Equity, Diversity and Bullying in Neurosurgery: results of the Society of British Neurological Surgeons Engagement Survey

By the Equity, Diversity and Inclusion Working Group, Society of British Neurological Surgeons

A foreword from the President of the SBNS

The Kennedy report, commissioned by the Royal College of Surgeons of England, and published in 2021, raised major concerns about the lack of equality, diversity and inclusivity in surgery. In response to this report, the SBNS Council, established an Equity, Diversity and Inclusivity working group which conducted a survey of neurosurgeons in the UK and Ireland in March-June 2022. The results of the survey provide the basis for this report.

Although the response rate of 18% seems low, it represents the views of 175 members working in the UK and Ireland. The report clearly shows that bullying, undermining and harassment behaviours occur in many neurosurgical units. Additionally, respondents report barriers to progression. Furthermore, it is clear that the SBNS Council does not reach out in a relevant manner to all members.

There is no place for discriminatory behaviours. All our team members, whatever their status, background or characteristics, should feel safe in the workplace. All should have equity of opportunity. We must change the culture so that unacceptable behaviours are eradicated, and barriers, real, or perceived, are razed. Changing culture is a challenge to the surgical community. The SBNS strongly supports an open culture where people feel valued, able to speak up and listened to. We need to lead by example and take actions against bullying, undermining and harassment in our own departments. We must embrace diversity.

I commend the Equity, Diversity and Inclusivity working group for their work to date, and for providing us with a report that acts as a barometer of the current situation and a guide for action. I consider it important for us to monitor and implement improvements in this sensitive area.

Peter Whitfield, SBNS President

The Society of British Neurological Surgeons (SBNS) is a professional group consisting of, and representing, neurosurgeons in the United Kingdom and Ireland. All those with neurosurgical interest can become members including UK/Irish neurosurgical consultants (Full members); UK/Irish trainees (Associate members); students and allied health professionals (Affiliated members) as well as retired and international neurosurgeons. The SBNS Council consists of elected members and ex-officio members, with the latter representing sub-specialty groups, trainees and affiliated professional societies.

Discrimination in medicine, surgery, and neurosurgery has always been a contentious issue, but difficult to explore. Victims, especially in small specialties, are wprried about the effect whistleblowing may have upon their career progression. The influence of social expectations and cultural differences on people's surgical careers is complex, nuanced, and often unfair. This has been explored by the Royal College of Surgeons of England in a report by Baroness Helena Kennedy QC, revealing some uncomfortable, yet sadly unsurprising, truths on how minorities feel about this Royal College (Royal College of Surgeons of England, 2021).

Bullying, harassment and undermining are known to be rife throughout the NHS. Bullying was identified in the Francis Report (2013) as a cause of staff intimidation, inhibiting people from speaking out with concerns about patient care. The 2019 NHS England Staff Survey found that 28.5% of respondents had been bullied, harassed or undermined by patients or their families, 12.3% by managers, and 19% by colleagues. In an Australian survey of general surgeons (Ling et al, 2016), 47% had experienced bullying, and 68% had witnessed it in the previous 12 months. This was higher for trainees and females, but only 18% had made a formal complaint.

Neurosurgery is a competitive, demanding and high-stakes discipline in which surgeons strive for perfection. This can create a culture medium where bullying and undermining can grow. Many of us will have witnessed or personally experienced examples of behaviour that make us uncomfortable, from microaggressions to outright victimisation and intimidation. In the USA, members of the Congress of Neurological Surgeons (CNS) completed a survey (8.9% response rate), with 61.4% having been the victim of abusive behaviour, and 47.9% being a victim of at least one form of discrimination. Female respondents were more likely to have been victims of abuse; whilst females and people from ethnic minorities were more likely to have been a victim of discrimination (Gadjradj and Harhangi, 2021). Only one-third made a complaint, and these were more likely to be male.

Surgical societies themselves have been called upon to take a lead on addressing issues of bias and inequity (Clarke 2022). On reflection of these ongoing problems, thus far kept occult, whispered in corridors or suspected but never openly addressed, the SBNS created an Equity, Diversity and Inclusion (EDI) Working Group. One aspect of their work was

to create and distribute a survey to find out more about the demographics of neurosurgeons in the United Kingdom and Ireland; their experience of bullying, harassment and undermining; and if they felt that the SBNS truly represented them. This is a report of the results of that survey, and discussion of the steps required to move forward and improve the culture within UK and Ireland neurosurgery, with an inclusive SBNS at the helm.

Methods

A 31-item questionnaire was developed by the Equity, Diversity and Inclusion committee and ratified through the council of the SBNS. The questionnaire was composed of three sections relevant to these issues- demographics; understanding how people feel in the workplace; and perceptions of the role of the SBNS. The survey was anonymous, with deliberate decisions to not include questions regarding the geographical location and age of respondents, to ensure that they could not be identified. At the end, respondents could consent for anonymous quotes to be used, and were invited to include their email address if they were willing to be contacted in the future, at the expense of anonymity. The introduction explained and linked to the SBNS Equity, Diversity and Inclusion statement, and contact details for the SBNS Bullying Liaison Officer and other anti-bullying resources were also provided. All compulsory items included the option "prefer not to say".

The survey was undertaken via Google Forms, with the link and QR code disseminated via the SBNS Spring Conference in Cardiff, the SBNS email list, and the British Neurosurgery Trainees' Association (BNTA) email list. This is available in the references below. Further dissemination via local units was encouraged, to try to engage those who are not members of the SBNS or BNTA. The survey was open for 10 weeks from late March to early June 2022.

The first item of the survey was "Are you a neurosurgeon working in the UK or Ireland?", only data from those who responded "Yes" were included.

Descriptive statistics were used to demonstrate the data, with 2 x 2 Chi-squared contingency tables to find if there was an significant relationship between demographic variables and other variables, with an hypothesis that variables were independent, and a significance level set at $p<0.05$. Demographic variables included being male or female; primary carer vs not; White UK/Irish vs not; current/previous national training number (NTN) vs not; Christian/no religion vs not; UK/Eire vs not; and personal experience of bullying vs not. The influenced variables included consultant status or other; being a primary carer or not (only male vs female compared); never bullied vs bullied; feeling comfortable in the workplace vs not; experiencing barriers to progression vs not; SBNS good engagement (defined as 3 to 5 on the Likert scale) vs not; and feeling that the SBNS/council represented them (3 to 5 on the Likert scale) or not.

For free text responses, thematic analysis was undertaken by two authors (KW and TG).

Results

There were 189 respondents, of which 175 stated that they were neurosurgeons working in the UK or Ireland, and thus were included in the analysis.

Demographics

Based upon the SBNS Workforce Census 2021, the number and career level of UK and Ireland neurosurgeons is known and could be used to calculate response rates. The overall response rate for the survey was 18.0%. The highest proportion of responders were substantive consultants (25.8%), and females (31.8%). According to the 2021 census, there were two consultant-level SAS doctors in the UK and Ireland, and there were two responders who self-identified as an SAS doctor, but it is considered likely that there is a discrepancy in the definition between the census and the survey. The lowest response rate was from doctors in senior non-training grades. The relative representation, compared to the 2021 census, is shown in Table 1, below.

	Total in 2021 census	In current survey N (% of 2021 census)
Grade of respondent		
All	975	175 (18.0)
Consultants	480	118 (24.6)
Substantive consultant	446	115 (25.8)
Locum consultant	34	3 (8.8)
Trainees	257	36 (14.0)
ST1 - 4	144	19 (13.2)
ST5 - 8	113	17 (15.0)
Post CCT (NTN)	28	4 (14.3)
Other reg-level	238	18 (7.6)
Junior non-training (ST1-4)	41	5 (12.2)
Senior non-training	130	4 (3.1)
Non-UK trained, fully qualified registrar level	33	5 (15.2)
SAS doctor	2	2 (100)
Gender		
Female	126	40 (31.8)
Male	849	131 (15.4)
Prefer not to say	N/A	4 (NA)

Table 1. Grades and gender of respondents, as a proportion of the national numbers, in the 2021 workforce census.

Most respondents (69.71%) said they were predominantly educated in university in the UK or Ireland, with 20.57% having attended university outside the EU, and 9.14% within another EU country. One person preferred not to say. 81.71% completed their main neurosurgical training in the UK or Ireland via the National Training Number route; 6.29% in the UK or Ireland via the CESR route; 5.14% in another EU country; and 6.29% in a country outside the EU. One person preferred not to say.

90.9% of respondents identified as heterosexual, 4.0% as bisexual, and 1.1% as homosexual. 4.0% preferred not to say. 4 people said they had a physical disability (2.29%), and one a mental health disability (0.6%).

Table 2 shows further demographics of the respondents, divided by whether they are a consultant or not.

Of the primary demographic data, the only variable in the 2 x 2 Chi squared test that was significantly associated with being a consultant was being male (χ^2 14.5, p<.001). White ethnicity was not significantly related to this (χ^2 3.52, p=0.06), nor NTN status (χ^2 0.17, p=0.68), religion (χ^2 0.75, p=0.39), nor country of university of qualification (χ^2 = 0.379, p=0.54). Men were also more likely to have a primary carer responsibility (χ^2 11.4, p<0.001).

	N. (%) of consultants	N. (%) of those not a consultant
Ethnicity		
African	3 (2.5)	0
Any other Asian background	7 (5.9)	2 (3.6)
Any other ethnic group	13 (11.0)	8 (14.3)
Any other mixed or multiple ethnic background	1 (0.8)	3 (5.4)
Arab	2 (1.7)	4 (7.1)
Bangladeshi	1 (0.8)	1 (1.8)
Caribbean	0	2 (3.6)
Chinese	1 (0.8)	2 (3.6)
Indian	20 (16.9)	7 (12.5)
Pakistani	4 (3.4)	3 (5.4)
Prefer not to say	6 (5.1)	1 (1.8)
White and Asian	3 (2.5)	3 (5.4)
White English, Welsh, Scottish, Northern Irish, British	52 (44.1)	19 (33.9)
White Irish	5 (4.2)	1 (1.8)
Religion		
Any other religion	0	1 (1.8)
Christian	47 (39.8)	14 (25.0)
Hindu	15 (12.7)	7 (12.5)
Jewish	5 (4.2)	0
Muslim	9 (7.6)	9 (16.1)
No religion	34 (28.8)	21 (37.5)
Prefer not to say	8 (6.8)	4 (7.1)
Caregiver/parental status		
I do not have a primary care giving/parental role	30 (25.4)	36 (64.3)
I have a child/children under the age of 18	71 (60.2)	19 (33.9)
I have a child/children over the age of 18	25 (21.2)	2 (3.6)
I am a carer for an adult (eg parent, adult with disabilities)	6 (5.1)	1 (1.8)

Table 2. The responses to ethnicity, religion and caregiver/parental questions, divided by consultant status or otherwise

Bullying, undermining and harassment (BUH)

113 (64.6%) respondents answered yes to "Do you feel you have ever been a victim of bullying/harassment/undermining?", with 34.3% responding "no". Two people preferred not to say. However, 133 people inserted a job title or the grade of people they felt had exhibited these behaviours towards them, with some entering multiple responses (Figure 1). 69.7% reported witnessing these behaviours towards another neurosurgeon, with 4% preferring not to say.

37.7% of respondents had personally experienced bullying, undermining or harassment (BUH) on one or two occasions in their career, 9.1% annually, 5.7% once per month, 5.2% once per week, and 6.3% daily. 5.7% were currently feeling a victim of these behaviours, 5.7% had felt this way within the last month, 6.9% in the last 6 months, 12.6% in the past year, 34.9% within the last 6 years, and 17.1% prior to that.

Figure 2 shows the characteristics that respondents felt the negative behaviours were based upon.

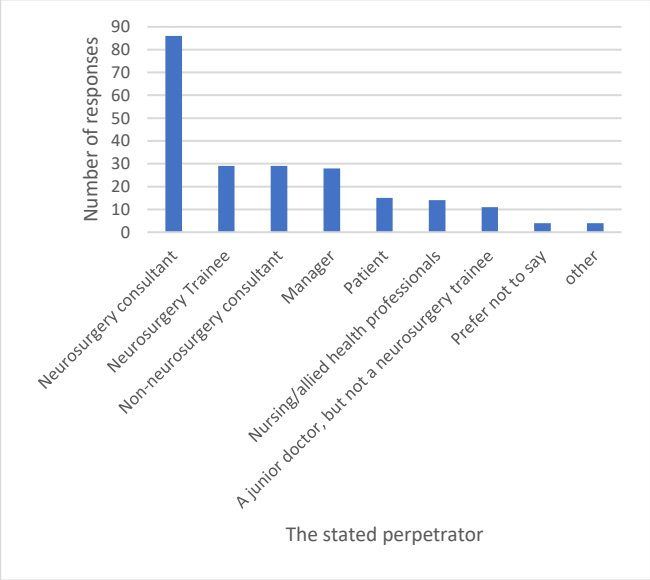

Figure 1. The responses to the question "Who was the bully/harasser/perpetrator?" for personal experiences. A total of 133 people responded to this item

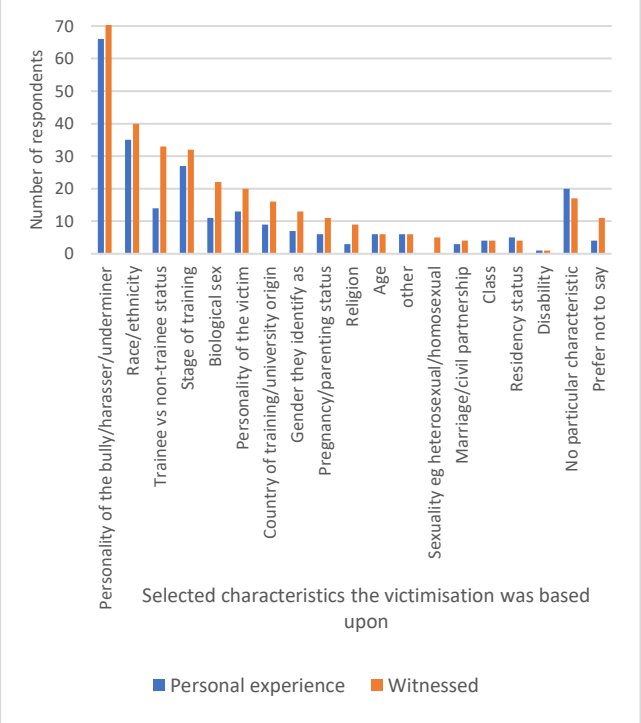

Figure 2. Responses to "Which characteristic do you feel the bullying/harassment/undermining was based upon", for personal and witnessed experiences.

In an item asking for respondents to state, if they felt comfortable doing so, in which hospitals they experienced or witnessed these negative behaviours, 27 different units/regions were named (mode = 1, median = 2, maximum 9 nominations per neurosurgical unit/region). Seven units were named more than twice.

In the Chi-squared tests, the only demographic that was significantly more likely to have been bullied/undermined/harassed was female gender (χ^2 8.34,

p=0.004). Being bullied was not associated with caregiver role (χ^2 1.30, p=0.25), UK/Irish white ethnicity or not (χ^2 3.51, p=0.06), previous/current NTN status (χ^2 1.83, p=0.18), religion (χ^2 1.50, p=0.22) or UK university status (χ^2 = 0.90, p=0.76).

Feeling open in the workplace, and barriers to progression

23.4% of the respondents answered "yes" to "Have you ever felt uncomfortable with being open about yourself within your workplace?". 6 preferred not to say. 39.4% had felt a barrier to their career progression, based upon a particular characteristic, with 2 preferring not to say. The reasons selected for these issues can be found in Figure 3, and exclusions experienced in Figure 4.

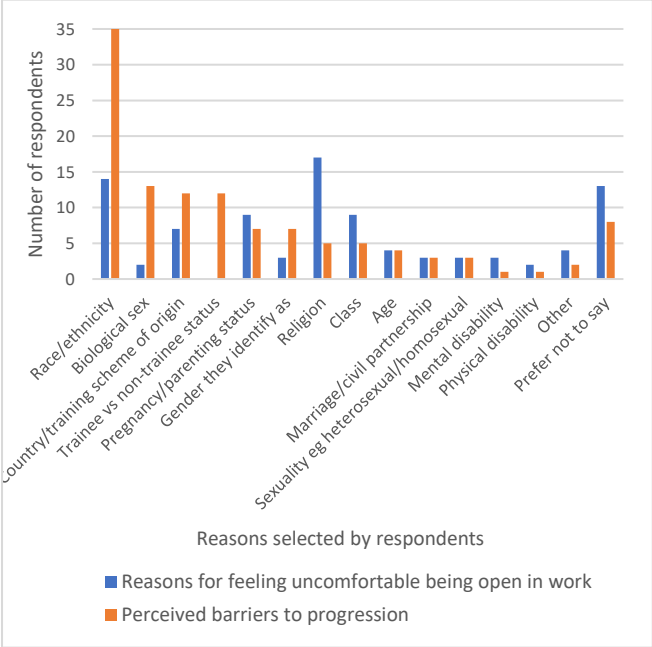

Figure 3. Responses selected for items "Why did you feel uncomfortable about being open about yourself within work)" and "Which characteristic do you feel affected your progression/options?"

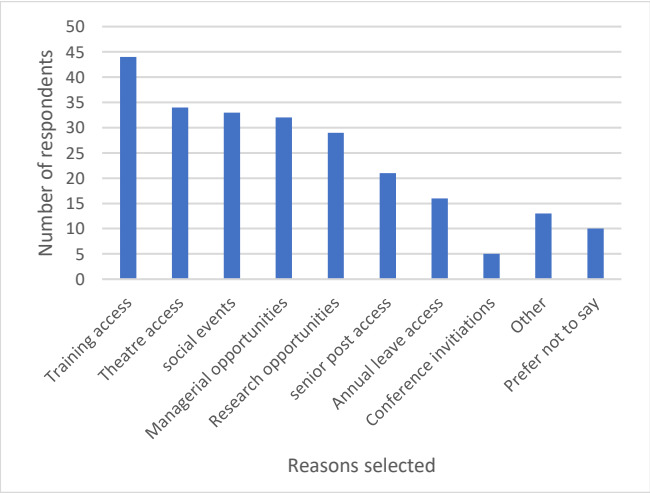

Figure 4. Selected responses to "What, if any, exclusions have you experienced?"

In the comparative tests, people who did not identify as white British/Irish were more likely to feel uncomfortable being themselves in the workplace (χ^2 4.71, p=0.03). Also those who did not identify in the Christian/no religion categories were less likely to feel comfortable (χ^2 3.91, p=0.048), along with those who had personally experienced bullying (χ^2 12.73, p<.001). Gender (χ^2 2.67, p=0.10), primary carer status (χ^2 0.03, p=0.85), previous/current NTN status (χ^2 0.50, p=0.48), and university in UK/Eire vs not (χ^2 0.68, p=0.41), did not have a significant association with feeling uncomfortable.

Women (χ^2 12.67 p<0.001), those who did not identify as white British/Irish (χ^2 38.12 p<0.001), those did not go to university in the UK/Eire (χ^2 4.78 p<0.029), those not in the Christian/no religion categories (χ^2 15.13 p<0.001), and those who had been bullied (χ^2 23.67 p<0.001) all reported a perceived barrier to progression. Primary carer status (χ^2 0.12 p=0.73) and previous/current NTN status (χ^2 0.24, p=0.62) did not have an association with this.

SBNS membership and opinions

69.7% of respondents were full members of the SBNS, 24% associate members, 0.57% (1 person) an honorary member, and 4% not members. 3 people preferred not to say. On a scale of 1 (not at all) to 5 (very engaged) for feeling engaged with the SBNS, there was a normal distribution, with 33% choosing 3 out of 5, which was also the median and modal choice. Figure 5 shows the awareness of respondents for SBNS-related endeavours.

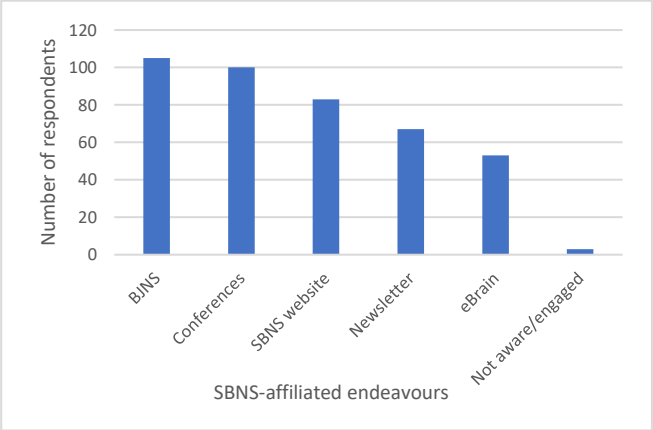

Figure 5. Responses to the item "Are you aware of/do you engage with the following SBNS endeavours?". BJNS = British Journal of Neurosurgery, SBNS = Society of British Neurological Surgeons.

In response to the question "Do you feel the SBNS and council represents you?" from 1 (not at all) to 5 (very much so) there was again a normal distribution, with 43.4% selecting "3", a median and mode of 3. Respondents were invited to select from options of potential reasons for this, of which 54 (30.9%) chose "It is an Old Boys' network", 40 (22.9%) the "ethnicity/gender representation of the SBNS council", 32 (18.3%) "not aware of any of the work of the SBNS or the council. Twenty-three (13.1%) said they had not been given the opportunity, 22 (12.5%) that "the SBNS does not understand me and my needs", 12 (6.9%) felt "it only cares about UK/Irish-trained neurosurgeons. 4 (6.9%) selected that they had previously been ignored by the SBNS. 3 preferred not to say, and 12 (6.9%) said there were other issues such as lack of geographical and devolved

nation representation, and difficulty with access to council positions.

No demographic categories, nor bullied status, had an association with engagement with the SBNS (3 to 5 on the Likert scale) vs not. However, those who were not white British/Irish ethnicity (χ^2 9.68, p=0.002) and those who were bullied (χ^2 6.54, p=0.01), felt that the SBNS and council did not represent them (1 to 2 on the Likert scale).

At the end of the survey were free-text responses to the question "How do you think the SBNS could improve to better represent its members and the wider neurosurgical community?". The three main themes were diversity and inclusion; SBNS engagement and communication; and structural and organisational. Within diversity and inclusion, there were sixteen general comments about diversity and inclusion, including that there should be more diverse representation in leadership roles, and the need for "open access to opportunities based on professional capabilities". There were eleven comments specifically relating to ethnicity including a need to understand representation from units across the UK, and acknowledging those who have specific dietary needs, including those who do not drink alcohol. There were eight comments about gender, including positive discrimination for leadership positions. There were eight comments about youth including calls for younger representation as the council is not in touch with modern, and trainee, issues. There were three comments regarding representation for SAS doctors, including access to full membership.

The SBNS engagement and communication comments included twelve statements regarding national/wider representation within the SBNS, and better interaction with the devolved NHS organisations. There was also desire for communication with each unit, global neurosurgery engagement, and regional reports regarding SBNS activity. There were eleven comments about improving transparency and communication with the membership, some saying that they do not know what they are getting for their annual subscription, website improvement, and better visibility. There were five comments calling for support, at a local level, highlighting the intensive work that is undertaken "in comparison to specialties with less intensive working and patient responsibilities". Financial aid for those who have difficulty accessing educational opportunities was also mentioned, to widen access.

There were sixteen structural and organisational comments included four about the SBNS council, including shorter terms and ineligibility to reapply, and "a majority elected council rather than a majority appointed council". Four comments mentioned governmental/policy work, including advocating in the face of long waiting lists, the difficulty of having a voice considering the relative size of the specialty, and access to becoming dual-accredited with vascular interventional work.

There were two generally positive comments, including the positive effect of the President's visits to local units; but seven comments that were negative. These included that there is a lack of leadership, that the council should be disbanded, and some disparaging remarks regarding equity, diversity and inclusion including accusations of being "woke".

What could be improved in the SBNS?

The second free-text question was "What are the top 3 things that you think the SBNS could do better?". There were many comments regarding diversity and inclusion, including widening chair and speaker opportunities, increasing inclusivity for senior leadership posts and improving understanding of equity, diversity and inclusion, including unconscious bias. There were 13 responses regarding ethnicity and international recruitment, including positive discrimination for leadership roles; encouraging participation from those who are not UK-trained neurosurgeons; not insisting on CCT and FRCS for consultant posts; and advocating for religious dress codes. This links to three comments about increasing involvement for non-trainees and SAS/locally-employed doctors.

Four comments mentioned parenting and less-than-full-time training (LTFT), including encouraging shared parental leave and enabling different ways of working to facilitate different lifestyles/other situations for individuals. Two respondents mentioned having younger people represented on council, and two made statements to increase the number of women applying and at senior levels. There was one comment that neurosurgery is "far too middle class".

There were eighteen responses discussing training, with some asking for a more flexible approach and support, to recognise the diversity of career pathways. There were comments to say that everyone should do FRCS, that ST1 selection should be stronger, that guidance should be clearer for CCT vs CESR, and that trainers should be supported by robust mechanisms if there are trainees that are failing to progress without the threat of repercussions. Understandably, workforce planning was mentioned, with ten comments, including an assessment of the ethnicity of new consultants, support with job planning, and "solve the post-CCT bottleneck problem".

Communication is an issue that was raised frequently, with eleven comments about transparency and publicising – that the SBNS needs to "be much more visible", provide updates for surveys that are undertaken, and communicate the national caseloads and variation in practice. Seven additional remarks were made about increasing engagement or publicising how to get engaged with things like National Selection, training courses etc. Four people mentioned upgrading the website and engaging more with social media.

Four people mentioned improving support – of wellbeing and for those who are victims of bullying/harassment including those who are not in a training programme.

There were a number of improvements that were suggested, including making elections transparent, expanding academic neurosurgery, improving British Journal of Neurosurgery turnaround time, visits to local neurosurgery units and creating standard electronic consenting for common operations. Seven people mentioned widening national representation, including that a lot of council work covers NHS England issues (eg GIRFT [Getting It Right First Time], NNAP [Neurosurgery National Audit Programme], Low Volume Surgery).

Six people mentioned the SBNS conferences, mostly recommending that the standard is poor and should be improved. Two additional comments wanted cheaper conferences.

Three comments were made about increasing sustainability and environmental awareness.

Discussion

This survey was undertaken by the Neurosurgery Equity, Diversity and Inclusion Working Group, affiliated with the SBNS. A response rate of nearly 18% of a population is a good response rate for a survey of this nature, although of course we must be mindful that although attempts were made to be as inclusive as possible of all UK and Irish neurosurgeons, the method of distribution may have resulted in disproportionately more responses from members of the SBNS or those interested in the topic at hand. We thank all those who took the time to respond and aid us understand who we are as a specialty and help shape our future direction as a society. For the first time, we have evidence of the diverse community that makes up neurosurgery in the UK and Ireland, and the issues that individuals face.

We know through the annual National Neurosurgery Census that women make up less than 10% of consultants, but over 20% of trainees, which will contribute to female respondents being less likely to be a consultant. This survey has also shown that female respondents were less likely to identify as primary caregivers than male respondents. This could be a reflection of the relatively younger cohort of females responding, who might not yet have had children. It could alternatively reflect that female neurosurgeons are less likely to have children than men. However, females were the only subcategory to have been more likely to experience bullying, and this was not related to caregiver status.

Around two-thirds of neurosurgeons say they have either been a victim of bullying/harassment/undermining or witnessed it towards a neurosurgical colleague. Neurosurgery consultants were by far the biggest perpetrators, but there were instances from all categories of colleague and patients. Mostly this had occurred a few times in a person's career, but around two-fifths had experienced it within the past year. It was only significantly associated with females as victims, however those who were not UK/Irish white ethnicity were close to significance (χ^2 3.51, p=0.06). Of interest, the amount of witnessed bullying/harassment/undermining towards females was almost double that which was personally experienced.

The unique aspect of this survey is not only to concentrate on these negative behaviours, but also on if people feel able to be open about themselves at work, and if they feel that there are barriers to their progression due to a certain characteristic. Nearly a quarter of respondents were uncomfortable about being open, most significantly those who were not of British/Irish white ethnicity, those who did not identify as Christian or no religion, and those who had been bullied. These groups also felt barriers to progression, along with women and those who did not go to university in the UK/Eire. It is very sad to hear that some of our colleagues feel this way, which may impact on their wellbeing and their willingness to keep working within neurosurgery. Figure 4 shows the ways that people feel they are excluded, and certainly highlights areas where improvements can be made.

The SBNS engagement scores are equivocal, and there certainly is a demand for better communication and engagement. There are concerns that all nations and geographical regions of the UK and Ireland are not represented in council, and frustration that output seems to be NHS England focussed. NHS England has a larger population and a number of different and diverse Care Boards. To manage and regulate this it has a number of initiatives that draw on the expertise of the SBNS, such as GIRFT and NNAP, along with commissioning decisions. These are funded by NHS England, but other nations can benefit from some of the outputs – for example, they can take the advice from NICE guidance or use NNAP data to reflect on their own services and improvements that can be made.

There were concerns about the demographics of council and representation of those from minorities, especially those who did not identify as British/Irish white ethnicity and those who had experienced bullying. Suggestions were made to try to widen access and promoting equity, diversity and inclusion, themes which link in with communication and engagement; along with empowering those who do not feel like they "fit the mould".

Of course, we need to acknowledge the limitations of the survey – this survey only represents 18% of the career neurosurgeons in the UK and Ireland. Due to the method of distribution via the SBNS and its links, the people who completed it were more likely to be members of the Society and therefore consultants and those in run-through training. Also, those who would fill in a survey of this topic may have more interest in the subject or more likely to have experienced these negative behaviours and thus want to make their voices heard.

This survey has given us much food for thought, highlighting areas upon which we need to reflect, as a surgical society, within units and as individuals. It is one part of a multi-layered approach to making UK and Irish

neurosurgeons feel more confident with who they are, and within their society. Now we must take action to try to improve matters

Changes that are already occurring in the SBNS

1. It has already been recognised that the SBNS Council is predominantly represented by senior consultants, and a "Consultant in first five years" elected position has been created, to represent those at the start of their career, and transitioning from training.
2. The EDI committee has been created, a mission statement written (available at https://www.sbns.org.uk/index.php/about-us/equity-diversity-and-inclusion-statement/), and this survey and report written to better understand the people working in neurosurgery.
3. An Equity, Diversity and Inclusion session is included in the ST7/8 National Neurosurgery Finishing School.
4. The SBNS meetings are still held twice a year, but there have been changes in the scheduling, including rapid-fire "poster" presentations. We have an update at each about the trials being undertaken in the UK. One afternoon per conference now has a topical debate/update on themes that are relevant to UK neurosurgeons. Thus far these have included a discussion about workforce planning, update on improvements within the BJNS, and the NNAP/GIRFT initiatives. The Preston SBNS had an update on the EDI work, and from Women in Neurosurgery. We now also request formal feedback from attendees to assess quality. This has been very positive over recent conferences, so we urge everyone to attend to see these improvements, and please feedback if further changes could be made. We want all to feel welcome and to be proud that they are part of the UK/Irish neurosurgery that they see at these meetings.
5. There has been a tour of UK units by the SBNS Immediate Past President, Alistair Jenkins, sadly paused by COVID. "Alistair's Curry Club" was an invite to neurosurgeons from local units to show off their local units and speak to the President in an informal setting, to understand more about what the council does, and how to get involved. These were positively reviewed in the survey, and plans are to restart now that restrictions have been eased.
6. There is a biannual newsletter, sent to all members of the SBNS via email with updates regarding trials, new members, new initiatives and courses. Previous copies are available on the website (https://www.sbns.org.uk/index.php/policies-and-publications/newsletter/). Full members can also sign in to the website to see confirmed council minutes and to see what the SBNS council is doing (https://www.sbns.org.uk/index.php/councils/minutes-archive/).
7. The BNTA have released a call for applications for a committee member to represent non-trainees.
8. The SBNS committee is looking into redesigning and updating the website to improve communication and access to important documents.
9. There are scholarships available, from Codman and via the BNTA, for those undertaking fellowships. The SBNS are also supporting two applicants for a national leadership course.
10. The British Journal of Neurosurgery has undergone significant improvement in turnaround time thanks to the efforts of Mr Mukerji, the appointment of BJNS fellows and the Associate Editors. We thank them for their great work to achieve this.
11. A bullying liaison officer, Prof Ian Kamaly-Asl (ian.kamaly@nhs.net), has been appointed as a contact for people who are victims of unsuitable behaviour or need support. If anyone needs advice, please contact him and he can guide you in a non-judgemental fashion. Prof Kamaly-Asl has also been looking at mentoring schemes, so hopefully there will be a formal mentoring process for those who are interested. Watch this space!
12. The SBNS is a member of the Federation of Surgical Specialty Associations, along with nine other Specialty Associations of the UK and Ireland. The Federation has gathered representatives from each Society to discuss the various initiatives that are being undertaken, to help tackle issues of BUH across surgery; and encourage collaboration, learning and development.

Areas that require further exploration and progress

1. We are aware that there are some trainees who leave National Training, for many reasons, but there has not been any co-ordinated effort to find common themes for leaving. We shall explore whether we are able to debrief or have feedback from those who have left, to find if there is anything that can be done to support individuals before the point where they feel that leaving training is the best choice.
2. The SBNS needs to understand more about the demographics of the whole society and shall look at introducing demographics fields into the membership application and online log in details. We shall first start by seeking and publishing the demographic information of council members, including photos and a map of where they work. To demonstrate the diverse pathways to council, we shall also show information on why they joined council and what path they took, to show those who are interested how they could do similar in the future.
3. To improve communication and understanding, we shall increase our use of Twitter, including research updates, explanatory tweets about what can be found on the website, and perhaps profiles of UK and Irish neurosurgeons.
4. We shall look at newsletters of other subspecialties to see how we could improve, have a "Featured neurosurgery unit" page, and add a section on "how to get involved" for better signposting to national

endeavours, such as National Selection panels and how to get involved in examining for the FRCS.

5. We encourage unconscious bias and EDI training for all neurosurgeons, and to explore these options in their local units. In the meantime, the EDI group will explore research upon the effects of EDI, unconscious bias and bystander training on medical professionals. They shall also look into well designed internet resources and courses that are already available and could be recommended. For those who wish to learn more about anti-bullying campaigns, the Royal College of Surgeons of Edinburgh (RCSEd) has a suite of information and e-learning at https://www.rcsed.ac.uk/professional-support-development-resources/anti-bullying-and-undermining-campaign .
6. We encourage units to consider their social occasions, trying to ensure that they are accessible to all, for example understanding that some people do not drink alcohol or like to contribute to alcoholic presents; that some might have different dietary needs eg halal, vegetarian; or not be able to attend a regular social occasion due to childcare requirements.
7. The EDI group will look into focus groups for SAS/LEDs along with trainees to work out ways to cater fairly for these two groups, without endangering training opportunities; and for those who feel like they are not comfortable or have progression held back to better understand areas where we can improve.
8. We shall empower those who do not look like "stereotypical" neurosurgeons to realise their worth and value of the work they do, to feel entitled to apply for leadership positions. We do not want to undertake "positive discrimination" for positions, because we do not want people to feel that they have got positions because they "tick a box", but to feel that they are just as worthy as others to put themselves forward.
9. We encourage voters for elected council positions to vote for the best candidate based on their manifesto, not based solely upon their familiarity, exposure or how they look.
10. We shall discuss with the units in devolved nations regarding if they are interested in spreading NHS England initiatives including NNAP and GIRFT. The workforce planning/census team will engage with NNAP to pool knowledge and resources, ensuring that the focus continues to be on the whole UK/Ireland.

This is an ambitious list, which will take time to enact and will not solve all problems that we have in our Society, but is a good start. We will keep members updated with progress.

Thank you so much to all those who have helped thus far, including the EDI Working Group, SBNS Council, and all those who completed the survey. For all those who are interested, the EDI group has an open invitation; and if you are a consultant and interested in helping with National Selection, examining, or question writing, please contact Suzanne or Alix in the SBNS office for further details (admin@sbns.org.uk, admin2@sbns.org.uk).

References

- Clarke C 2022. Surgical societies must lead the way on addressing bias and microaggressions. Ann Surg Oncol 29:755-757
- Francis R 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The National Archives, UK
- Gadjradj PS and Harhangi BS 2021. Mistreatment, discrimination and burn-out in neurosurgery. Clin Neur Neurosurg 202.106517
- Google Forms, Google 2022 [online]. Available from: https://docs.google.com/forms/d/e/1FAIpQLSdZgbA_CKmKEPzCn1V9U2Rb6y21Akvn1XU4QhcrRYaTtAS2vw/viewform Accessed 13th December 2022
- Ling M, Young CJ, Shepherd HL, Mak C and Saw RPM. 2016. Workplace Bullying in Surgery. World J Surg 40(11):2560-2566
- NHS England. 2020 [online]. NHS Staff Survey 2019 National results briefing. Survey Coordination Centre. Available from: https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/ Accessed 26th July 2020
- Royal College of Surgeons of England 2021. The Royal College – Our Professional Home. An independent review on diversity and inclusion for the Royal College of Surgeons of England. RCSEng, London, UK.

January 2023. London, UK.