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Renegotiating HRM Practices and Delivering Service Transformation of Frontline Workers: Insights From the UK's NHS Ambulance Trust During a Significant Disruption

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ABSTRACT

We note that while the institutional environment determines the actions and structures of constituent organizations, there are still limited insights available in the literature on the nature and process of interactions between key stakeholders in ambulance services, especially as they respond during a significant crisis. This study specifically examines how a positive social exchange between senior leadership, managers, and frontline staff, accompanied by changes to the leadership style and HR practices, resulted in significant service transformation. An in-depth qualitative case study design was used to interview 52 frontline staff and leaders from the UK National Health Service's (NHS) Ambulance Service over a prolonged period of 8 months (October 2020 to May 2021). Interviews and secondary data were abductively analyzed, showing how changes to HRM and leadership practices shaped service transformation's content, process, and logic. The findings suggest that an iterative social exchange between the key social actors in the Ambulance Trust led to adaptations to the nature of HRM and leadership practices, which positively impacted the changes to service delivery, leading to service transformation and improved health and well-being of paramedics. Our conceptual framework contributes to the literature by integrating how the use of agency, new HRM, and leadership practices in the context of institutionalized structures can result in service transformation. Implications for theory and practice are also discussed.

1 | Introduction

Not long ago, we can recall how the healthcare and ambulance services globally were reeling under an already crippling infrastructure and the incessant pressure of saving the lives of the patients and medical staff involved during the COVID-19 pandemic. In times of significant and extraordinary crises, such as the pandemic, disruptions to the extant menu of practices and service delivery protocols become apparent (Nuffield Trust 2023; Willis et al. 2021). In essence, frontline ambulance staff routinely operate in emotionally demanding, intense, and highly stressful roles, but the demand and intensity of their work during the pandemic exacerbated the prevailing situation, thus adversely impacting the capacity of ambulance services globally and in the UK to meet patient demands (National Audit Office 2017; NAO 2023; Public Accounts Committee 2023; The

King's Fund 2021). A recent UK parliamentary report describes the lack of adaptability of ambulance services as a "national emergency" (House of Lords 2023). Furthermore, evidence highlights the dysfunctional effects of ambulance targets, performance indicators (e.g., the headline 8-min response time target, which essentially measures the clock rather than the quality of care provided to the patient) and current leadership approaches on service delivery and staff wellbeing (McCann et al. 2015; Wankhade 2011; Wankhade et al. 2020). Most public services, including ambulance service organizations, are structured hierarchically, reinforcing rank and seniority, characterized by a "command-and-control" culture with limited leeway and choice for maneuver and adaptive behavior (Wankhade and Murphy 2023; McCann 2022). These conditions pose significant leadership and HR challenges in the functioning and delivering critical and life-saving services (Rodriguez et al. 2023; NAO 2023). Though Grint (2005) contends that the directive leadership style is effective in times of crisis and disruption, we argue that leadership-as-a-process approach (see Jackson and Parry 2018) is more effective in times of a crisis, which highlights the importance of collective decision-making.

The pandemic provided a critical juncture and created conditions for change in practices in a highly institutionalized environment at our case organization—hereinafter referred to as *Apollo*. Repeated interactions and negotiations between frontline staff and HR and organizational leaders were used to change the dominant logic of top-down and command-and-control settings to embed new and re-negotiated norms (Cardinale 2018; Lewis et al. 2019). This study employs the Social Exchange Theory (SET) as a useful lens to analyze how employees and leaders behave in evaluating their relationships with others in a social context (Cropanzano et al. 2017; Porter 2018). It is also important to highlight that notwithstanding the prominence of the SET, very few studies have provided evidence of how the "black box" of social exchange processes unfolds in times of a significant crisis (Cropanzano and Mitchell 2005; Cortez and Johnston 2020; Garner 2017).

The contribution of this study is first, to the service transformation literature in the context of a highly institutionalized setting in times of crisis (Subramony et al. 2023). Specifically, our paper addresses the gap in service transformation literature by using the theoretical lenses of social exchange. We highlight that through a negotiated social exchange and the interactions between the processes, structure, and agency, social exchange was enabled. To this end, we develop a heuristic tool for understanding how the *content, process*, and *logic* of service transformation occur (Ostrom et al. 2021; Voorhees et al. 2020).

Second, although there are limited studies in general on the implementation of SET, literature is even more sparse on the underlying mechanisms, especially in times of a crisis. Our study especially unpacks the mechanisms of social value exchange, thus throwing light on the black box of SET (Cropanzano et al. 2017; Porter 2018). Our findings point to the dynamic interactions and negotiations between senior leadership, managers, and frontline staff based on the norms of reciprocity, a distributed leadership style, which led to the emergence of a new bundle of HRM practices. These new HRM practices were conducive to managing staff and resources as the crisis unfolded. In essence, *Apollo* was able to create a valuable social exchange between frontline staff, managers, and leaders, resulting in decent, inclusive, and sustainable employment for frontline staff (Voorhees et al. 2020; Kandampully et al. 2021). We further argue that the implementation of HRM practices is a social process and involves social, economic, and emotional value exchange between the key actors (senior leadership, managers and frontline staff) to bring about the needed changes in the form of revised HRM practices for better employee and organizational outcomes (Bos-Nehles and Meijerink 2018; Kuvaas et al. 2014).

A third, and related contribution of the paper is to the emerging body of literature on leadership practices in time-critical service delivery organizations, such as the blue light (police, fire and ambulance) organizations, that are mandated to respond to life-threatening emergencies. Our study offers a distinctive contribution by showing the mechanisms that enable a new social exchange by adopting a distributed leadership; a renegotiated set of HRM practices is possible. We depart from the extant literature on leadership in such organizations, which is characterized by a dominant logic of a command-and-control leadership style and top-down style of decision-making (Cardinale 2018; Grint 2020; Lewis et al. 2019) by arguing that such leadership approaches are ineffective in times of a crisis (Grint 2022; Tourish 2020). Our analysis points to the usefulness of a distributed leadership style in such dynamic contexts (Bolden 2011). A distributed approach to leadership humanizes the social exchange processes within an organizational system by enhancing interpersonal trust, reciprocity, and a positive engagement between all actors. Through this study, we highlight how these mechanisms (of distributed leadership style and the social value exchange, evident through the interactions between structure, process, and agency) led to a renegotiated and new set of HRM practices, which we posit is better suited in times of a crisis (Boon et al. 2009; Malik and Sanders 2021).

Finally, we contribute by developing a conceptual framework that unpacks the above interactions and mechanisms of social exchange in times of crisis, resulting in service transformation. Discussing our conceptual framework, we highlight how aspects of a new social exchange occur between senior leaders, managers, and frontline ambulance staff, which then led to changes in the HRM and leadership practices. These changes underpinned service transformation in our case organization. We further highlight implications for theory, policy, and practice.

Based on our study's contributions noted above, and especially in times of an unprecedented and significant event, such as the 2020 Pandemic, we argue that service transformation must consider a more humanized approach to service delivery, one that questions the relevance of the current core processes and challenges the assumptions in the way the services are delivered. To this end, and based on Kandampully et al. (2021) and Voorhees et al. (2020) conceptualization, we define service transformation as a process that entails a rethink and redesign of the core services (what) and their underpinning activities (processes) to enable a positive and sustainable change for front-line staff and managers (i.e., the why or logic) that led to a strategic change in response to significant turbulence.

This definition is particularly important, as in times of a crisis, front-line employees' physical, mental, and emotional well-being and resilience are severely challenged, and their ability to effectively continue to deliver services is tested. These disruptions warrant a significant change to the nature of work and workflow processes, leveraging existing and developing new capabilities, including reflection on and questioning of the norm, where necessary.

Our study adopts a contemporaneous and in-depth qualitative case study design (during the pandemic) of *Apollo*, our Ambulance Service Trust, as part of the UK's NHS and presents unique insights from the data collected over an extensive and prolonged period from October 2020 to May 2021. Given *Apollo* is a publicly funded organization and exhibits high levels of institutional isomorphism and design homogeneity in the face of coercive regulation for the implementation of service delivery practices (DiMaggio and Powell 1983), its core purpose remains saving lives. This is delivered in adherence to a nationally determined set of HR practices, organizational protocols, and performance targets. Unlike for-profit organizations, where service design and transformation often drive the strategic leadership and HRM choices, organizations such as *Apollo* have very little wriggle room for changing their service delivery practices, especially given the highly institutionalized and regulated policy and delivery frameworks. Hence, this study's main research question is as follows: *How do HRM and leadership practices shape the content, process, and logic of service transformation, especially during the pandemic in a highly institutionalized environment?*

We analyze the data to address our overarching question by examining how the nature and extent of social exchange between leaders and frontline employees, their distinctive leadership process, and concomitant changes to *Apollo's* rigid institutional underpinnings of HR practices (Paauwe and Boselie 2003; Boon et al. 2009; Lewis et al. 2019) led to changes in the service delivery protocols of the trust. We specifically pay attention to how senior leadership, managers, and frontline staff used their agentic resources and adopted a collective approach (Bolden 2011) based on mutuality of trust (Blau 1964) to bring about changes to *Apollo's* HRM ability-, motivation-, and opportunity-enhancing HRM practices (Appelbaum et al. 2000; Blumberg and Pringle 1982). Faced with a specific turbulent environment that was characterized by the rapidly spreading pandemic infections and a growing number of fatalities, organizational leaders' and employees' agentic resources of distributed leadership, negotiation, and persuasion helped embed innovative HRM practices while retaining some aspects of the rigid institutional norms. Following this, the frontline staff, managers, and senior leadership changed the *content, process*, and *logic* of service transformation at *Apollo*.

The rest of the paper is structured as follows. To put things in context, the next section provides a brief context of the ambulance services in the UK's NHS system. This is followed by a review of the theoretical literature guiding this research. Next, we discuss the details of the research methodology employed, leading to the analysis and findings of the study. Next, we discuss the findings and conclude by offering the study's limitations, implications, and future research avenues.

2 | Context

We begin by providing a broader population context of ambulance care, followed by the changes the Pandemic brought to it and then providing an overview of our case organization—*Apollo* for further details about the specific research context.

2.1 | Broader Ambulance Context

In recent years, organizational theorists and HRM scholars have called for paying greater attention to the external socio-cultural and institutional contexts of organizations (see Lewis et al. 2019; Mayrhofer et al. 2024) that influence and shape strategies and practices, including HRM practices adopted by firms (Schotter et al. 2021). Several scholars (Ferris et al. 2004; Paauwe and Boselie 2003; Mayrhofer et al. 2024) have highlighted that many internal, external, and formal and informal institutional factors shape HRM practices. Therefore, it is critical to understand and account for the context (the pandemic) to explore the nature and effectiveness of HRM systems in general and HRM practices in particular (Malik and Sanders 2021; Do et al. 2020).

Emergency prehospital care in the UK is primarily provided by the thirteen publicly funded NHS ambulance trusts, which deal with over twelve million 999 calls annually (Wankhade and Murphy 2023). These organizations provide essential life-saving services and play a critical role within the wider emergency networks. Historically, ambulance services are predicated on a "fast-response" model for quick transfer of patients to hospital emergency departments (EDs) and, therefore, measured against a set of response-time targets based upon the level of emergency of the caller. Despite the weak correlation between the benefit of faster response and patient outcomes, these organizations continued to be performance-managed against response-time targets (Swan and Baumstark 2022; NAO 2023; Wilde 2013). The current shifts in the professional identity of paramedics mark a move away from a semi-skilled role (McCann et al. 2013) to a pre-hospital care professional (e.g., College of Paramedics in the UK) who possesses a university degree. This has enhanced the scope of clinical practice to include skills such as telephone advice or at-the-scene consultation by frontline staff (Eastwood et al. 2023; Prener 2022; Corman 2017). However, the existing organizational practices still fail to recognize these shifts in their professional identity, leading to dents in their professional optimism. Ambulance services are still characterized by hierarchical and rank-based decision-making structures, wherein a "command-and-control" culture reinforces compliance to organizational norms, routines, and rituals and control social boundaries between leaders and frontline staff, which reinforces organizational inertia (Feldman and Pentland 2003; Kirk et al. 2018). Additionally, the constant challenge of balancing managerial control with clinical and operational autonomy for frontline employees and paramedics generates ongoing tensions, which creates a wedge between leaders and junior staff leading to a blame culture (Leech 2024). Such tensions are further reflected in the poor quality of feedback given by ambulance staff in the successive annual employee voice surveys (NHS Survey 2022). The above insights highlight a lack of compassionate organizational climate, poor leadership, and conditions that create work-related stress and burnout (NHS Survey 2022).

2.2 | The Role of Ambulance Services During the COVID-19 Pandemic

The Coronavirus Act 2020 designated the healthcare system as an essential service, requiring healthcare organizations to operate at full capacity to manage the escalating pandemic and increasing infections. Organizations like *Apollo*, which are entrusted with the responsibility of saving lives, were forced to operate in an environment marked by high infection and mortality rates among the public and patients, lockdown restrictions, and a significant shortage of essential resources for managing the pandemic (Association of Ambulance Chief Executives AACE 2021). The risks were especially heightened for ambulance staff, as they were in continuous contact with infected patients and colleagues. In the following section, we provide an overview of *Apollo*—our case organization and—how the pandemic led to changes in its functioning.

2.3 | The Case Organization—*Apollo*

Apollo is one of the ten regional NHS ambulance services in England, which attends to more than 1.4 million emergency (999) calls and handles over a million emergency incidents each year. *Apollo* also provides non-urgent 111 services and attends to over 1.2 million calls annually. Furthermore, it also provides the patient transport service (PTS), which makes more than a million non-emergency patient transport journeys each year. The above services are delivered by more than 6500 staff using a fleet of approximately 750 ambulances and other vehicles. Structurally, *Apollo*'s staffing has four distinct levels: senior leadership (comprising of board of directors, led by the chairman, supported by executive and non-executive directors), senior and middle level managers (e.g., corporate and operations station managers), enabling functions (emergency control room, back-end functions e.g., HR, payroll, etc.) and frontline staff (paramedics, technicians and allied support staff). It is important to highlight here that the nature of the leadership and management of how these organizations are led, organized, and function is largely unexplored within the HRM literature (Granter et al. 2019; McCann et al. 2013; Bevan and Hood 2006).

In the above context, we argue that in a post-pandemic work environment, a new leadership approach to managing people and employing appropriate HR practices, which is based on a compassionate and care-oriented AMO logic, is needed (Ebben et al. 2023; Rodriguez et al. 2023; Greenberg et al. 2020; Willis et al. 2021; Grint 2020; Tourish 2020). Further, the new context requires an understanding of how agentic resources, such as distributed leadership, an open and transparent communication style, two-way negotiation, and empathetic persuasion, lead to a mutually rewarding social exchange between the key social actors. These agentic resources facilitated a favorable climate for embedding change and renewed service transformation.

3 | Theoretical Framing

This section explicates the key theoretical lenses that guide and shape our research question. In the process, we explain the logic and connectedness of these lenses to better account for the phenomenon of service transformation in the context of a highly regulated blue-light service organization during a crisis, such as the pandemic. There have been several calls in service transformation literature on the need for research on frontline employees in the context of a crisis (e.g., see calls by Voorhees et al. 2020; Kandampully et al. 2021). Our research on *Apollo*, which was conducted during the pandemic, offers insights into how a time-critical lifesaving healthcare provider functions in a highly institutionalized and regulated environment. Undertaking studies of this nature necessitates a deeper understanding of how an organization's internal and external configurations are impacted during crises. Second, as change was inevitable during this crisis, it made sense for us to investigate the mechanisms that enabled a social value exchange in this highly regulated setting. We build on the key tenets of social exchange theory to unpack the black box of interactions during the crisis (Cropanzano et al. 2017; Porter 2018).

Prior literature on leading in times of crisis (Grint 2020) highlights the importance of a command-and-control model. However, the pandemic was an unusual-scale crisis, challenging the extant understanding of leadership styles in such situations. In line with subsequent expositions on leadership, which show the weaknesses of a command-and-control model of leadership (Grint 2022), it could be argued that the pandemic was a combination of tame, critical, and wicked problems requiring a combination of agentic resources, such as collaborative and consultative approaches, to innovatively solve the problems at hand (Grint 2023). In such cases, the agentic resources of leaders, frontline managers, and employees are well aligned with the leadership-through-process metaphor (Jackson and Parry 2018), often requiring a distributed leadership approach (Bolden 2011). We also note that to effect changes in such organizations, repeated interactions between the structure, process, and agency were in order (Cardinale 2018; Lewis et al. 2019). This would also necessitate changes to its bundle of nationally determined and prescriptive set of HRM best practices and service delivery protocols, leading to a renegotiated bundle of supportive HRM practices (Boon et al. 2009). Finally, through a collective analysis of these theoretical lenses, which focus on how change can be embedded to suit changes to a context, we extend the literature on service transformation by proposing a heuristic tool of content, process, and logic in such a context. Given the interconnectedness between these theories discussed above and in the introduction section, we provide a brief overview of these theoretical lenses and show their relevance to our research question.

3.1 | Social Exchange Theory and Implementation of Strategic Choices

Social exchange theory is considered one of the most influential paradigms for understanding how employees interact, behave, and build relationships at their workplace (Cropanzano et al. 2017; Porter 2018; Shore et al. 2006). Its application has been seen in recent crisis management studies (Cortez and Johnston 2020; Garner 2017), including studies on leader-member exchange (Kuvaas et al. 2012). The SET provides a viable framework to understand how two or more social entities

develop a potentially high-quality relationship through repeated, meaningful interactions that generate obligations (Blau 1964; Emerson 1976). Simply put, SET acknowledges that productive (and meaningful) social relationships in organizational settings evolve when employers (and senior managers) take care of employees, thus creating conditions for a socio-economic or emotional value exchange between the actors that result in productive work behavior, positive employee attitude, and benefits the organization as well (Bos-Nehles and Meijerink 2018; Kuvaas et al. 2014).

For social relationships to evolve into trusting, mutually beneficial, and productive commitments, the parties involved (e.g., the employers/senior managers and employees) must abide by "rules" that would govern the exchange process between them. Through this lens, prevailing or emerging external and internal situations provide the context for repeated interaction and reciprocity between and among the parties. Cropanzano and Mitchell (2005) note that SET scholars have overwhelmingly been considered and engaged with the rule of reciprocity at the expense of other rules. As Liden et al. (1997) and Cropanzano and Mitchell (2005) noted, few studies have explored the social exchange "black box" in times of crisis. The ambulance service organizations provide an exciting setting to adopt SET insights to delineate negotiated organizational practice changes. These organizations operate in a highly institutionalized, routinized, and regulated context, and therefore, to save as many lives of infected patients and ambulance service frontline workers—as possible during the pandemic, a significant service transformation was critical. To achieve this service transformation, the organizational leaders had to negotiate with frontline staff and managers based on an approach that showed care and compassion to generate obligations. This approach of repeated interaction between organizational leaders and frontline employees brought about changes in practices without losing or abandoning the institutional fit, which stands in direct contrast to the command-and-control style of leadership and HR practices and a hierarchical approach to decision-making that characterizes such organizations (Public Accounts Committee 2023). Central to this was the enactment of agentic resources and the exercise of strategic choice by expanding the leeway that frontline staff were afforded.

3.2 | Agentic Resources, Leeway, and Choice of HRM Practices

Although HR managers in organizations must confront paradoxical challenges within their organizations to bring about changes in systems of HR practices (Boon et al. 2019) and align them with changes in the environmental and institutional contexts, there are limited studies (Malik and Sanders 2021) that provide insights on *how* organizational leaders and HR managers use their agency to implement strategic choices in the design and implementation of new or modifying existing systems of HRM practices to respond to their external environmental context in real time. Exploring *how* organizational leaders and HR managers at *Apollo* used their agency to formulate strategic choices and implement them in an organization that operates in a highly regulated and institutionalized setting is important because it challenges the assumption that the institutional environment broadly pre-determines the actions and structures of the constituent organizations.

3.3 | Applications of SET to HRM Practices

The literature examining the applications of the SET in the field of HRM has gathered significant interest in the last three decades. A major focus of these studies has been in identifying the role of frontline line managers (FLM) or the organizational as a critical enabler in embedding social exchange between FLMs' enactment of HRM practices and its impact on organizational (Zhang and Jia 2010) and employee outcomes (Ko and Hur 2013). Most studies have tended to focus on integrating either FLM-employee interactions or FLM, organization and employee level interactions to influence a range of employee outcomes and behaviors (Masterson et al. 2000; Wayne et al. 1997). A critical focus of these studies is on developing appropriate values, attitudes and behaviors of FLMs that are perceived as favorable by employees—thus form the basis for a valuable social exchange. For instance, Bannya and Bainbridge (2022) emphasize the importance of supportive, fair, and resourceful managerial behaviors in fostering positive employee and organizational outcomes. Similarly, Zhang and Jia (2010) highlighted the role of culture and perceived organizational support in strengthening the link between high-performance HRM practices and corporate entrepreneurship. Multi-level interactions in the literature are scarce. In a similar vein, Kilroy et al. (2023) noted that FLMs are a heterogenous entity, and they can be at different managerial levels, with different attitudes, values, perceptions, and behaviors. They evolve and become important social agents to shape firm and employee level outcomes. The authors further introduce the idea of a "zone of reciprocity", which the FLMs must engage with employees. This refines our understanding of the causal link between how diverse FLM leadership styles and organizational and HR policies interact to deliver employee outcomes, such as increased organizational citizenship behavior and commitment.

To summarize, the majority of the studies have either focused on FLM and employee interactions or on the organization, FLM, and the employees (Roy Bannya and Bainbridge 2022; Kilroy et al. 2023; Zhang and Jia 2010). However, there is limited evidence of interactions between the senior leadership, FLM, and employees in enforcing a social exchange. Further, most studies have employed an ex-post facto cross-sectional survey design to gather insights into the mechanisms of social exchange, thus unpacking the black box of SET, especially in times of a significant crisis, which assumes greater significance theoretically and empirically. In addressing the gaps in the literature that employs SET in the study of HRM practices, firstly, our study adopts an in-depth qualitative case study design, thus departing from the above survey-focused design approaches to uncover the actual interactions, temporally and over a prolonged period (8 months vs. the typical cross-sectional designs). Doing soallows us to study the iterative interactions between the three sets of actors (senior leadership, managers and frontline staff) in the field as the pandemic unfolded. It also helps to unpack the mechanisms that support the social exchange between these three sets of social actors. Finally, we address the black box gap of SET in times of a crisis (Cropanzano and Mitchell 2005).

3.4 | AMO-Enhancing HRM Practices: From Institutional to Neo-Institutional Approaches

The extant body of institutional theory in HRM literature does not capture dynamic interactions within organizations as they change their practices to attain the desired institutional fit as their contextual environment changes (Harney and Collings 2021; Lewis et al. 2019). The studies paint a picture of organizational practices and actions as mechanical, which can be molded and changed when required to make the organization adapt to its institutional environment. However, this view of organizational practices, including HRM practices, is incompatible with how practice theorists conceptualize organizational practices (see Corradi et al. 2010).

Several studies have pointed to the use of complementary bundles of HRM practices as critical in explaining employee (Boxall et al. 2016) and firm-level performance (Subramony et al. 2008; Subramony 2009). Lewis et al. (2019) credit Wright and McMahan (1992) and Barringer and Milkovich (1998) for introducing institutional theory to HRM scholarship. These initial works put forward the view that decisions and practices relating to HRM are not necessarily a result of rational decision-making based on organizational strategies and goals but are embedded in its external social and contextual settings. Lewis et al. (2019), who assessed the state of institutional theory in HRM scholarship, conclude that notwithstanding these initial studies, the application of institutional theory within HRM research is somewhat limited, a view shared by others (Allen and Wood 2021; Mayrhofer et al. 2024), especially on how firms adapt and change in response to the pressures from contextual factors and deeply entrenched institutional regimes. Some have argued the importance of expanding the leeway in institutionalized contexts and exercising strategic choices through the agentic resources of key social actors, e.g., leaders and frontline managers or the dominant coalition (Boon et al. 2009; Malik and Sanders 2021), to achieve a better institutional fit, such as an *innovative* fit through active and positive developmental agency or a *deviant* fit using one's agency to push back and resist in times of major environmental turbulence (Dacin et al. 2002; Malik and Sanders 2021). We concur that complexities in the external environment, including the institutional environment, present a challenge and an opportunity for HRM (Keegan et al. 2018; Brandl et al. 2022).

In the context of the ambulance services, their nationally determined menu of HRM practices is prescriptive. For example, these practices stipulated that only fully trained and qualified paramedics and emergency medical technicians (EMTs) can be a part of the ambulance response, wherein the practices further prohibited employing students, temporary workers, and agency staff in control rooms during the pandemic, which limited the effectiveness of this resourcing model. The training and development practices specified very narrow competency-based assessment and certification of learning modules with set learning volume and study hours (as against recalling trainees from their studies to help support the services). Similarly, the rewards and benefits were regulated by national awards for different role categories (missing any opportunities for informal recognition and acknowledgement of discretionary effort). Finally, a risk-averse approach to key performance indicators for specific clinical and ambulatory tasks and service delivery protocols was set nationally, leaving little room for negotiation and adaptation.

We highlight how social exchange occurred between the leaders, frontline managers, and staff, which led to the emergence of a new bundle of HRM practices. To this end, we employ the ability, motivation, and opportunity (AMO) framework to unpack a new set of HRM practices (Appelbaum et al. 2000; Blumberg and Pringle 1982; Lepak et al. 2006).

3.5 | AMO-Enhancing HRM Practices

The literature on systems of HRM practices is diverse and often conceptualized inconsistently. For example, Boon et al. (2019) reviewed 516 HR systems, ranging from high performance through high commitment to high involvement or other variants. Despite the diverse conceptualizations of HR systems, there are, nevertheless, common strands of good and widely accepted sub-bundles of HRM practices, akin to the popular AMO enhancing HRM practices framework (Appelbaum et al. 2000; Blumberg and Pringle 1982; Lepak et al. 2006). Nevertheless, we argue that the AMO framework is generic enough to accommodate commonly understood HRM practices into a coherent system. It also allows flexibility to include diverse variations of ability-enhancing HRM practices (e.g., recruitment and selection, training and development), motivation-enhancing HRM practices (e.g., rewards and remuneration, performance management and social support), and opportunity-enhancing HRM practices (e.g., work design, participation, and involvement, work climate and communication) as broad sub-clusters of the AMO framework. Further, this stream of work has examined individual and organizational level influences of the AMO with their collective impacts and individual pathways of each sub-cluster or combinations thereof (Bos-Nehles et al. 2023). The AMO framework allows for a valuable heuristic to organize various AMO-enhancing practices. Our knowledge of the highly institutionalized and nationalized systems of HRM practices of the NHS and its sub-frameworks within its trusts makes the AMO framework a useful lens for further analysis as it will allow us to see changes in the sub-clusters of A, M, and O enhancing practices at *Apollo*, especially following the exercise of agentic resources of leaders and frontline managers to allow for leeway and choice in responding to an improved and transformed service delivery. Further, as Boon et al. (2009) and Malik and Sanders (2021) highlight, the role of leaders' and employees' agentic resources in an innovative institutional fit with the environment is vital. The following section explores leadership as a process and a resource.

3.6 | Distributed Leadership

We delineate the events that led to the emergence of a distinctive humanized leadership style (distributed leadership) and a renegotiated bundle of HRM practices. First, with the onset of the pandemic, the existing command-and-control leadership style and a hierarchical top-down culture, historically and culturally associated with ambulance services, were severely tested (Wankhade et al. 2018). This had to give way to a new way of working, which focused on collaborative

decision-making with people at the frontline who were at the coalface of the problem and had real solutions to implement. On the other hand, the leaders have been historically detached from the on-ground realities and from managing the relationship with frontline staff. In this context, they had little leeway and choice but to listen to the feedback from the frontline staff and take some negotiated risks in changing established routines and practices. This, in many ways, demonstrated a remarked departure from the traditional top-down decision-making approaches toward a more collaborative and distributed leadership style. This meant a new norm of reciprocity had to be invoked. This led to a new social value exchange between the leaders and frontline staff to change the ambulance service delivery and the underpinning HRM principles and practices. Such an approach was only desirable, as in times of a crisis of this magnitude, a command-and-control leadership style is not the answer (Grint 2022).

Leadership is a collective and distributive agentic resource and a process requiring collaboration and support from followers and other stakeholders. As *Apollo* operates in a highly institutionalized environment, it gains legitimacy through historical and cultural evolution. The practice of leadership within the ambulance services can be viewed as one that is rooted in historical and cultural factors, ranks, hierarchy, and forms, encouraging social boundaries, and a blame culture wherein staff do not feel confident to challenge management decisions for fear of reprisals (Kirk et al. 2018). Recent evidence indicates a strong correlation between poor well-being support, low staff retention and motivation, and lack of critical engagement between leaders and employees (Wankhade et al. 2020; Williams et al. 2017). The significance of organizational support (leadership by implication) as an integral part of managing the emotional labor of frontline staff and driving motivational levels has also been highlighted recently within the HRM literature (Brunetto et al. 2023; Rodriguez et al. 2023; Cooke et al. 2019). Shared or distributed leadership (Bolden 2011) helps build resilient organizations and be able to cope with adversity for "achievement of effective performance in situations of crisis" (Santarone et al. 2020, 257; also see Grint 2020; Tomkins 2020). Hannah et al. (2009) argue that leaders can potentially influence many attenuating and intensifying factors in one of the few specific leadership frameworks in extreme contexts. This argument echoes debates in the leadership discourse on distributed, community, and relation-based approaches to leadership (Santos and Eisenhardt 2005).

4 | Methodology

Data were collected from *Apollo* (a pseudo name used here for ethics and confidentiality reasons), a large NHS ambulance trust in England. Our main research question was to explore the change in the content, process, and logic of service transformation through an analysis of the responses of the UK's frontline ambulance workers during the pandemic to capture a rich and contextual understanding of the issues and capture the complex interactions between the key social actors as they happened. Thus, a qualitative case study design was considered the most appropriate logical way to analyze how changes to HR and leadership practices can shape the nature and extent of service transformation during a sustained crisis (Yin 2014). We conducted 52 in-depth and semi-structured interviews over a period of eight months (between October 2020 and May 2021) spanning the first two waves of the pandemic (see also, Figure 1).

Following Eisenhardt and Graebner (2007) advice of selecting a revelatory case and ensuring a maximum variation in the sample of "polar" extremes of senior leaders and frontline employees (2007: 27), and other occupational roles within *Apollo*, such as control room staff, HR, operations and corporate managers, formed a critical design feature of the study. The participants included senior leadership (board executives and non-executives), managers (corporate and operational), and frontline staff such as paramedics, patient transport staff, students, and control room 999 call takers and vehicle dispatchers (see Table 1). Our approach was to interview participants while the pandemic unfolded to facilitate a "real-time" and contemporaneous understanding of the core themes, and staying close to the phenomenon, data, and theory allowed us to abductively develop novel insights (Magnani and Gioia 2023; Peirce 1901; Reichertz 2007) of how the process, as it unfolded during our prolonged engagement in the field (Yin 2014; Eisenhardt and Graebner 2007). This allowed us to investigate the dynamic response of various organizational actors experiencing the crisis. Such an approach is described by Morgan (1983) as "research as engagement" and finds support in the literature (Watson 2011; Van Maanen 2011).

Each interview lasted between 25 and 70 min, and they were digitally recorded with prior consent and transcribed verbatim. These yielded recordings of 32.25 h and transcripts totaling 279,491 words. Questions typically explored the senior leadership and employee responses to issues around resource management, recruitment, reward management, work rigidity/autonomy, performance and targets, command-and-control, blame culture, well-being, resilience, and motivation while dealing with the pandemic. A copy of the interview protocol is appended to the paper (Appendix A). To further protect the confidentiality of our participants, quotes from the data are attributed to their generic roles in the findings section (e.g., interview 6, board executive 1).

Furthermore, we complemented primary data with secondary data by continuing to analyze the minutes of 13 Board meetings between 2021 and 2024 (Meeting 1–13, 2020–2024, yielding PDF files of 3945 pages). This helped us to track the extent to which some of these changes have been sustained in the current work and leadership practices. The latest NHS Staff Surveys covering the period of the study and beyond confirm the shifts in these practices (NHS Staff Survey 2022). The minutes of the 13 Board meetings also highlighted the temporal nature of the changes as they unfolded during and after the crisis (see also Appendix B).

However, since the board papers and survey results are publicly available and would risk identifying the Trust's name, we decided not to present the selected excerpts verbatim. Instead, we have embedded the essence of the minutes and survey throughout the analysis on various topics in our language, taking adequate care not to distort the actual meaning and the respondent source.

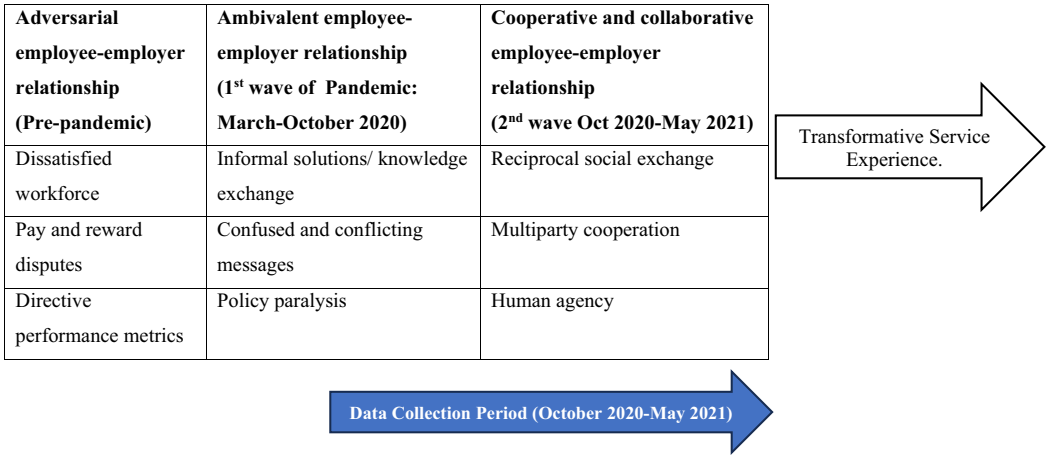

FIGURE 1 | Temporal shifts in employee-employer relationships leading to transformative service experience.

TABLE 1 | Respondent sample.

Senior leadership (board executives and non-executive directors)	08
Managers (operational and corporate)	13
Frontline staff (paramedics, technicians, patient transport staff and students)	20
Emergency Control Room (call handlers and dispatchers)	11

4.1 | Data Analysis

All authors independently read the anonymized transcripts to familiarize themselves with the data, triangulate emerging themes, and minimize researcher bias. In terms of theoretical saturation and the appropriate sample size in qualitative studies, different studies point to a diverse number of interviewees, ranging from a minimum of 5 to up to 25 people (Brinkmann and Kvale 2014), through between 15 and 60 (Saunders and Townsend 2016) to a much smaller number (Short et al. 2009). A key consideration is the nature of the research design, the researcher's skills in interviewing, and the time spent in the field (Strauss and Corbin 1990). In this study, our number of interviewees (52) is toward the upper end of the commonly understood threshold. We saw theoretical saturation emerging in most constructs in the first six months of data collection, comprising 31 interviewees. Several additional themes also started replicating toward the end of the seventh month, with about 36 interviews completed. As we had the opportunity and access to additional data collection, we continued with another 16 interviews to see if the changing crisis context would yield new theoretical categories. However, only incremental knowledge was gained. Hence, we stopped collecting data at the end of May 2021 (52 interviews).

We began with an open coding approach following Strauss and Corbin (1990) and Gioia et al. (2013) approach. The analysis typically involved moving from open codes to second-order constructs and then to aggregate dimensions resulting in our conceptual framework, abductively using the Gioia methodology (Magnani and Gioia 2023) to derive our final data structure tables (see Tables 2–5). The Gioia et al. (2013) approach suggests generating first-order concepts, which emerge from the raw data and serve as the initial codes for the first-order concepts in the data set. For example, the key concept in our study is service transformation and its content, process, and logic. As an illustration, the "what" or "the content" of service transformation, as presented in the data structure (Table 5), involved identifying and categorizing informant terms and phrases from the participants' raw excerpts that led to the identification of codes that relate to different dimensions of service transformation. A constant iteration between the researchers, theory, and data helped refine these codes. More specifically, the first-order codes of improved communication, increased coordination, and effective internal support system aggregated to a second-order theme of new internal and external feedback loops for effective service flow, and so on. Next, the second-order themes were coded using the same process as above. To this end, we identified additional patterns and relationships leading to the broader themes, reflecting the researchers' interpreted schemas and the raw first-order codes and descriptions into a theme. For example, the data structure on the what theme (Table 5) of service transformation uncovered the following sub-themes: new internal and external feedback loops for an effective service flow, new equality, diversity and inclusion (EDI) initiatives for psychological safety, direct employee voice channels guardian review, innovative workflow, and reduced bureaucracy for responsive service delivery and greater appetite for trailing alternative pathways, and new performance targets and innovative approaches. Finally, the aggregate dimensions comprised an aggregation of the three themes of content process and logic, resulting in service transformation. This stage involved further abstraction to identify an overarching dimension that captured the essence of the data and linked the second-order themes into an aggregate dimension of the content of service transformation. Collectively, several aggregate dimensions were then informed based on presenting our evidence through our conceptual framework (see Figure 2).

TABLE 2 | Data structure: leeway and strategic choice—new (innovative) institutional fit and leadership practices.

Raw quotes	First-order codes	Second-order themes	Aggregate dimension
The ambulance service seems to have got a lot more flexible, you know, with home working and things for... Obviously, it doesn't affect paramedics/ambulance staff on the road, but for the wider organization, you know, like adapting so people can still work from a safer environment at home. (Interview 1, Paramedic)	Performance rigidity		Leeway and strategic choice—new (innovative) Institutional fit
I think we have had to adapt. We have seen a lot more complex situations. So, patients who we would predominantly convey into hospital, while I am not saying that we would not still take patients to hospital, we have had to weigh-up, "Does that patient categorically need conveyance to ED, or are we able to look at other alternative workstreams, service providers, to refer them into?" (interview 34, paramedic)	Relaxation of standards	Increased autonomy to frontline staff to address rigidity of performance metrics	
There were several changes that went in. So, there was a BT filter. So, when someone was ringing 999, if their call was COVID-related and there weren't any other confounding issues, they were directed to 111, so it didn't come to 999. Then, within the 999, they also had what's referred nationally as card 36 or the pandemic card and that was put in. So, the pandemic card just almost pushed certain groups or presentations slightly lower, from one into two, twos into threes and then threes into fours, just to be able to manage those critically ill quicker, rather than having lots and lots of jobs on the stacks in the control room. (Interview 7, Board Executive)	Increased corporate citizenship		
I never knew of anyone that refused to go in to treat a patient {without PPE}, but we just had to be really mindful. Anyone that probably did look like they had COVID, obviously the first thing you do is put a mask on them and just try not to get too close to them really. That is what we had to do... I have been quite proud of the staff, and especially some of the younger ones really. (Interview 47, Paramedic Team Leader)			
I speak to quite a lot of my colleagues, or my friends as well. We can always speak to each other about it... It's one of those, in my current circle of friends from work, there is always somebody you can talk to if you're feeling down. (Interview 42, Paramedic)	Risk averseness	Greater experimentation and psychological safety nets through problem-solving and resource allocation	
There were occasions where we had to push back really and have some discussions through our executive leadership team about getting that balance right. Because obviously the pressure was always on, getting staff prepared and released to the front line as soon as possible. It made us to be much more agile in our decision-making. (Interview 11, Board Executive).	Leadership team's discretion		
As a leader I probably could and should have been stronger in terms of saying, "This is not the right thing to do as quickly as prescribed, these are the organizational risks to this." So instead of making the decision about when the right time to implement change was we were making decisions around how we mitigate the risk of doing this quickly. (Interview 29, Strategic Commander)	Leader's agentic choices		
Some of the managers have really raised their game and have been absolutely outstanding in these last 12 months, and that's not just in service delivery. That's a number of people across the whole trust. (Interview 21, senior commander)	Wellbeing and resilience	Improved self-efficacy	
One of our paramedics ended up in ITU. He's back to work now, but he's not on frontline ambulance, because his health isn't to a level where he thinks he can do the job anymore. So, he's working in the background helping out more organizational, rather than frontline paramedic anymore, which is a shame, because he does love the job. There is support for him coming back, and I think they made referrals for him for talking therapy. (Interview 42, paramedic)	Employee support		

(Continues)

TABLE 2 | (Continued)

Raw quotes	First-order codes	Second-order themes	Aggregate dimension
We worked with a company who had helped us previously in developing some interventions in our operation centres. We identified some staff who had either contacted us individually or we knew through health and wellbeing work that we'd done, and they talked directly to those staff to get their experiences, their fears, and use that then to really target the podcast that we produced as short interventions. We got some positive feedback from those. But also, things like the chaplaincy support, we expedited. That hadn't really been on the cards (interview 11, board executive)	Emotional support		
Call-taking is definitely at the forefront of that. So, we've done a lot of work with the connection across all ambulance trusts and including devolved nations. That enables us to take each other's calls and just push those incidents into their respective CADs. We've discussed that for a long time, and we were doing some work prior to the pandemic on that. The pandemic has made it happen. (Interview 17, Senior Commander)	Service delivery	Flexibility and innovative options in delivering service	
We knew that we would need more 999 fleets, but you can't just magic up a 999 fleet that doesn't exist. So, we repurposed part of our PTS fleet. We turned PTS vehicles into 999 vehicles, we retrained some of the PTS staff to become urgent care staff. We would stick them with their paramedics and split crews up. So, we increased our resources. Again, across 111, we increased the number of homeworkers... So all those things that probably we have thought are probably not possible, suddenly became possible. (Interview 12, Board Executive).	Recombining and repurposing resources		
We became a lot bolder about what degree, what severity, of sickness we would discharge at home. You'd get a patient who has COVID, they've got the diagnosis, there is no cure, they've just sort of got to get on with it and see how it goes. Whereas before I would be taking people to hospital because they've got a respiratory infection. (Interview 38, Senior Paramedic).	Exploration of clinical choices		
I think communicating to staff was a starting point. I think we used a lot more social media. We set up our own Facebook page. We used Facebook Live sessions as well on a Friday afternoon. On our Facebook page, we'd run for a few days saying that "An exec will be on Friday at 1:00. This is the subject we're going to talk about." It might have been PPE, it might have been staff testing questions in advance, or, come on live and listen and ask questions as things come up.' So, that ability to communicate was massive (Interview 12, Board Exec)	Improved communication channels	Improved relational coordination	
I think the lessons that we've learnt and have adapted along the way is how we communicate to our staff... We've learnt that, actually, there's no requirement to wear, maybe, Tyvek suits for all jobs. We've learnt that the paperwork can be removed and replaced by more automated collection of information. We've also learnt that we can still manage, as an organization, without having face to face meetings, and so many of them. We've learnt to come more into this century. (Interview 9, Paramedic).	Changes to communication protocols		
Sometimes being a manager is not always about giving advice. It's about listening to people. And people aren't looking for answers. They're just looking for an ear. They just want you to sit for a minute and listen to their concerns. They don't always want an answer. They just want to be heard. (Interview 27, Paramedic Team Leader) It's very clear we've under-resourced mental health for a long period of time, and I would be very, very clear that we have, as a system, completely under-resourced the 111 and the 999 service. I...the NHS can't run. So I think it has made it very visible, the chronic underfunding. (Interview 6, Board Executive)	Employee voice & empathy	Contribution of staff recognition	

(Continues)

TABLE 2 | (Continued)

Raw quotes	First-order codes	Second-order themes	Aggregate dimension
I think what the public and the professionals accepted was that preceding the pandemic, there was an ever-increasing risk-averse culture....And it was a very healthy debate about what Command and Control structure we put in place, the levels from Operations, Tactical Strategic, but was really keen to ensure the Executive always existed... And that was very helpful from the outset. .... (Interview 6, Board Executive)	Softened and relaxed hierarchy	Loosening of command and control	Distributed leadership
It was an opportunity for us to move at pace, having that in place. Whereas having meetings, having committee meetings, having executive meetings and board meetings are very clunky, to get things done in what would be deemed as a normal world. But through a pandemic, decisions were made pretty damn quickly. (Interview 17, Senior operations commander)	Decision-making agility		
Also with management, like supervisors, when I first started there was only one supervisor on every shift. Then maybe on a few day shifts there would be two supervisors. But now we have a minimum of two on every shift, because it is needed, and it works so much better because there is always somebody there for you to ask for help. (Interview 18, control room dispatcher).	Expanding choice and leeway		
I think the ambulance service has been a particularly unique organization in the pandemic because we've been the service that ran, or we run the 111, obviously, the classic 999 service, also the patient transport service. Unlike the rest of the NHS who could prepare, our preparation, our lead time was much less, and we have very little, if anything, to turn off (Interview 6, Board Executive)	Changed identity and reduced rigidity	New Empowered managerial and leadership tasks	
To come into this job is difficult enough, but to come into it as a paramedic in a pandemic, that's a whole new... That will probably have lasting effects for years and years. Probably change the whole view of their job and the vulnerability of being on the front line. (Interview 27, Paramedic Team Leader)	Changes to negative feedback loops		
Because part of that contact shift with staff is helping them deal with stress and it's not just COVID stress, any stress...One of my students was particularly stressed... She already suffered mental health and so I had to physically, "Come on, let's go for a walk...And this Saturday, she said that she believes that it's absolutely maintained her health just doing that, going for a walk for an hour. And even on a freezing cold day because it matters, you know. (Interview 27, Paramedic Team Leader)	Empowering staff with strategies to deal with stress	Promoting Collaborative culture	
I think it's really enabled them {corporate staff) to see that connection between what they do on a day-to-day basis and frontline delivery in a way that they don't necessarily see as easily during normal operating times... In that sense, I think it has helped to bring teams together as well and to build bridges and relationships across teams. (Interview 11, Board Executive).	Strengthening team ethos and bonding		
The departments that I've found have had the biggest pressures on them have been operations and service delivery, and also to a degree the HR and People directorate. You know, sometimes, we think in ops we're the only people that are working flat out, and it's not true... Both directorates have been exceptionally busy trying to keep staff safe, trying to get the flow testing sorted, trying to get, recently, the vaccinations. (Interview 21, Senior Ops Commander).	Improved Relationship cooperation & collaboration		
There was a lot of pressure on the hospitals to ensure that we weren't taking patients unnecessarily in. That puts a lot of pressure on you, as a clinician. We had good support ...and had a clinical leadership that we were able to run by any sort of decision-making that they will obviously support us and give us guidance if they feel that there's an alternative pathway. (Interview 2, Paramedic).	Ability to explore new decision pathways	Empowered decision-making and delegated tasks and processes	

(Continues)

TABLE 2 | (Continued)

Raw quotes	First-order codes	Second-order themes	Aggregate dimension
We increased our resources. We did things in a quick time that we'd have probably taken years to do in—if you call it "peacetime"—when normal modes of operations are in place. So, we had to respond in a different way, and we had to break down some barriers that were there. (Interview 12, Board Executive)	Resource flexibility		
We had to do what we had to do. We also refined it, so it was a continual refinement of what it was we were doing. Things got slicker. I noticed that we all became much more confident about making these decisions and almost, not blasé but it was kind of like, "Oh, we've got to make a decision now for the trust so we'll do it, this is what we say." (Interview 8, Senior Manager)	Task and process flexibility		

Conscious that our data was derived from a single case organization, generalizability across other ambulance settings is an issue notwithstanding the value of case studies in generating new theoretical insights (Yin 2014; Eisenhardt and Graebner 2007). However, our study provides a rich contextual account of how paramedics and ambulance services implemented service transformation in form and practice in a challenging clinical and highly institutionalized environment, a setting that is primarily under-researched and underrepresented within the HRM literature.

5 | Findings

The preliminary codes were extracted from the interviewees' quotes, and these concepts informed and served as the first-order concepts and the subsequent theoretical building blocks of the second-order themes and aggregate dimensions using abductive logic (Magnani and Gioia 2023; Reichertz 2007). Finally, we developed our data structure and the emergent conceptual framework (Figure 2 and Tables 2–5). Evidence of several interview excerpts is provided for each first-order code and second-order theme in Tables 2–5. In analyzing the findings below, we first provide our analytic text of the emerging themes and aggregate dimensions. This includes evidence from secondary data, namely, board meetings and staff surveys. Each aggregate dimension has one exemplar quote with supporting insights from the secondary data, for example, minutes from the Board Meeting or NHS Staff Survey results. Additional quotes for each second-order theme and aggregate dimension are provided in Tables 2–5.

5.1 | Expanded Leeway and Choice-Innovative Institutional Fit and Leadership Practices

The challenges faced by leaders and frontline staff in the wake of the pandemic necessitated the adoption of a more diffused and distributed approach to leadership. The current bureaucratic and rule-based decision-making approach was deemed ineffective as the pandemic presented a dynamic and complex unfolding of the situations. Thus, leaders and frontline employees had to engage in a new norm of reciprocity and social exchange, such that knowledge or experience of what was happening at the coalface and faced by the frontline staff had to be shared, appreciated, and actioned appropriately. This distributed approach of leadership required renegotiation and an open communication channel, as well as empowering frontline staff to take calculated risks and, where appropriate, exercise their expanded professional autonomy to address the challenges that the pandemic presented. Well-documented examples include acquiring PPE kits (Interview 27, Table 3) and safe accommodation arrangements (Interview 29, Table 4) for frontline staff and their families.

Table 2 illustrates the expanded leeway and better institutional fit resulting from the changed HR and leadership practices and the new social exchange described in the preceding two sections. The innovative institutional fit primarily resulted from increased task autonomy for frontline employees, senior leadership's adaptive response to resource challenges, improvement in communication channels, and greater staff engagement and motivation from wellbeing support provided through leaders' agentic choices.

It would not be an exaggeration to argue that the increased autonomy of staff and greater trust and collaboration between leaders and employees brought a range of new benefits, fostering a better institutional fit. For instance, it tempered the rigidity of the performance metrics with a new recognition (and realization) for prioritizing staff safety in service delivery and patient care. *Apollo's* agility and adaptive response and, by implication, that of senior leadership is reflected in senior executive comments (interview 12) and senior commander (interview 17) in protecting staff and ensuring an adequate supply of PPE, notwithstanding the challenges imposed by centralized procurement and distribution hurdles:

> Despite all the press that's occurred with PPE, I'd say, hand on heart, we never run out of PPE. The challenges we had to adapt to what was available. So, from procuring hoods and undertaking FIT testing with one particular mask, then a second mask, and then a third mask, and now a fourth mask, to make sure we can deal with the diminishing stock levels, internally as well as globally, we adapted to those challenges. (Interview 17, Senior Commander).

This does not suggest that the PPE issue was not emotive, especially for the frontline crews and control room staff. Still, the

TABLE 3 | Data structure—new bundle of AMO-enhancing HRM.

Raw quotes	First-order codes	Second-order themes	Aggregate dimensions
It meant the redeployment of students into paid employment opportunities. We got the skilled part of the workforce to work in the emergency service rather than the patient transport service. And we've used agency resources in the control centres. (Interview 11, board executive)	Alternate employee sources	Ability-enhancing HRM practice (expanded recruitment channels and selection criteria) (new informal and online learning and development)	New bundle of AMO enhancing HRM practices
I was helping out as an emergency care assistant on the emergency support vehicles, the patient transport vehicles. I helped with COVID patient transfers and attending patients who are lower category calls... so it was a good opportunity for us to basically go out on the road and have some form of responsibility other than being mentored. (Interview 20, Student Paramedic).	Hiring alternate care and support workers		
And we were well staffed because we put in agency staff and we recruited extra staff to cover the non-clinical roles to take the pressure off at a time when demand dropped. So, actually being in work wasn't too stressful other than the fear factor of contracting COVID from your work colleagues. (Interview 30, Service Delivery Manager)	Hiring volunteer and non-clinical contract staff		
Now we've got full hoods with respirator belts. We've got people who clean. Out of the pandemic came cleaners outside A&E who when we take the patient off, the ambulance gets completely cleaned and wiped down inside before we've even handed over. And that is good practice whether you're in a pandemic or not...A clean and clinical environment. (Interview 27, Paramedic Team Leader)	New resources and staff to free up valuable resources		
So I think we've had to make a number of adaptions to our recruitment and training in terms of social distancing and all of those kind of impacts as well. We've had to truncate some of our training programs in order to, I suppose, deliver a safe level of training but perhaps not giving our new staff some of the broader range of skills and experiences that we would normally do during our training processes... (Interview 11, Board Executive)	Increased and new training		
I think we were unique in the way we responded to the challenges. I think it has led to a huge amount of both innovation, and also, changing prescribed ways of doing things. So innovative ways of delivering care and changing what we would not normally do outside the pandemic. So we're using PTS colleagues and training them for a number of days to then work as PES, using students, truncating previous training programs. (Interview 6, Board Executive)	Embracing new and innovative learning routines		
We have had to learn very quickly about doing basic observations, for example, recording outcomes on patient report forms, PRFs. It has been a very, very steep learning curve, but quite an enjoyable one as well. (Interview 15, Patient Transport Service Care Assistant)	Informal and incidental learning		
The pandemic is the best example I think across the last 12 months, it's the first time really the sector has tried to coordinate a consistency of response, and I guess they were going on a journey of learning as well. (Interview 29, Senior operations manager)	Knowledge sharing activities		
I think the support mechanisms that are in place, they're in your face daily. We've got communications that are going out daily, religiously go out daily, whether it be wellbeing or whether it be a communication in relation to anything to do with a COVID pandemic, whether it's to do with self-isolation or a PPE or fit testing... There was always that section that highlighted there are people around you, there are people to support you... I previously worked in a private organization, and I never saw as much support from a mental wellbeing point of view than I have at (Apollo) (interview 22, Tactical commander)	Employee wellbeing and mental health	Motivation-enhancing HRM practice (intrinsic reward and benefits management) (greater flexibility with performance management and review cycles)	

(Continues)

TABLE 3 | (Continued)

Raw quotes	First-order codes	Second-order themes	Aggregate dimensions
I think staff are a lot closer with each other, because they've been through something that nobody ever envisioned happening. I think the wellbeing is taken more seriously. The things that we've got in place now, they're not going to be taken away, I don't think. So, I think that's a positive thing to come out of the pandemic (Interview 42, Paramedic).	Employee support		
We've looked to expand our chaplaincy support, which we didn't have in place in any real strength previously...We've developed and put in place our own 24-h employee assistance program. We've expanded our benefits office. We've opened up a financial wellbeing offer as well, recognizing how people are being impacted from a financial perspective. (Interview 11, Board Executive)	Employee assistant programs		
My senior team leaders, I've spoken to them about if there was a particular issue, I would sit down and have a chat. We'd just go over the details about the job. Then they would support my decision making and obviously explain what's happening in the community with the GP's, with community response teams, with different pathways. (Interview 2, Paramedic)	Parking performance targets for flexibility		
Obviously there is the fear {in control room}that you're putting a crew in danger. But if you've got a cardiac arrest you were sometimes torn really at the beginning when we weren't quite sure what level of PPE was necessary. It's getting that out to the dispatchers who dispatch the ambulance and then them to let the crews know. (Interview 35, Performance Manager)	Performance criteria adjustments		
The main challenges have been increasing resources and managing resource levels. Certainly in both waves we've aimed to increase the number of staff available to deliver frontline services. In the first wave that meant the redeployment of students into paid employment opportunities. We got the skilled part of the workforce to work in the emergency service rather than the patient transport service. And we've used agency resources in the control centres. (Interview 11, board executive)	Changing targets for new resourcing mix and levels		
We haven't got a good digital platform, currently, within (Delta), so there was nothing that was a click of a button. All these models of assurance were developed at pace, in a basic way, as things changed. They were changing weekly, sometimes daily and by the hour. (Interview 23, Tactical Commander)	New workflow processes and overtime	Opportunity enhancing practices (work redesign and increased (clinical) Autonomy)	
I think the first bit I would say, and very clearly, was that nobody was ever instructed to behave differently. I think what they were doing was almost a bit of a clinical reset to do what they always wanted to do, but somehow felt inhibited. So I would say that the better hear and treat and see and treat work that we did was actually reinforcing clinicians what they always wanted to do, and felt somehow inhibited, or felt fearful of. (Interview 6, Board Executive)	Flexible workflow and professional task autonomy		
We haven't got a good digital platform, currently, within (Delta), so there was nothing that was a click of a button. All these models of assurance were developed at pace, in a basic way, as things changed. They were changing weekly, sometimes daily and by the hour. (Interview 23, Tactical Commander)	New technology processes		

new social exchange meant that the staff appreciated leadership's efforts much more than in the past, especially in this new climate of empathy and greater staff voice.

Our secondary sources also back such positive comments. The *Apollo* board papers (during and after the study period) fully endorsed this new and positive focus on staff welfare and well-being measures while acknowledging the increased focus on the visibility of senior leadership in supporting EDI work (Meeting 3, 2020; Meetings, 4–5, 2021; Meetings 11, 2023). EDI was established as a key critical management priority, and the trust won an award for its work (Meeting 12, 2023), and the well-being and resilience of staff became central to service transformation (Meeting 9, 2022, Meeting 13, 2024). It

TABLE 4 | Data structure: new reciprocity norms.

Raw quotes	First-order codes	Second-order themes	Aggregate dimension
The main challenges have been increasing resources and managing resource levels... In the first wave that meant the redeployment of students into paid employment opportunities. We got the skilled part of the workforce to work in the emergency service rather than the patient transport service. And we've used agency resources in the control centres. (Interview 11, Board Executive)	Increased resource needs	Changes in social value exchange and support mechanisms	New reciprocity norms
On a local level my immediate line manager is a paramedic, I have a really good senior paramedic team leader team locally, so they have been very accessible and really helpful with answering queries and helping out with any issues. (Interview 1, Paramedic).	Team-level leadership		
It's going to sound stupid, but treating quite a lot of people to stupid gifts just to put a smile on their face, throughout, to keep them going. It's that appreciation, isn't it? When you work in the public sector, very few people say, "Thank you." So, I actually dread to think the amount of money I've spent sending people bottles of whiskey, bottles of wine, just anything to say, "It really, really is appreciated on a personal level, the support they give me." (Interview 32, Control Room Manager)	Mutuality and respect		
I have been pleasantly surprised as to the level of knowledge and expertise, the way that they're looking at their things. The processes in place are actually quite impressive. I have to say I'm very, very surprised, really. Maybe I shouldn't be surprised, it's a £340 m-a-year business and of course it has to have those safeguards and processes. It is pretty impressive, actually. It is well prepared. (Interview 45, Board Executive)	Changed blame culture	New psychological safety net	
As an EOC {control room} manager, the biggest issue I've had, is keeping staff involved enough that they still want to come to work, that they are appreciated at what they're doing. Even though I know a lot of them have been frightened a lot of the time and have obviously had their own anxieties throughout it... And keeping them as upbeat as we possibly can, talking to them, encouraging them to talk to each other, especially after they'd dealt with seriously bad incidents. (Interview 25, Control Room Manager)	Positive and encouraged staff		
It's transformed management culture a lot, in that they're a lot less about instilling fear in staff, and they're a lot more about empowering staff, I would say. (Interview 46, Paramedic)	Increased trust		
The highest levels of anxiety we've had have been from staff who have vulnerable family members at home...Also from, from ethnic minority groups. We then undertook 100% risk assessments with our BAME staff and then we had two phases of online risk assessments that we then followed up, where underlying conditions were identified, to have face to face discussions. (Interview 11, Board Executive).	State of wellbeing	Increased focus on wellbeing	
It has been very apparent during the pandemic that the Trust have made really big efforts to try and look after front line staff's mental health, and they've provided lots of different points of access, if you feel that you need something additional. If you feel like you are stressed or you need someone to talk to, or you're worried about your mental health. (Interview 3, Paramedic)	Emotional support		
In regard to staff wellbeing and welfare, obviously, for instance, we've had packages delivered of lunches, treats etc. to keep them going which I think are morale boosters and exactly what's kept them going at the moment. (Interview 13, Performance Mgr)	Staff welfare		

(Continues)

TABLE 4 | (Continued)

Raw quotes	First-order codes	Second-order themes	Aggregate dimension
I think the most important lesson is that when we work together, we can do something. That's a key lesson. Also, the lesson is sometimes we put barriers when actually, when you're forced to, you get rid of them. It's all about working together. I think the system worked together really well. (Interview 45, Board Executive)	Collective occupational tribes	Mutuality of trust and purpose	
I think it has required the organization to respond as an organization, so it has been incredibly helpful in terms of bridging the gaps between service lines. I think the link between the patient and back-office functions has never been more tangible. So if you take procurement for example, someone sat in HQ filling out invoicing, actually what they were doing was fundamentally protecting our workforce and our patients through the work they did. (Interview 29, Strategic Commander)	Care and worker support		
Yes. I think the Trust did try to go out of their way to try to offer the crews, that were face-to-face, as much guidance as possible to help make those difficult decisions. And those guidelines were welcome, because it was a bit uncertain in the first few weeks, I would say. (Interview 3, Paramedic)	Discretionary efforts		
Also, if a member of staff would have been required to self-isolate because a family member got it, we would pay for them to stay in a hotel, if they wanted to, for seven nights, or until the incubation period had passed. So, at one time, 60 or 70 people stayed in hotels, looking after them in hotels... So things that we'd never done before that we needed to do to look after the staff, because the staff are the priority with the patients. (Interview 12, Board Exec).	Leadership apathy	Appreciation for leadership	
But I've also found that our immediate managers {Senior Paramedic Team Leaders, STPL}... They are paramedics who are still on the road, but also have clinical and admin duties as well... I have noticed that all of them have made conscious efforts to ask after you all the time really, how you're doing, how you're feeling. I have noticed that is something that has been happening on a regular basis really. (Interview 3, Paramedic)	Care and support increased		
We've become more agile. Being able to devolve decision-making more effectively, perhaps, than we would do. You've worked with the NHS for a while, you know how bureaucratic it can be. But actually, this has allowed us to be more agile in our decision-making but also keep levels of assurance in place. But also I think it's given teams confidence as well, that actually they can be innovative and work in different ways. (Interview 12, Board Executive)	Work rigidity	Increased flexibility and choices	
We introduced a whole new protocol, if you will, which is the pandemic protocol 36, which our call takers have had to come to grips with quite rapidly. We've had ECHs, emergency call handlers, who are not actually emergency medical dispatchers, but they've had to be trained up quite rapidly in regard to staff intake. (Interview 13, Control Room Manager)	New protocols		
All in all, we do feel supported and, yes, the management teams, at whatever level, have always been supportive. That's one thing I can say for Delta, we do always feel supported and included in the team. (Interview 4, Paramedic).	Co-worker and leader support		

also acknowledged the value of greater representation across different administrative wings of the organization for improving governance structures (Meeting 6, 2021). The additional spending on new vehicles and staff recruitment (Meeting, 9) along with the flexibility in the recruitment of agency staff in control rooms and patient transport employees to improve 999 emergency response capacity was both highlighted and acknowledged as good organizational practices (Meetings 4 & 6, 2021). The staff survey (2022) scores on teamwork and line management showed either better or equal scores (5.9/6.1)

TABLE 5 | Data structure—service transformation (changes to content, logic, and process).

Raw quotes	First-order codes	Second-order themes	Aggregate dimensions
("What" or the "content" of service transformation)			Service transformation (changes to the content, logic, and process)
I think one of the things that we're very clear about, because part of the workforce and wellbeing piece of work was to have a trade union cell. So, it has run from the first day, if you like, of the pandemic until now, it's still running. Everything we've done in terms of workforce; we've talked through with our trade unions. We've had some pressure points; we've had some things we don't agree with. But they've been fantastic. (Interview 12, board executive)	Improved communication	New internal and external feedback/ communication loops for effective service flow	
I probably have got closer to my team in many ways, got to know them a little better. I felt I was pretty good anyway but I felt I've probably got to know them a little bit better. (Interview 21, senior paramedic)	Increased coordination		
We all came up with different ways to help each other through your night off and stuff like that. Especially someone that had been upset during the day, if someone was having a down day were they were really missing their family and stuff the rest of us all would say, "Right, let's just surprise them tonight. We'll send them a text with a code and we'll do a Zoom party and we'll do Karaoke or something." (interview 50, EOC Supervisor)	Effective internal support systems		
I just think, for myself, if I've had a very difficult, stressful day, then I'll just book myself in for a yoga class or something like that. DELTA does that, as well, so there's a yoga class which is free, you just book that in through Zoom and you can get that every week. So, there is a lot available. (Interview 41, control room call taker)	Health and Wellbeing options	New EDI initiatives for psychological safety	
There are more wellbeing days that we're planning, where we're going to be doing team building activities together, to give us all, not a break, but something to do outside of work together, to continue the good communication that we've already got, but to make it better. (Interview 42, paramedic).	Improved relational coordination	Direct employee voice channels guardian review	
A huge amount of innovation because it was required. I think the phrase is that you don't waste a good crisis. I think we've learnt a lot that we will use once the pandemic is over. We'll use a lot of those lessons to actually become business as usual. (Interview 6, board executive)	Routine decision making	Innovative workflow and reduced bureaucracy for responsive service delivery	
But the best thing to come out of it {pandemic} I think, is the cleaning schedule. Handles, seatbelts, seats, cupboards. Everything gets wiped. Blood pressure cuffs. And that is good practice whether you're in a pandemic or not. That clinical environment is exactly what that's said. A clean and clinical environment. (Interview, 27, paramedic team leader)	Flexible work scheduling		
We've got cleaning teams at the hospital. When we arrive at the hospital they clean the ambulances for us, while we go in to hand the patient over, because there were delays leaving the hospital. We'd hand over, and hand overs were taking a long time because the hospital was very, very busy. Then, we were having to come out and decontaminate the ambulance and it was just delaying us getting to patients. Now, we've got this, (interview, 42, paramedic)	Process flexibility		
Organizationally we've always been quite risk-averse... Because we drafted in extra staff and bringing them in from private providers, students and all sorts, we started to run out of vehicles for them for A&E use. So we very quickly converted 60 PTS vehicles to have some A&E capability. Normally we'd go through business cases, a load of assessments, "Is it safe?" Risk assessments and a number of other things, and we did do those processes, but we did them much more truncated and very effective, if I'm honest. (Interview 10, board executive)	Increased risk-taking performance targets vs. innovation	Greater appetite for trailing alternative pathways and new performance targets	
Firstly, in terms of challenges for work, it's been about ensuring our people have confidence in the safe systems and work that have been put in place for them in terms of their PPE, in terms of their response and environments and clinical pathways and escalation that they've been able to do. (Interview 23, Tactical commander).	Better guidance	Innovative approaches	
I think it was easier once we had some clearer guidance about it and I think it felt less of a risk, I guess, when you are following what you are told to do rather than kind of fumbling your way through trying to work out what the best thing is to do. (Interview 1, paramedic).			
("Why"—the new rationale or "logic" of service transformation)			
There is a shift in the way that the service is responding to incidents, so that's good. I think we need to just stay focused and keep that momentum. The Trust have also done a lot of social media, radio stuff in regard to inappropriate uses of the ambulance service. They've also made them aware that if you do need an ambulance, don't sit there, and suffer in pain. (Interview 2, paramedic).	New ambulance service identity	Re-enforced cultural identity of an autonomous clinical practitioner.	

(Continues)

TABLE 5 | (Continued)

Raw quotes	First-order codes	Second-order themes	Aggregate dimensions
I think there was just a layer of emotion that came on the organization that I don't think they've experienced before... I think one of the telling moments, the day that a staff member died, I got an email from the chief operating officer from the hospital saying that he didn't die alone. And their staff gave him a guard of honor out of ICU to his resting place in hospital. That just brought a level of emotion that I'd not experienced before. (Interview 12, board executive)	Professional pride in the renewed workflow		
I think staff, generally speaking in the community, are more likely to leave a patient at home or find an alternative care pathway, whether that be mental health services or the diabetic service or a district nurse or something like that, to treat them at home safely rather than take them to hospital. That's been good. Staff have increased their confidence quite markedly in doing so because habits change and practices change. (Interview 31, paramedic team leader).	New habits to explore alternate and innovative pathways	Improved external perception by NHS partners	
I think that I'd just be more sympathetic toward patients. At that time, I didn't realize the impact and I just think being kind to each other, being helpful and understanding that everyone's in the same boat, just taking time with patients. Having a, you know, "Hi, how are you doing today?" just having that normal conversation with people, I'd just do that. (Interview 41, control room call taker)	Increased autonomy vs. control	Internal change-new desire to balance clinical autonomy to frontline staff with management control	
I'd be very clear to say that every innovation we did, every change in clinical practice was a result of the patient, not trying to stem demand. So I think all the work we've implemented, very little of it will we deescalate. I think the clinical integrity of the decisions and the transparency of the decisions always have to stand scrutiny. I think our decision-making process still stands scrutiny, even now. (Interview, 6 board executive)	Improved transparency and faster decisions		
Yes, well that's sort of helped by the clinician in the room. At the end of the day, we have a duty to the public to help them and protect them. That's what we've all signed up to do regardless of circumstances, of what's happening in the world. We've never lost sight of the fact that these people need our help, our immediate help. Considering the ambulance crews' safety and protection will never stop our insistence of helping every man, woman, and child who needs us. (Interview 36, EOC manager)	Public service ethos		
("How" or the "processes" of service transformation)			
We've put much more emphasis on to what we can do in our control rooms, because literally, our strategy has always been before the call is made, and as soon as the call is made is where the patient journey starts. So, if we can get the call handling elements right, so greater investment in call handling and skill, what it does, it means that the patients don't keep phoning back. It means we answer the phone quickly. It means we give them that assurance which means that the moment the journey starts, we get it right. (Interview 6, board executive)	Demand vs. resources		
There are a lot of tools in place to help you with any mental health problems, if you need counseling, if you need any help with... if you want to talk to anyone, whether it's personal or work-related. So, in terms of that sense, it's easy DELTA is a supportive and caring environment, (interview 41, control room call taker)	Caring environment	Resource and support pragmatism	
You know, the things that were brought in have only benefited them. We had a COVID desk which was manned by a senior paramedic 24 h a day, 7 days a week. Just having that level of clinician in the control room will have lowered some stress for the staff. Just having that sort of safety net of going, "Right, this is what it's saying here, what do I need to do?" The senior paramedic going, "Right, don't worry, you need to do this, this, and this, let me do that for you." It has brought a sense of calm. (Interview 33, EOC Performance manager)	Safety net		
I remember when our first paramedic passed away from COVID. As far as we know, he caught the COVID through a family member rather than through his work. But you couldn't help but feel that you'd let them down. You don't come to work to find yourself in that situation. Being there on the day when he was buried, or cremated, but the day of his funeral, it was a really upsetting day for us, because you question whether you could have done more to protect [people (interview 12, board executive)]	Detached leadership		
Yes. We have seen a lot more presence of managers throughout the shifts on the unsocial hours. Yes, that's good in itself because we, as clinicians, have then got a senior member of staff on shift with us that we can contact for support or decision making. That's something that's positive that's come out of this pandemic is that they're more frontline. They're there to be seen. (Interview 2, paramedic)	Increased managerial support for faster decision-making	Human-centered leadership	
Sometimes being a manager is not always about giving advice. It's about listening to people. And people aren't looking for answers. They're just looking for an ear...for a minute and listen to their concerns... (interview 27, paramedic team leader)	Active listening		

(Continues)

TABLE 5 | (Continued)

Raw quotes	First-order codes	Second-order themes	Aggregate dimensions
And just simple things like, you know, I recognize every single member's birthday when it happens. And it just takes your focus away even if it's just for a few minutes onto something nice in your life like somebody's birthday and the promise that there will be cake when you get to A&E. It's just little things, you know. Things like that. (Interview 27, paramedic team leader)			
I feel a bit more protected, so I am more confident at work in that respect. I think we've put in different procedures for vehicle cleaning, station cleaning. There has been a lot more IPC stuff which is always positive for me. I'd like to see it carried on now, regardless of the pandemic, us utilizing aprons. (Interview 2, paramedic)	Mentoring of staff	Increased mentoring of frontline staff by managers-additional resources	
I think the unions saw the importance of us being able to react quickly. They were more helpful and supportive with what we needed to do. So I think, as an organization, slow at first but overall as a team we all pulled together, and the whole organization delivered what we needed to do. It wasn't one department. It wasn't operations or it wasn't HR. (Interview 10, board executive).			

than average, and *Apollo* did much better than worst performers (5.6/5.4), respectively. On the important issue of giving voice to staff and raising concerns, the 2023 Survey showed an improved score over 2022 (6.03/5.86) and (6.16/5.96), which was also better than the sector average of 5.99 and 6.03, respectively during the same period.

5.2 | Changes to AMO-Enhancing HRM Practices

Table 3 depicts the changes to HRM and leadership practices at *Apollo*, illustrating the evidence of changes to the AMO enhancing HRM practices to bring about such changes. Analysis of interviews from different employee groups revealed changes to recruitment, selection, and reward management practices, flexibility in learning and training routines, greater adaptability toward performance targets, and task autonomy linked to work processes and technology changes. Such an account also points to softened notions of a "command-and-control" management style and a hierarchical top-down culture, which has been historically and culturally associated with ambulance services. The changed recruitment source of student paramedics and patient transport staff into mainstream 999 emergency work, including agency staff in the control rooms, as highlighted in the quotes of leaders, managers, and student paramedics in Table 2 was revealing. This marks a key departure in working for a service bound by strict training protocols and a risk-averse approach to targets and performance. It demonstrated a new flexibility in leadership thinking and HR practices for service delivery and resource flexibility, highlighting expanded leeway and choice and a new approach. Another remarkable change was a visible softening of the dominant command-and-control culture, wherein the top-down approach gave way to a more collaborative and compassionate approach to decision-making, visibly increasing cooperation and collaboration between leaders and employees:

> Management culture changed. We've historically had quite a punitive management culture in the ambulance service; it's like they're very slow to congratulate you on anything good that you do, but if there's a complaint or if something goes wrong, they're there the next morning to take you into the office start... that culture seemed to change; there was a lot less of a blame culture and more autonomy culture. (Interview 46, Paramedic).

This is equally significant in the backdrop of the archetypical depiction of service with a command and culture accompanied with a hierarchical mode of decision-making, which was seen being replaced by "care and compassion."

As the pandemic evolved, this became apparent as a focal area for the frontline managers to protect the safety of the frontline crews from contracting COVID-19. Ambulance personnel are trained to perform professionally while attending to very sick patients during their long 12-h shifts in a highly emotional, demanding, stressful, and challenging work environment. However, staff deaths from contracting COVID-19 were an unprecedented event for ambulance services, something to which *Apollo* was also not immune, having lost five staff due to COVID-19-related deaths. Hence, the safety of staff, coupled with the precarious PPE situation during the early stages of the pandemic, became an emotive issue for staff and leadership. A coroner labeled one such COVID-19 related death of a paramedic in Wales as "employment-related" (BBC 2023).

During the pandemic, there were several facets of this shift toward the safety of the frontline staff. For example, there was an urgency toward higher levels of cleanliness and hygiene, wherein the frontline staff were required to always use face masks, and respirator hoods, gloves, and aprons were also part of the new normal. Additionally, ambulances and equipment were being cleaned regularly in each shift. New preceptor screens were installed in the 999 control rooms between two seats to provide additional safety to staff. The trust ensured that the paramedic crews were accommodated in hotels to minimize the transmission of infection to families and friends. We provide below additional excerpts from the interviews with paramedics:

> I haven't seen most staff wipe a blood pressure cuff before, and they're only used for... But now the staff are learning actually it's critical whether you're in

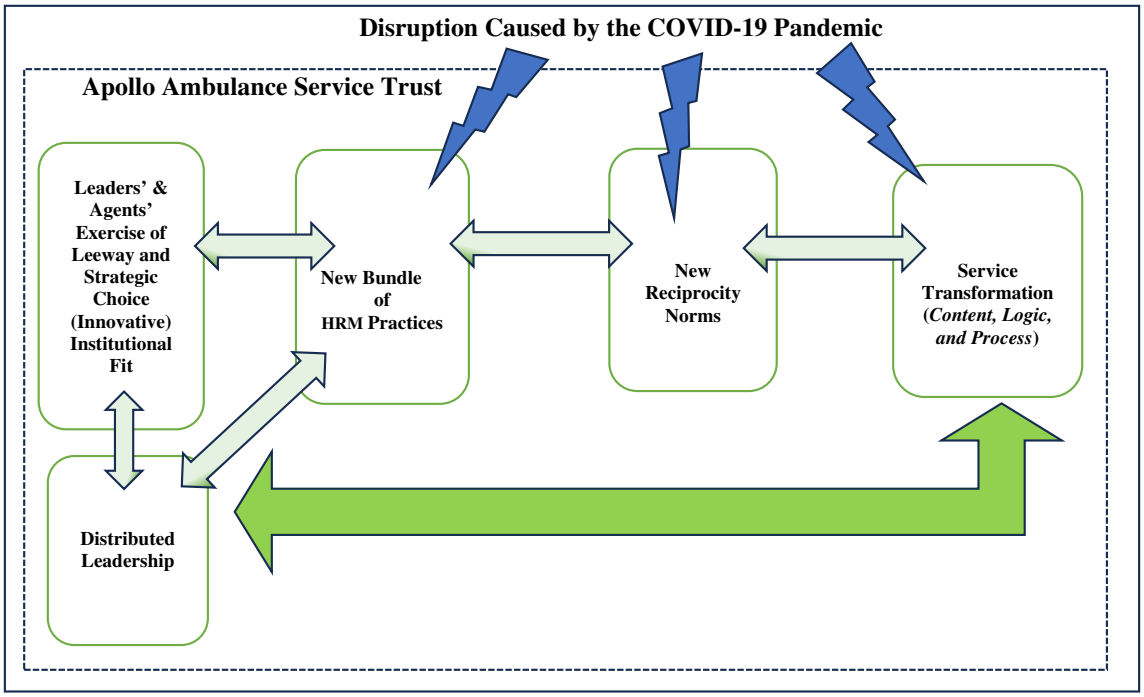

FIGURE 2 | Conceptual framework. Disruption caused by the COVID-19 pandemic. *Apollo* ambulance service trust.

> a pandemic or not that your equipment is clean. (Interview 27, paramedic team leader).

> We lost one of our paramedics to COVID, a young man with two children and a wife, who didn't really have any, sort of, medical history...I think that was the turning point for a lot of us emotionally, for, sort of, the challenges because we didn't know how we were going to be affected, or who was going to be affected and how severely. So, I think that was the biggest thing. (Interview 37, paramedic).

However, this new focus on wearing PPE and following stricter hygiene protocols frustrated staff. The nature of frustration was around (1) the new triage protocols and role conflict, (2) the familiarization with the new equipment, and (3) the difficulties and the delay in attending to the patients, as depicted in the quotes below. Examples of these frustrations are provided below.

> We've been given a lot more autonomy to make decisions around contacting doctors, who then seem to have more autonomy to say, "Don't convey [transport] that patient." Patients who are COVID positive, [or] who have become red flag sepsis, they're triggering for red flag sepsis; patients that historically we would have conveyed." (interview 46, paramedic).

> It was a lot of extra hassle working in PPE, and it still is. I did a cardiac arrest, the other day, I wear glasses, and with a visor and a mask over the top... things like you can't see where you're walking; it's stressful. You're trying to carry somebody out of a building on a scoop and you can't see where your feet are going, because your glasses are all steamed up. (Interview, 46, paramedic).

> I was attending a 22-year-old hanging with CPR in progress, and the control [room] came on and told me that this was a viable [cardiac] arrest. So, the dilemma for me, because I was on the response car [being solo], was, how do I stop in front of that house and waste, not waste exactly, but defer going into that job for two to three minutes while I get all of my PPE on? Which means a full suit, a face mask, and goggles because that is the requirement for a cardiac arrest in case you produce any air-generated procedures... In the end, I didn't put it on. I put an ordinary surgical mask on and went in. (Interview 27, paramedic team leader).

Secondary data also support evidence from our fieldwork. Flexible recruitment and selection practice to employ students or patient transport staff on frontline duties, including additional spent on new vehicles, was recorded in board papers (Meeting 4, 2021; Meeting 9, 2022); it was also recorded that the pandemic experience would help the trust to stockpile PPE regardless of the infection status of any patient as part of the regular business (Meeting 7, 2021). While the importance of command structure was lauded for effective decision-making and governance, initiatives such as launching a new Wellbeing and Culture Audit and Learning Forums for staff groups demonstrated a new thinking (Meeting 4 & 8, 2021). Equally, the realization that meeting the stringent performance targets—was challenging, and a more realistic approach was needed, signaled a new approach Meeting 5, 2021). The Staff Survey also reflected a similar set of positive changes (Staff Survey 2022). *Apollo* recorded better or equal scores for compassionate culture, compassionate leadership, and autonomy and control

TABLE 6 | Summary of the nature and extent of changed HRM practices.

Existing guiding principles (pre-Covid)	Existing HRM practices	New guiding principles	New HRM practices	Nature and processes explaining social exchange in the implementation of new HRM practices
Recruitment and selection	Highly regulated, experience and qualification-based hiring	Flexibility in allowing low experience/qualification student paramedics and patient transport staff. The use of third-party agency staff increased	Increase in Non-standard employment Agile and Flexible scheduling and criteria	Increased employee voice, interpersonal trust, and empowerment
Training and development	Regulatory compliance framework of training and development	Agile L&D: Need-based and emergent response to new learning demands.	Responsive and adaptive learning and development Technology-based learning vs. traditional face-to-face	Open communication, interpersonal trust, risk-taking and empowerment
Reward and remuneration	Fixed and awards-based remuneration. There is no evidence of rewards and work-recognition	Variability through an increased menu of intrinsic and extrinsic rewards and recognition programs	A combination of intrinsic and extrinsic rewards premised on variability	Interpersonal trust, appreciation of value exchange for both
Mental health/ wellbeing & EDI	Highly stressed and strained workflow characterized by strikes, job dissatisfaction, high turnover, and adversarial relations between managers and unions	Allowing people flexible time-offs through a flexible roster system to offset work-related stressors. Greater acknowledgment and resolution of well-being and EDI issues	A well-developed set of mental health and well-being initiatives was developed to address employees' emotional, physical, and psychosocial needs. EDI program was firmly established as a key organizational priority	Open communication, willingness to act and support provide an increased employee voice, and interpersonal trust
Work design	High level of control and restrictions on workflow based on risk-averseness	Higher levels of trust mutual reciprocity, and clinical autonomy to better manage workflow	Flexibility in workflow scheduling and an expanded leeway in the scope of service delivery protocols (e.g., greater time spent on attending to the patients).	Empowerment, distributed leadership, inter-personal trust, voice and lowering of risk averseness
Performance management	The primacy of response-time targets (e.g., 8-min rule)	Deferring/parking of performance indicators, including relaxations to time response targets	Punitive approaches to the non-achievement of KPIs were replaced by a greater appreciation of efforts expended on ground realities. Employee wellbeing and safety became a central focal point.	Open communication, empowerment, distributed leadership, and inter-personal trust

and did much better than the worst performers. The 2023 Survey improved from 2022 (6.93/6.73), scoring better than the sector average (6.90). The 2023 Survey also showed improved scores on twin issues of staff appraisals and staff engagement, showing an improved score on all the dimensions of these categories from the previous year, with better than average sector scores (staff appraisals) and those of the worst performers (engagement).

5.3 | New Deal and Mutuality of Social Exchange

Table 4 shows a new deal and the mutuality of social exchange, emphasizing a new social order based on mutual trust and respect between senior leaders and employees. Staff well-being was firmly established as a critical management and organizational priority. It also reveals increased reciprocity from

managers and frontline staff, demonstrating greater teamwork approaches, improved relationships within and between different employee groups, and visible appreciation for leadership. The value of social exchange was thus established in moving away from a climate of a "blame culture" to one offering a new psychological safety net:

> I think, above everything, It's really aided relationships...Historically, there may have been stone-throwing between organizations but now people have really found that why and that shared purpose of what it is they're there to do and have been able to remove some of that historical stone throwing, just literally, away and put it to bed for now and focus on what people are here to do. (Interview 23, Tactical Commander 23).

Two concepts emanate from these findings. The new psychological safety net experienced by frontline staff in the performance of their roles, especially the frontline clinicians, is unique in a service that has historically been performance managed through centrally driven targets and highly operational when non-performance against key targets would typically risk losing creditability, lead to adverse media coverage or even loss of jobs of senior leaders. Secondly, the tendency for the "blame culture" was increasingly replaced with this new mutuality of trust and purpose, as reflected in the quotes of managers and senior leaders (see interview 45, interview 29).

Findings from our empirical data also resonate with secondary data sources. The board papers recorded how the culture audit resulted in new work undertaken around leadership and culture for inclusion in the new values framework (Meeting 4, 2021). Similarly, the value of increased leader visibility and greater staff representation across *Apollo* was noted and applauded (Meeting 1, 2020). Renewed commitment to a patient-centered culture of openness and transparency with staff reflected a positive shift toward a more compassionate and distributed leadership (Meeting 13, 2024). It was also noted how using patient transport staff during the pandemic led to the development of an internal pre-apprenticeship program for them (Meeting 4, 2021). The creation of a new training package to deal with mental health cases and issues during the induction of frontline crews was also recorded (Meeting 12, 2023). Staff survey (2022) also recorded such a positive trajectory. Regarding the opportunity to work remotely/from home, *Apollo* scored 6.1, which was higher than the average score of 6.0 and way higher than the worst performers (5.1). Regarding compassionate leadership, the 2023 survey showed an improved score on all four dimensions from the previous year and recorded better scores than the worst performers.

5.4 | Service Transformation

Table 5 depicts the dimensions of service transformation with *Apollo*. It provides specific instances of changes to its *content, process*, and overall *logic*, leading to a new understanding of an autonomous clinical ambulance practitioner's "identity" at an individual level. This positively impacted its internal and more comprehensive external NHS partners. Importantly, it gave rise to a more innovative and less rule-bound approach, enabling workflow decision-making. It also led to a new resource pragmatism, better line management support, and a more human-centric leadership approach. The EDI agenda became embedded into organizational practice on a more permanent basis to support staff well-being:

> We didn't have a [Black, Asian and Minority Ethnic] BAME network in place, but we had a race equality forum, that was organized by my team. We started to have very regular meetings of that, which were open to all of our BAME staff. We also ensured that we had quite a lot of executive input to those. So, at different points the board joined those groups... Actually, the process enabled us to develop that group now into a network. (Interview 11, board executive).

We want to emphasize the three aspects of such transformation. Firstly, the *content* of such transformation was evidenced in establishing staff well-being as a critical management objective, and the value of EDI was finally acknowledged. This is significant in the backdrop of a "macho culture" with a "just-get-on and do-it" attitude. Most of our interviewees spoke positively about this perceptible change and how, for the first time, welfare and wellbeing issues were not being brushed under the carpet or seen as just an HR issue. The second example was the new communication approach, moving from an impersonal, information-heavy email-based system to a more interactive approach using technology, social media channels, and internal bulletins to engage with staff and seek feedback and concerns. This helped in two ways. Firstly, it made the message more personal, genuine (and humane). Secondly, the message could reach more staff spread geographically in a large catchment area. Interview 50 captures this issue quite well and how technology could be used to organize a "Zoom party" if a staff member felt lonely or needed support. Again, this was a fundamental change not witnessed before in the service.

The *logic* of the transformation is best illustrated in the quote of the board executive (Interview 12) about the new respect and recognition for the ambulance service from external NHS partners since, historically, the service has found itself on the periphery of decision-making within the health economy. The essence of the service transformation process is captured in the quotes highlighting human-centered leadership, a marked departure from the traditional rank and hierarchy-based decision-making styles. We noted several examples of service practice changes, such as the establishment of green rooms, 24/7 helplines, and internal forums available for staff should they need help. Some other quotes (interviews 27, 2, 10) also reaffirm this fresh commitment toward staff mentoring and this new collective sense of purpose and belonging.

Our fieldwork evidence is also supported in the secondary data. Board papers recorded how *a trust-wide* approach guided *Apollo's* response. Such a flexible approach allowed the trust to function properly, such as dispensing with non-essential travel

and face-to-face contacts (Meetings 2 & 3, 2020). The establishment of a new workforce group in relation to the issue of resources is also recorded (Meeting 5, 2021). The papers also mentioned the innovative use of social media channels (including records) to engage with staff, including the establishment of an EDI assurance group in the drive to improve communication with staff (Meeting 3, 2020; Meeting 5, 2021; Meeting 10, 2022). Specific measures for raising concerns (such as Freedom to Speak up Guardian), including a commitment to share concerns via bulletins and newsletters, were explicitly covered too (Meeting 3, 2020; Meeting 4, 2021; Meeting 8, 2021; Meeting 9, 2022). The staff survey (2022) scores on staff engagement (motivation and involvement) and staff morale turnover intentions and work pressure again showed either better or almost equal scores (6.3/5.4) than average (6.2/5.5) and much better than the worst performers (5.9/4.9). The 2023 Survey on the issue of EDI showed an improvement from 2022 in five categories of thematic areas and was better than both the sector average and the worst performers.

6 | Discussion

We provide below insights into the SET black box (Cropanzano and Mitchell 2005) during a crisis by: (1) identifying the primacy of multilevel interactions and social value exchange that must occur between actors at different power and hierarchical levels, which in our case (*Apollo*) included the following: senior leadership (Board executives and Non-executives), managers (corporate and operational) and frontline staff (paramedics, frontline crews and emergency control room staff), (2) outlining the nature and process of interactions (changes to the approach to communication, which was based on principles of open communication, willingness to provide an increased employee voice, increased trust between senior leadership, managers and frontline staff, distributed leadership approach, and empowerment (see details for example, in Tables 2, 4 and Appendix B) between the key actors, and 3) which led to addressing the value exchange (changes that were of value and importance to each of these levels of social actors) to enable the norm of reciprocity between these actors (see for example, details regarding value exchange and reciprocity in Table 4). Doing so allows us to specify the conditions, processes, and outcomes of social exchange.

In our conceptual framework (see Figure 2), we depict the dynamic interactions between the three social actors (i.e., senior leadership (Board Executives), managers (corporate and operational) and frontline staff) at *Apollo* and how through iterative interactions these senior leaders and managers offered their consent, approval, and support to the frontline staff to embed the new bundle of HRM practices and reciprocity norms leading to the new content, processes and logics of service transformation. *Apollo*. The above allowed the frontline staff to exercise their agentic resources, thus establishing the norms of reciprocity between the three social actors in *Apollo*'s system. Consequently, *Apollo* quickly adapted to the dynamic, complex and emerging environmental disruptions and made concomitant changes to the HRM and service delivery practices. Specifically, we note that these interactions and negotiations unfolded as a process of social exchange between frontline staff, managers and *Apollo*'s leaders. We further found evidence of relaxation of leaders' command-and-control style to accommodate a more distributive and collaborative processual leadership style (Bolden 2011).

To bring to this social process of exchange between these actors to life, we provide a few illustrations from our data. As *Apollo* was struggling with systemic structural and processual rigidity in the face of a crisis, an alternate social exchange was deemed necessary by the key actors in the system. Among several examples identified in Tables 2–4, we found, for instance, in the case of employees' wellbeing and mental health, which took a major hit, almost bordering on moral injury, the need for a new value exchange to be implemented swiftly was imminent. The key social actors (frontline staff, managers and senior leaders) iteratively discussed the problems through the opening of the communication channels, and then showed an active commitment to engage with frontline staff and managers with the aim to effectively resolve for sustained levels of service delivery by catering to both the employee and *Apollo*'s needs (see interviews 3, 12 and 13 in Table 4). The frontline staff viewed this commitment and openness to listen and change as a positive shift in the senior leaders' and managers' thinking, which cemented the social value exchange to take place. The above examples (as identified in the Tables above) are in sharp contrast with the prevailing (before crisis/pandemic) social exchange that existed at *Apollo*. For instance, the extant social exchange at the time typified culture and practices such as low trust between rank and file, and command-and-control based interactions between the three actors, guided by rank and seniority (McCann 2022). Such interactions were often transactional in nature with little to no leeway and choice for frontline staff and managers. This was evidenced in their prevailing menu of HRM and service delivery practices, wherein there was no flexibility in recruitment, rigid appraisal systems, fear of reprisal, and very stringent service delivery protocols (see Table 6 and Appendix B for details).

The social exchange between these social actors enabled the development of a new and renegotiated set of AMO-enhancing HRM practices (Appelbaum et al. 2000; Blumberg and Pringle 1982), thus marking a transition from a pre-determined national framework of HRM practices to a new one. This view is consistent with the neo-institutional theoretical lenses of HRM practices, noting how senior leaders and managers help navigate and influence change during environmental turbulences and constraints (Boon et al. 2009; Malik and Sanders 2021) to deliver wellbeing (Voorhees et al. 2020). In doing so, our study helps unpack the black box of SET (Cropanzano et al. 2017), especially in times of and in response to a crisis. The social exchange process was enabled through the norms of reciprocity and mutuality of trust between the leaders and frontline staff, which were iteratively explored and recommended to senior leaders by frontline staff who were at the coalface of these challenges. Often, the discussion involved leaving the rank at the door and parking the KPIs and frameworks for managing people to deal with the disruptive force.

Apollo made concomitant changes to several new and renegotiated bundles of HRM practices (see Table 3 for data structure). For example, not only did the practices change, but the guiding principles and underpinning rationale for some of these practices were also changed (See Table 6 for a summary of these

changes). For example, the data structure (Table 3) provides interviewee excerpts of specific changes in HRM practices: (1) the hiring and recruitment practices, as evidenced through the use of non-conventional resources (e.g., students, PTS, agency workers, volunteers, and the Army), (2) the training and development menu was also enhanced by adding new modules on wellbeing, EDI, and an updated version of Triage Protocol (36), which allowed frontline ambulance workers to override existing systems response with specific pandemic-related prioritization, (3) changes were also made to work design (flexible and remote working), and increased nature and extent of communication channels (e.g., social media platform such as Facebook was very actively used, recorded staff interviews, staff zoom celebrations and other new technology platforms), and (4) employees were also given a new combination of intrinsic (recognition from other ambulance partners and leaders, guard of honor) and extrinsic (paid overtime, paid hotel accommodation, and meals) rewards, and finally, several changes were made to the wellbeing and resilience of employees at the frontline (e.g., improved psychological safety net helped create a culture compassion and mutual appreciation, employee support groups, establishment of green rooms and 24/7 helplines for mental health issues).

The effectiveness of the above changes can partly be explained by the mutuality of trust and acceptance of ideas from the coalface by the senior leadership, which created an openness and a sense of pragmatism in dealing with employee wellbeing and service delivery issues. Our prolonged engagement in the field during the COVID-19 pandemic, coupled with secondary evidence (both during and beyond the study period), revealed that some of the adaptive responses to the changes to HRM and leadership practices were a result of social value exchange between the leaders and frontline staff to create an innovative institutional fit (Boon et al. 2009; Malik and Sanders 2021), as a status quo or a conformist fit was not a viable option. Collectively, iterative negotiations and discussions between the frontline staff and senior leaders led to exploring new routines and options that were not part of the pre-determined national framework of HRM practices and emergency service protocols.

A trusting and distributed leadership enabled a social exchange that offered some relaxation of the existing norms and protocols (Bolden 2011; Blau 1964). Our evidence confirms that frontline staff felt their leaders were listening to them and allowed them to exercise some leeway and choice by relaxing existing norms and policies, such as putting formal processes and performance metrics on hold. This triggered a norm of reciprocity among the frontline ambulance workers who were closest to the coalface and cognizant of the limitations of the existing rigid HR and service delivery framework. The distributed leadership approach and trust allowed for changes to the HRM practices from a highly prescriptive and regulated HR policy framework of practices to a more accommodative, flexible, and adaptive approach. As noted in Table 6, several changes were made to the renegotiated bundle of HRM practices. These changes reflected new initiatives and practices surrounding employee wellbeing, equity, diversity, and inclusion to give a much-needed respite in emotionally draining times and are supported by recent evidence (Heath et al. 2024; Lawn et al. 2020; Santarone et al. 2020).

The mutuality of trust and distributed leadership approach meant a meaningful and pragmatic service transformation of the ambulance workers' routines and identity. The positive shift in perception about the paramedics' identity as autonomous clinical practitioners, both within *Apollo* and from the wider NHS partners, is quite significant. The role of a paramedic has historically been associated and often portrayed in media and documentaries with one that has a fast response, stabilization, and transfer of patients to hospital Eds, or the so-called "scoop and run" model. Over the last decade, ambulance services have been undergoing a journey of transformation, underpinned by university-badged degree programs and accompanied by greater clinical knowledge and skill sets of paramedics to provide care at the scene to minimize conveyance to hospitals. These shifts have been characterized by an ongoing process of professionalization, role expansion, the ability for independent prescribing, and increased recognition within the healthcare system (Eastwood et al. 2023; Johnston and Acker 2016). For instance, the paramedic profession is now expanding into other clinical settings, such as primary care, end-of-life care, neonatal care, and other clinical roles (Eaton 2023; Reed et al. 2019). The shift in the identity of paramedics was also accompanied by an expanded empowerment in their professional roles.

This significant shift in the nature and extent of the identity was also evident among the paramedics at *Apollo*. For instance, frontline crews took much pride in describing several instances wherein their decision-making on a particular call was supported and respected by the management (Table 3, interview 6; Table 5, interview 31) or wherein they deviated from the guidance to do more for the patient (Table 4 interviews 45). Similarly, there was further acknowledgment (and respect) from external NHS partners about the multifaceted identity of ambulance workers, highlighting their critical role in modern healthcare in such a challenging environment (Table 5, interview 12).

Overall, there was evidence of service transformation in *Apollo*'s service delivery models' content, process, and underlying logic (Kandampully et al. 2021; Ostrom et al. 2021; Voorhees et al. 2020). The environmental disruption and the social exchange between frontline staff and leaders enabled the exploration of new areas (i.e., the *content* of service transformation) that needed change to the internal and external activities and to the processes (i.e., the *process* of service transformation) underpinning these activities (Kandampully et al. 2021; Voorhees et al. 2020). Finally, these changes were driven by an underpinning rationale (i.e., the *logic* of service transformation) that required a significant departure from the prescriptive and institutionalized routines to a transformative service delivery model and a change in the approach, form, and practice. The impact distributed leadership had in this process cannot be undermined as it changed the culture within the ambulance services and is a departure from the extant accounts of heroic leadership styles (Bolden 2011; Grint 2022; Voorhees et al. 2020).

7 | Implications and Limitations

The paper raises several implications for theory and practice, as outlined below.

7.1 | Implications for Theory

First, from a theoretical perspective, we highlight how changes implemented by frontline staff and leaders led to a new and renegotiated set of HRM practices to unpack aspects of the heuristic (content, process, and logic) of service transformation through leaders' and agents' capabilities and choices. A direct consequence of this was improvements not only in an adaptive HRM model but also in the mental health and well-being of ambulance workers, something which has been highlighted recently by HRM scholars (De Cieri and Lazarova 2021) and service transformation (Voorhees et al. 2020). Second, the study challenges the argument that leadership in times of crisis is best delivered through a directive style coupled with a command-and-control approach (Grint 2005). Instead, we found significant support for distributed leadership, which encompasses shared, adaptive, compassionate elements in leading (Grint 2023), for effectively leveraging the agentic resources of frontline staff and leaders to change service delivery protocols. Third, using agentic resources and mutuality of purpose demonstrates a balanced and negotiated approach to individual and collective goals. Finally, the exceptional performance of ambulance services, going against all odds, also departs from the reactive and work-to-protocol norms, as noted in the literature (Wankhade et al. 2020; McCann 2022).

7.2 | Implications for Practice and Policy

In terms of the implications for practice, first, the findings are a valuable resource for other emergency services (such as police and fire services) and other healthcare organizations operating in similarly routinized, high-stress, and dynamic work environments as it shows the mechanisms and interventions that lead to service transformation in such highly institutionalized environments in times of crises. Our study points to the critical role of agentic resources at the frontline staff and leadership level, which shaped the emergence of a distributed style of leadership and a renegotiated bundle of AMO-enhancing HRM practices.

Second, it provides a much-needed understanding of the HRM dynamics that can enable successful change and transformation even during a crisis. More specifically, by investing in a new and renegotiated bundle of AMO-enhancing HRM practices. For example, for ability-enhancing HRM practices, *Apollo* invested in allowing autonomy and flexibility in hiring, training, and development, which focused now more on new induction training packages, encompassing themes of employee mental health, wellbeing, EDI, and resilience-building competencies. Additionally, to drive the motivation of staff, the leadership showed a compassionate approach, and in doing so, they acknowledged and recognized the efforts of their frontline staff using a more personalized and humanized manner (which was missing earlier), showing more significant concern and signaling an openness toward employees. For enhancing the opportunity to contribute for frontline staff allowed an increased level of problem-solving and decision-making, which effectively reduced the blame culture and a punitive environment as employees started to take greater ownership of their tasks and clinical decision-making.

Third, it offers better insights into employees' experiences amidst existential challenges and paves the way for improved HR practices and better stakeholder responses toward organizational objectives. This was enabled first by the creation of a trusting environment and allowing greater levels of involvement and participation in the decision-making by frontline staff. These changes were evident at *Apollo* in their follow-up staff and employee voice surveys as well as through the publicly available board meeting papers, evidence of which is noted in the findings, discussion and the data structure tables.

Fifth, policymakers can also learn about the value of flexibility in centrally directed performance objectives and for placing greater confidence in organizational leaders on the frontline, especially in times of crisis, where a more adaptive and distributed leadership approach is much needed. Finally, another key policy implication that arises from this study, in such a service context, is that leaders feel unsupported on the issue of balancing risk with complying with the norm. Therefore, embracing the duality of adhering to regulations and yet responding with openness and agility to change without fear of retribution is vital for effective service delivery in the context of similar complex public sector services. As argued in our study, the need for substantive cultural reform also aligns with the recommendations of a recent independent policy review (NHS England 2024).

7.3 | Limitations

Despite the merits of the findings generated using a robust single case study design, this study is not free from its limitations. First, a single case study in-depth design does not offer generalization to the broader population like ex-post facto designs do. Second, the findings of this study are contextually and temporally bound and may differ in times of stable conditions with established routines or for a very specific crisis. Third, although the evidence from *Apollos's* new policy documents and our interactions with this organization suggests that these changes have had an impact on and are embedded in the new ambulatory service delivery protocols and HRM practices. Finally, another limitation of this study was our inability to track these changes on a longitudinal and ongoing basis.

8 | Conclusions

Our paper contributes to the literature on service transformation, social exchange theory, and HRM practices and develops a conceptual framework that captures the interactions between structure, process, and agency to bring about change in times of crisis. Our study also provides empirical evidence supported by primary (interviews) and secondary (documents, board minutes, and staff surveys) data to capture how leaders and frontline staff exercised their agentic resources to create a better and innovative institutional fit (Boon et al. 2009; Lewis et al. 2019). The resultant changes to a new model of HRM practices and service delivery protocols were also enabled through a distributed leadership approach that created trusting relationships within *Apollo*, which enabled a more accommodative, flexible, and adaptive approach (Paauwe and

Boselie 2003). We further expand the propositions in Collings et al. (2021) by highlighting how disruptive events can influence employee behaviors and actions through adaptive leadership and HRM practices.

Ethics Statement

Ethical approval was obtained through the NHS Integrated Research Application System (IRAS), which is a central system for applying for the permissions and approvals for all health and social care and community care research in the UK.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Appendix A

Project Title: An Exploration of the Impact of the COVID-19 Pandemic on Individual and Organizational Performance in an NHS Ambulance Service in England

Semi-Structured Interview Protocol-v2.

Data Collection Period: October 2020 to May 2021

1. What is your role within the organization? How effectively are you able to perform during this period?
2. As senior leaders and managers, do you think the pandemic has brought any new management and governance challenges to your work and responsibilities?
3. How did your current leadership and managerial style and the organization's current people and culture practices change during this period? Has there been any change in the exercise of managerial and leadership choices in this context? Please give practice-level examples. *[Researcher to explore HRM practices individually and holistically]*
4. What has been the impact of social interactions between individuals and groups on issues of cooperation, effectiveness, and performance at different levels in the organization?
5. Have there been significant changes in service delivery or to aspects of work design and the measurement of the ambulance service performance targets during the peak of the pandemic and more recently?
6. In what ways do you think that the pandemic has impacted the health and well-being of ambulance service employees? What were the nature and extent of effects, and how did this present in terms of their emotions on display? Finally, how is this being dealtwith?
7. How are the staff coping with the stress associated with the pandemic and what support (and resources) is available or provided by the organization?
8. How challenging is it for ambulance trust leadership to protect staff and deliver a safe service delivery during this period?
9. Is the organization offering and are employees experiencing a compassionate and caring environment, including any line manager support and mentoring?
10. Are you witnessing any changes in the social and relational aspects of work, such as the mutuality of trust and respect between frontline staff, managers, and senior leadership? [The researcher to explore with the interviewees evidence of any notable differences and changes against the historical background of command & control culture].
11. Have any changes been made to services, such as in the triage systems (for 999 calls) used in the control room? [Researcher to explore what these changes are and what are the effects of these changes on different groups, such as frontline staff and managers, patient care & safety, staff attitudes, and service efficiency]
12. Are there any noticeable changes in communication, protocols, practices, and processes to engage within the organization?
13. What are the most notable changes to service delivery for frontline staff and managers? How are these implemented or embedded in the changed environment, and how did the frontline staff and managers experience it?
14. Have you witnessed any change(s) in the perception of other NHS partners? Was it positive?

Appendix B

Evidence From Secondary Data Between 2021 and 2024

Board meeting minutes	Nature of changes	Commentary and implications for service transformation
Meeting 1	Changes to recruitment practice and principles Social exchange leading to staff empowerment	Consequential change to internal procedures and policies Process and logic were changed to achieve service transformation
Meeting 2	Additional spent on new vehicles and more staff A new partnership approach to provide a safe and supportive environment	Helped to ease performance pressure on staff The well-being and resilience of staff became central to the Trust's service transformation.
Meeting 3	Renewed focus on quality social exchange with staff New communication strategy to engage with frontline staff	Increased staff satisfaction levels to 90% Improved relational coordination between leaders and frontline staff
Meeting 4	A renewed focus on EDI issues within other emergency services Employee voice channels established through "Speak up" guardian	Commitment to EDI was firmly established at the board level, and the process and logic were changed to achieve service transformation using EDI principles in guiding recruitment, training, and development of staff. Improved service and relational contracts between staff bodies and the HR department
Meeting 5	Mental health training as part of staff induction	A new training package was created with a mental health focus to help minimize psychosocial safety breaches.
Meeting 6	Renewed commitment to a patient-centered culture underpinned by openness and transparency of staff	A more compassionate approach to service informed by distributed leadership