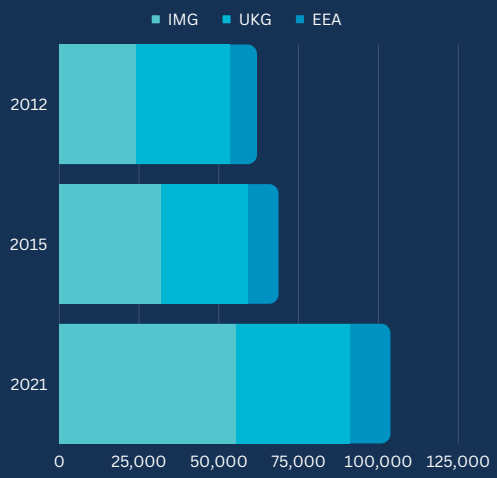
NHS hospital workforce data by grade; May 2022 | total; 128,027



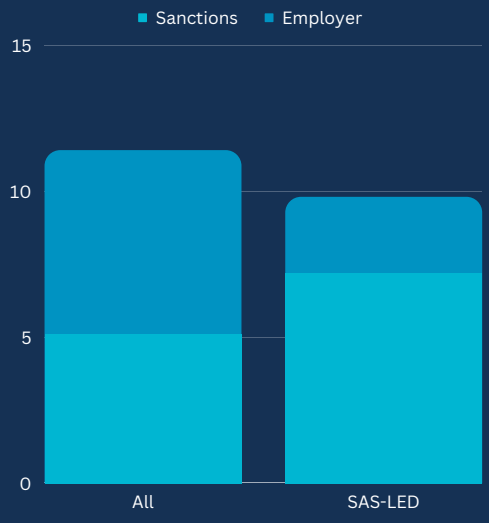
GP Workforce Permanent vs Locum; Total 35,257 | July 2022



Ethinicity of SAS-LEDs from GMC Register 2022

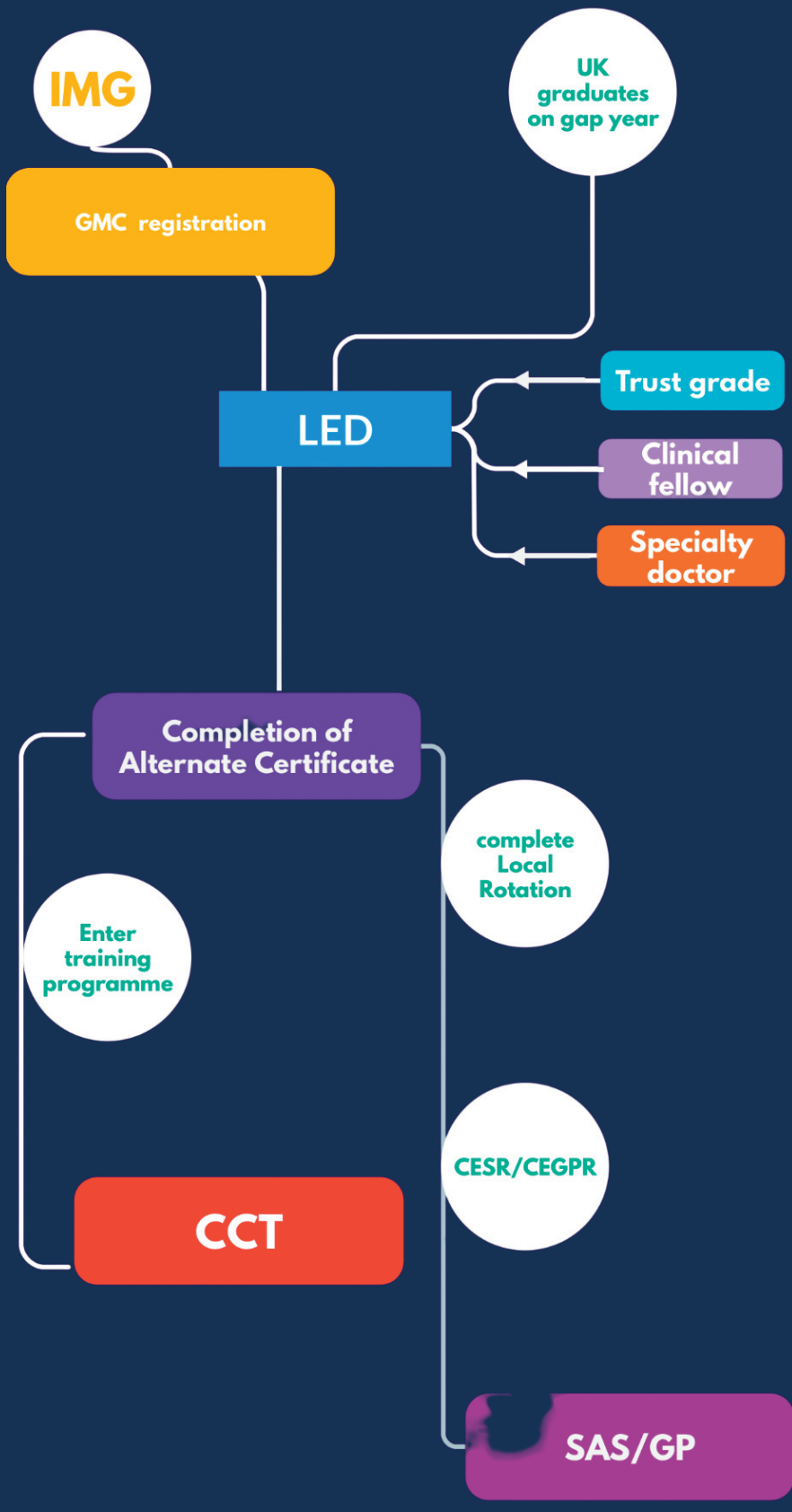


GMC Registration dataset for SAS-LEDs based on PMQ UK, IMG & EEA | Total 104,571 in 2021 out of 354,583 doctors in the register



Proportion of complaints and their outcomes- Sanctions vs being referred to employer | GMC Data 2017

LED CAREER PATHWAY



BACKGROUND

2.1 Types of LEDs careers

Locally Employed Doctors come from various backgrounds, have a wide range of clinical experience, and entertain a range of career aspirations and lifestyle choices. There are three distinctive subgroups:

2.1.1 Early LEDs (eLEDs)

This group comprises doctors within the first five years of their careers in the UK healthcare system. These are primarily UK-trained doctors who have completed their foundation or core training periods and are taking time out of formal training for career, research or lifestyle considerations.

They also include IMGs who are new to the NHS (newly registered with an approved practice settings restriction) or have worked in the system for less than five years.

A large subset of LEDs who are IMGs needs to procure a CREST (Certificate of Readiness for Specialty Training) to enter an approved training program in a hospital or primary care.

Recent or Periodic LEDs -
The UK General Medical Council (GMC UK) report also refers to them as Recent SAS and LEDs – doctors registered less than three years ago and have not entered an approved training programme. They are typically IMGs and younger doctors from the European Economic Area. Periodic SAS and LEDs – doctors who have started a training programme and then taken a break, predominantly young UK graduates in the early stages of their careers. [8]

2.1.2. Transitional LEDs (tLEDs)

Include doctors in the UK healthcare system for more than five years who have had breaks from training to pursue out-of-program career activities in research, leadership, management or alternative/ additional qualifications or have family commitments and caring responsibilities.

This includes IMGs who have postgraduate experience in their home countries. They often try to enter into formal training unsuccessfully and therefore require an alternative CESR (Certificate of Eligibility for Specialist Registration) or (CEGPR) to register as a specialist or general practitioner.

2.1.3. Senior LEDs (sLEDs)

These doctors have worked in the UK healthcare system for more than ten years. These doctors are usually proficient with the design and may or may not have previous formal training. They may be in temporary or fixed-term contracts, sometimes providing cover for substantial doctors on employment breaks (locum posts for maternity, sabbatical or health-related holidays) in various specialities or primary care.

They may also include IMG doctors with postgraduate or specialist experience in their home countries and significant UK experience to hold a CESR (Certificate of Eligibility for Specialist Registration).

GMC UK survey described them as Career SAS and LEDs – typically 30-50 years of age- mostly IMGs and have never entered a training programme.

BACKGROUND | 2

2.2 Transition from LEDs to SAS

SAS or Specialist and associate specialists include speciality doctors and specialist grade doctors with at least four years of postgraduate training. Locally employed doctors can progress their careers by either entering a training pathway, completing a substantive alternative path through CESR/ CEGPR route or becoming SAS doctors.

Several factors, including portfolio preparation, interview performance, application scoring, training rotation, geographical preference etc., influence the decision to pursue a training programme. Surveys have shown that the LEDs receive minimal support and supervision to either get appointed to a formal training post or progress in their career compared to trainees, especially for IMGs.[9]

2.3 Impact of Regulation & Complaints

As a regulated profession, doctors are held to high expectations based on the principles of Good Medical Practice, which the GMC enforces as per the provisions of the Medical Act (1983). Through the Maintaining High Professional Standards (MPTS) investigations, the GMC and tribunals implement their powers to warn, suspend, and restrict the practice of doctors or permanently remove them from the register.[10]

LEDs are not known to receive more than their fair share of complaints or be subject to MPTS investigations by their employers (relating to professional performance, honesty and fairness) compared to all doctors.

However, when these complaints are received or MPTS breaches are reported, they have a disproportionately high number being either reported to the GMC or given harsh outcomes against the NHS Complaints regulations (2009) encouraging local resolution.

Many doctors report being victimised after whistleblowing, bullied, or unable to work due to mental health trauma. Such complaints and investigations seriously affect all doctors, mainly LEDs. Almost 32% of doctors who receive complaints experience anxiety and depression.

Understandably, distress increases with complaint severity, with the highest levels after a referral to the regulator. Doctors with current/recent complaints were two times more likely to report thoughts of self-harm or suicidal ideation; several doctors have taken the final step. An internal report by the GMC investigating 28 cases of doctors who committed suicide while under fitness to practice investigation concluded these deaths were preventable and that the GMC has a legal duty to take positive actions to ensure fitness to practice proceedings do not damage the physical or mental health of doctors.[11,12]

Due to complaints or MPTS code breaches, almost 90% of doctors report defensive practices, including avoiding high-risk patients or procedures. [10,13] Due to an inherent lack of effective induction, employer support and often, in the case of IMGs, a lack of understanding of local systems, including culture and language, many end up facing the tribunals without legal representation or defence - thus facing harsher sanctions. [8]

BACKGROUND | 3

2.4 Induction & Support

The fundamental values of medicine may be universal. Still, how they are expressed will differ according to the social, cultural and organisational context in which care is delivered. It is, therefore, imperative that the proper support is in place to enable them to integrate successfully as quickly as possible, both professionally and personally.

The NHS People Plan [14] and the future of NHS human resources development report [15] recommend a welcoming culture and a safe and inclusive environment that engenders a sense of belonging for recruits into the NHS. The GMC has called for a standardised, supportive induction for doctors new to UK practice; they have already initiated an online pre-induction session (Welcome to UK Practice).

However, the induction provided to IMGs and often to LEDs remains variable, and there is no standardised, comprehensive induction with continued support for doctors coming to work in the UK. This is vital to ensure they can adapt to the NHS system and live in England as quickly as possible to reach their full potential and deliver safe, high-quality care.[16]

NHS Workforce Race Equality Standard (WRES) team received feedback from IMGs; many had not been allocated supervisors or appraisers and were instructed to start working independently soon after they arrived in the UK.

Most were pressed to frontline work without acclimatisation, relevant knowledge of healthcare systems, processes, procedures or policies, e.g., safeguarding or safe discharge arrangements, or briefing about social services or integrated care.[16] The survey conducted by GMC found that only 1% of LEDs and 2% of SAS doctors are involved in the induction of other SAS and LE doctors.

The GMC's State of Medical Education and Practice report identified, as far back as 2011, the need for a meaningful and comprehensive induction to reduce the disproportionately higher risk of IMGs being referred for fitness to practise investigation. So far, little has changed.

2.5 Linguistic & Cultural Competence

The most common challenge reported by IMGs in a 2019 study led by the Medical Adviser, Workforce Race Equality Strategy (WRES) Implementation Team, NHS England, was communication with patients, the public and colleagues, entailing common problems such as understanding colloquial English.

Professional medical practice in 2022 is highly complex and demanding, requiring considerable expertise, specialist knowledge, and the ability to communicate sensitively. These are essential requirements to ensure safe and effective doctor-patient or interprofessional exchange of information. [17]

BACKGROUND | 4

Research suggests that IMGs benefit from focused training in everyday medical language, fluency, idioms, pronunciation, humour, and local dialects. IMGs often felt confident in their communication skills (and thought others saw them as competent). Still, their colleagues report several concerns, including difficulty with small talk, nonverbal communication, and observance of (related) local cultural norms. Communication training programs targeting IMGs should address communication with colleagues and include instruction about language-related issues and explicit discussion of local cultural standards and expectations.[18]

Yet most new IMGs do not get adequate induction into this and are often expected to start work without it. If they have arrived from a country with a very different health system and cultural norms, with other medicines and technology, a completely different online patient record system, and very different rules around data protection and what information should be communicated to patients. [16]

2.6 Incivility & the work environment

One in four doctors in SAS-LED roles experiences challenging behaviours, bullying, belittling, and humiliation at the workplace. Rudeness and incivility in interactions with colleagues are the most common experience. In 1 in 10 doctors who have ceased to practice in the UK, bullying and harassment contribute to a high workforce turnover.

Almost a third perceive that the working environment is not supportive. These results are significantly worse than those reported by doctors in formal training posts (<6% in 2019) compared to the GMC National Training Survey results.

2.7 Leadership

Leadership at every level of an organisation is essential for a high-performing organisation such as the NHS. Leadership is more effective when it is trained and aligned with the values and goals of an organisation. [19] Hence, medical professionals at all levels must be formally educated and trained in leadership principles, become aware of their strengths and limitations and become effective agents for change and a cycle of constant improvement. A narrative analysis suggested that medical leadership, directly and indirectly, influences outcomes, safety and team performance at all levels. Doctors must also be supported in transitioning across different levels of autonomy and leadership roles.

While leadership is now considered essential for doctors in formal training and substantive consultants or GPs, this is not so for LEDs (and SAS doctors). There is a need to do things differently in healthcare, including better diversity and leadership distribution and fully utilising LEDs' potential. These skilled, experienced medics have much to offer yet are frequently overlooked, with little guidance or support from central organisations, medical royal colleges, or NHS Trusts and Primary care Clinical Commissioning Groups (CCGs).

BACKGROUND | 5

Opportunities are frequently missed to involve the more experienced doctors in the grade who would be well-placed to lead activities like appraisers and induction facilitators. There is a wide range of potential leadership and management roles in healthcare organisations: some might be more formalised, and some informal, such as joining and contributing to committees. Individuals will have varying motivations, including professional interests, curiosity, and personal development.[20] The system must therefore be designed to encourage inclusion from all doctors (SAS and LEDs) in leadership training, thus ensuring that the organisation benefits from the diversity of distributed leadership.

2.8 Challenges - Contracts/ Education & Training

LED doctors are employed through contracts which vary depending on local terms and conditions and job descriptions and are set for short-term contracts. Unlike SAS, Consultants, GPs and other doctors in formal training, there is no national agreement or direction regarding the contract for LEDs. There are no nationally recognised career or pay progression thresholds for these posts.

LEDs must engage in appraisals and revalidation processes like other doctors in training posts and yet have no formal time allocation for developmental activities. LEDs must receive training and develop skills to deliver high-quality patient care, as defined by good medical practice guidelines. Unless otherwise agreed in the employment plan, the employing organisation is under no duty to provide any formal training.

Those who wish to progress to a training post or pursue a CESR-CCT/ CESR-CGP route do not have any standard support or allocation of resources to meet their career aspirations. In some instances, LEDs are restricted from attending formal training sessions designed for doctors in formal training, often required to maintain a safe service.

Almost half of the LEDs report difficulties despite being more likely to have somebody to support them. LEDs are likely to be at an earlier career stage, perhaps changing employers more frequently, which may affect their ability to take advantage of opportunities available. [8]

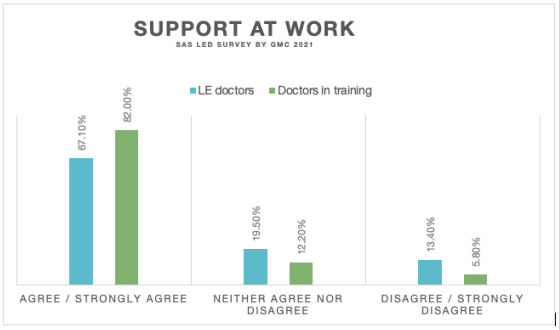
2.9 Wellbeing

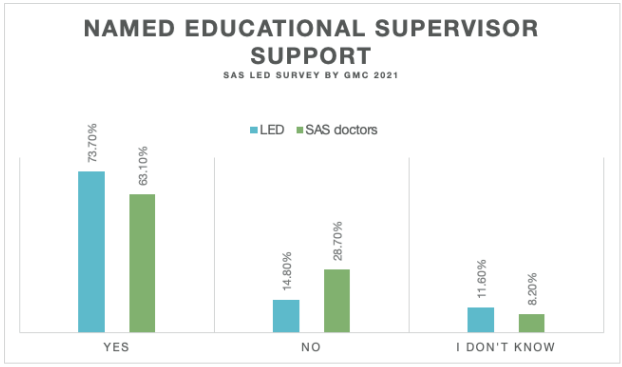
A study by GMC found that 41% of LEDs report emotional exhaustion, a third burnout and one-fourth experience physical and psychological exhaustion - mainly attributed to unsustainable rota hours, inhumane rota design, poor working relationships, and being asked on many occasions to undertake tasks that a doctor usually completes in a more senior role.

2.10 Mentorship

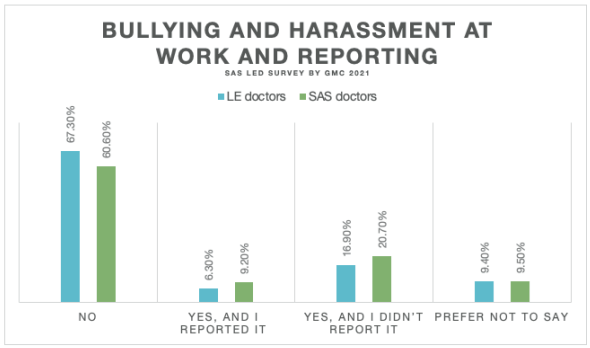
Confidential mentoring is essential for all doctors throughout their careers, especially during transition points, such as changes in role. Mentoring is vital for LEDs whose career choices and challenges are particularly stressful. However, mentors need to be trained and aware of the specific aspirations and hurdles. [21]

TABLE 4:The working environment is fully supportive (GMC, 2021)

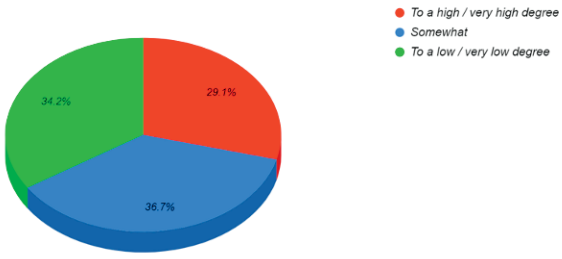


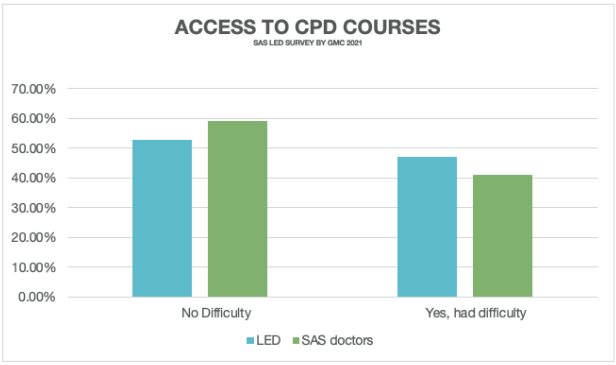


SAS-LED survey by GMC, 2021

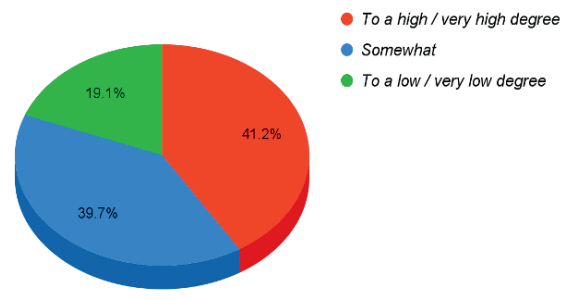


Degrees of Burnout among LEDs





Emotional exhaustion among LE doctors



RECOMMENDATIONS

Locally Employed Doctors Charter

1

National harmonised nomenclature, job description, criteria for recruitment and employment contracts.

a. Nomenclature

1. All names describing the LED roles, i.e. Trust Fellow, Clinical Fellow etc., should be replaced by the consensus nomenclature of Clinical Fellow. Based on seniority, these should be;
    a. Junior Clinical Fellow (JCF) in 'x' speciality (0-4/5 years post-qualification- thus equivalent to Foundation and Core training periods)
    b. Senior Clinical Fellow (SCF) (⅘ to <10 years post-qualification- therefore equal to Specialist training or registrar grades ST4-7/8)
    c. In primary care, these should be designated as Junior GP Fellow (0-4 years) and Senior GP Fellow (In year 5, thus equivalent to GPST3 and above)
    d. Speciality Doctor - is suitable for those in LED roles equivalent to SAS.

b. National consensus terms and conditions which offers

1. Equal employment terms and pay - compared to trainee grades, including access to NHS pension and pay protection when moving between NHS organisations as per time in employment and roles. JCFs will be equivalent to Foundation and Core trainee roles, while SCF will be equivalent to the specialist trainee pay scales.
2. Annual and study leave access should equal trainees working on the same rota.
3. After two years of continuous employment with an employer (back-to-back one-year contracts count as continuous), LEDs have the right not to be unfairly dismissed and to compensatory payment if made redundant. (BMA Checklist)
4. Recruitment - should be by standardised job descriptions which will model a 10-session job plan.
5. Out-of-hours work will be scheduled per the current working time directives and remunerated per national terms and conditions using the 'unsocial hours' formula agreed upon by NHS Employers and the trade unions.
6. When recruiting, IMGs should adhere to the WHO Global Code of Practice.
7. Job plans should provide a minimum of 1 session per week for continuing professional development, including appropriate funding for mandatory courses per speciality training schedules for JCFs and an additional Supporting Professional Activity session for SCFs.

RECOMMENDATIONS

Locally Employed Doctors Charter

2

2. LED Lead or Champion

Every healthcare organisation will appoint or delegate a senior clinician, preferably with appropriate experience or training to be the LED Lead/ Champion. The LED Champion will oversee the Job descriptions, ensure the quality of induction, supervision, and resources for career development, and seek and report on LED feedback to the HR Director of Trust Board annually.

3

3. LED Forum & Representation

Every healthcare organisation should resource and support a regular forum for LEDs to provide representatives from each speciality/ care group/department to discuss issues related to clinical work, governance, support, culture, education-training and career progression. This forum should be chaired by an LED representative duly elected/ appointed and will be attended by members of HR, trade unicorn, education and clinical leads.

4

4. LED Induction

1. UKGs - The fundamental principles of a comprehensive, meaningful induction at the corporate and speciality/ department levels will apply to any LEDs joining an organisation.
    a. This should include an introduction to/ refresher on the Good Medical Practice Guidance from the regulator and how to avoid common pitfalls.
    b. Importance of joining a medical defence body
    c. The role of medical royal colleges in curricula and training (portfolios)
    d. The part played by speciality societies and voluntary professional organisations in career development

RECOMMENDATIONS

Locally Employed Doctors Charter

4

4.b. Induction for International Medical Graduates

1. IMGs - should receive enhanced induction, which will include
    a. an appropriate introduction to NHS processes, management, structure,
        i. Names of key people in the organisation/departments.
        ii. Information about rota, working hours, and exception reporting. Ensure adherence to NHS Good Rostering Guide for unified work schedules and rota involving; safe shift swapping, shadowing and checking the system to avoid on-call duties in the first few months until LED settles, enables breaks and off-duty periods.
        iii. Access to appropriate handbooks (print or electronic) and e-learning modules.
        iv. Clinical Attachment period for two weeks to get accustomed to the NHS system.
    b. Governance processes and how to raise concerns
    c. Locally relevant linguistics, cultural competency and
    d. communication training, including safe use of social media/ networks
    e. Introduction to concepts of equality, diversity and inclusion - i.e. how to be aware of and tackle - differential attainment, bias, bullying and harassment
    f. Signposting to available support from employers, voluntary organisations, and trade unions.
    g. Wellbeing resources for self, family and social networks and sources for help in settling in the UK
    h. How to get an NHS number and register with a GP
    i. Initial accommodation assistance, relocation allowance and priority for hospital accommodation while relocating.
    j. Provide services and/or information on setting up banking, help with pay slips, pension contributions and taxation

RECOMMENDATIONS

Locally Employed Doctors Charter

5 Supervision and appraisals

5

1. All LEDs will be appointed an educational supervisor who will provide support for clinical training, agree on personal development plans, oversee access to and use of relevant speciality portfolios and provide career support/ signposting to developmental resources.
2. The ES will have allocated time in their job plans (equivalent to 0.25 PA) and be fully trained and accredited as a named supervisor meeting the GMC seven domains.
3. All LEDs will access their relevant portfolio and appraisal software/ toolkit to meet their annual appraisal and revalidation goals.
4. There will be minimum documentation of an induction, mid-term and end-of-placement meeting between ES and LED.

6 Education & Training

6

1. LEDs will have access to all the relevant education and training opportunities that are considered.
2. Statutory and mandatory for their employment by the employer
3. Content (generic, core and speciality related) that is within requirements for revalidation as per the relevant speciality curriculum or as laid down by the medical royal college or the regulator
4. A minimum of 50 hours per annum of documented training, including external or formal accredited courses amounting to 50% of the annual allocation
5. Supporting supervisors to give prompt, tailored and real-time formative feedback
6. Specific support for speciality examinations, CESR applications

RECOMMENDATIONS

Locally Employed Doctors Charter

7 Leadership

7

1. LEDs should have access to leadership and personal development training at different levels, either as foundation courses, middle grade and senior level depending on their roles and experience.
2. Access to funded or part-funded NHS Leadership Academy programs based on seniority and roles
3. Opportunities to undertake leadership and service level roles within the organisation, e.g. representatives, joining committees and project teams as per interest and expertise
4. Opportunities to undertake service improvement, audits and quality improvement projects will be provided with support, training, and resources to deliver.

8 Teaching

8

1. LEDs will have equal opportunity to develop as a teacher, train the trainer courses and additional teaching qualifications per personal interest, opportunity and organisational objectives.
2. LEDs will be provided training and resources to undertake roles as supervisors for doctors and healthcare staff (e.g. Physician Associates, Medical Assistants etc.) at the appropriate level, including formal roles as educational and clinical supervisors.

RECOMMENDATIONS

Locally Employed Doctors Charter

9 Career Support & Mentorship

9

1. LEDs will be encouraged to consider their career options and provided expert career guidance, taster sessions and support to take the next step in their career progression pathways.
2. Where relevant LEDs will be encouraged to consider the SAS career options
3. CESR application processes must be efficient and online. Flexible and proportionate methods should be implemented for gathering required education and training evidence from several institutions in the UK and abroad.
4. LEDs must be offered trained mentors by their employing organisations with appropriate awareness of the aspirations and hurdles.

10 Civility, Raising Concerns & Wellbeing

10

1. Employers should have systems that encourage a culture of inclusion, recognise diversity and offer a value-based team/ working environment.
2. Provide timely opportunities to raise concerns, and hold discussions without fear of repercussions
3. Provide anonymised and safe platforms to report issues with assurance to be dealt with and resolved promptly
4. Encourage a culture of zero-tolerance of incivility, participation in proactive awareness programs for EDI and signposting to specific guidance on culture and behaviour values.
5. Wellbeing
    a. National minimum standards for facilities in healthcare organisations must be introduced and followed to provide doctors with safe and effective means of transportation, hospital canteens,well-planned parking facilities, rest spaces and on-call rooms.
    b. To ensure the well-being of LEDs, they should have timely and efficiently accessible resources, e.g. well-being tools or questionnaires, which can recognise warning signs of stress or mental health issues.

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NEXT STEPS

CHARTER IMPLEMENTATION

The BAPIO SAS-LED forum will lead the work with all stakeholders to propose and implement a national job description, contract, terms and conditions and minimum standards per the Charter recommendations.

This will be followed by the design and delivery of a LED national survey collecting the experiences and comparing against the recommendations.

The team will develop and publish a self-assessment toolkit, an annual self-assessment schedule for all participating organisations and a national benchmark.

Once this has been accepted and necessary changes implemented, we expect this to become business as usual.

01 CHARTER Launch

02 LED National Contract & Terms of Service

03 LED National Survey

04 Benchmarking & Self-assessment

05 Business as usual

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