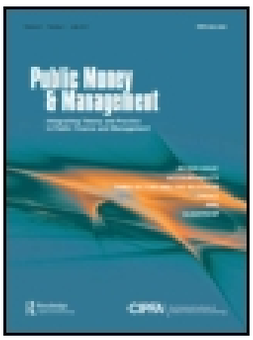

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A tale of two trusts: case study analysis of bullying and negative behaviours in the UK ambulance service

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IMPACT

The authors outline common problems in implementing the Health and Safety at Work Act 1974, which places specific requirements on UK employers to mitigate risks of stress at work. The authors discuss bullying and other negative acts in the UK ambulance service, highlighting concerns with some managerial practices. The article calls for a fundamental rethink of deficiencies in current organizational wellbeing measures and recommends ways of going beyond the provision of basic support for employees.

ABSTRACT

This article analyses the risk to workplace experiences for staff in the UK ambulance service. Adopting a case study methodology following interviews with front-line and management employees, the authors investigated two UK NHS ambulance trusts, Blue Light ($N = 1100$) and Green Cross ($N = 2093$) and found that efficiency targets—whether time or 'dashboard', increased job demands and reduced resources create a double-whammy effect of heightened claims of bullying and harassment, alongside diminished staff resilience and wellbeing.

KEYWORDS

Ambulance; bullying; case study analyses; emergency care; NHS; resilience

Introduction

Demand for the ambulance service's unique provision of emergency care for life-threatening situations, urgent care for critical but less serious injuries, as well as non-urgent and out-of-hours services, was on the rise before the Covid-19 pandemic (Wankhade, 2018; National Audit Office, 2017, p. 12). Several of the causes behind this growth in demand are clear and include an ageing population, proliferation in health conditions and substance misuse, funding challenges and resource limitations (National Audit Office, 2017, pp. 7–14). The insecurity and heightened scope for exploitation of workers in atypical and non-standard employment (Ba', 2020; Manolchev et al., 2018; Kalleberg, 2016), and as part of the neoliberal labour market context in the UK since the 1980s, has also been the subject of a growing number of studies, utilizing a labour process theory lens (Ng et al., 2019; Beale & Hoel, 2011). Response time targets set by successive governments have also been a major contributory factor detrimentally affecting ambulance services performance, while the subsequent introduction of 'dashboard' targets and annual 'quality accounts' has had a 'contradictory' effect (Heath & Wankhade, 2014).

Against such a stark terrain, ambulance staff navigate occupational status issues, historical low pay, demanding working conditions, limited progression opportunities and autonomy (McCann et al., 2013). Low staffing levels have also negatively affected the workplace experience for staff—leading to high levels of sickness absences which, at 4.51%, are the fourth highest for all NHS staff groups (NHS Digital February Report, 2019). Furthermore, 88% of emergency services employees are likely to experience stress and mental health issues, which is greater than any other occupational group (Mind, 2019, p. 6). High levels of suicide ideation and suicide attempts have also been reported in ambulance personnel—caused by emotional exhaustion, depleted resources and bullying at work (Sterud et al., 2008). These collectively have the potential to contribute to deteriorating quality of care provision (Nuffield Trust, 2017) and might suggest that organizations are struggling to implement the Health and Safety at Work Act 1974, which specifically places requirements on UK employers to mitigate risks of stress at work.

Although a concern in themselves, the drivers of stress and sickness absence also railroad a complex range of workplace behaviours, such as incivility and conflicts of varied severity. Frequently labelled 'bullying' and 'harassment', these encompass shouting and swearing, intimidation and threats, as well as lesser incivilities such as gossiping and rumour spreading (Einarsen & Nielsen, 2015). In turn, the topic of bullying and harassment commands a well-established body of literature across the UK and Australia (Kline & Lewis, 2018; Farr-Wharton et al., 2017), Europe (Einarsen et al., 2018; Høgh et al., 2011) and the USA (Lutgen-Sandvik et al., 2007; Namie & Namie, 2009). Yet, regardless of the types of behaviours enacted, several common outcomes can be detected, including reduced employee commitment, enhanced employee turnover, difficulties in recruitment, increased sickness absence and, in the case of the NHS, endangered patient safety (Kline & Lewis, 2018).

This is not surprising, given the link between the conditions of the working environment and resultant impact on overall employee wellbeing (Demerouti et al., 2001). This is recognized in such heuristic frameworks as the job demand–resources (JD-R) model (Schaufeli & Taris, 2014), extending Karasek's (1979) job demands–control

model and the effort–reward imbalance approaches of Siegrist (1996). Nevertheless, its study in the context of UK ambulance services has been limited and the above considerations highlight the need to study resilience and wellbeing issues in the ambulance services. Taking a case study approach (Stake, 1995; Thomas, 2014), we consider the challenges and experiences of employees in two NHS ambulance trusts: Blue Light ($N = 1100$) and Green Cross ($N = 2093$). We provide an overview of extant literature on bullying and harassment and the impact of job resources-demand tensions on staff wellbeing (Karasek, 1979; Schaufeli & Bakker, 2004). We discuss challenges and issues reported by employees at Blue Light and Green Cross and conclude with recommendations for managers and HR practitioners.

Background

Workplace bullying is a contemporary workplace issue that affects organizations of all sizes across all continents with multiple causes at individual, group and organizational level (Einarsen et al., 2003; Nielsen et al., 2016). Bullying is a complex phenomenon underpinned by prolonged exposure to systematic negative behaviours (Beale & Hoel, 2010) with the typical timeframe being several months or longer (Einarsen et al., 2018; Lewis et al., 2011). Bullying is usually enacted in situations of power inequality where the 'victim' is unable to protect and defend themselves from a suite of negative behaviours (Salin, 2008; Ågotnes et al., 2018), ranging from verbal or physical negative acts of unreasonable treatment (Lewis et al., 2017; Nielsen et al., 2016) which are likely to escalate and worsen over time (Blomberg & Rosander, 2019; Einarsen et al., 2003).

Since the 1980s, the UK labour market has offered little opportunity for alleviating the plight of workers in atypical and non-standard jobs (Manolchev et al., 2018; Vosko, 2010), such as those in the emergency service sector. As recognized by labor process theory scholars, worker exploitation is an inherent characteristic of neoliberal employment contexts (Beale & Hoel, 2011; Braverman, 1998). This is caused not only by the well-explored antagonism between the owners of capital and the commodified workers selling their labour power (Braverman, 1998; Burawoy, 2012 [1979]) but also by management's regulation of workers (Manolchev, 2020; Alvesson & Willmott, 2002). The negative consequences of bullying have been well documented and range from stress, anxiety and a general loss of wellbeing (Lewis, 2006; Vartia, 2001; Einarsen et al., 2018). In addition to the personal trauma which, on occasion, can bring about the symptoms of post-traumatic stress disorder (Matthiesen & Einarsen, 2004) and depression (Niedhammer et al., 2006), as well as suicide ideation and suicide attempts (Sterud et al., 2008), there is a wider organizational cost (Islamoska et al., 2018). This is particularly prominent in the health and social care sector in the UK, which is one of the main industry sectors for inappropriate behaviours at work (Fevre et al., 2012; Kline & Lewis, 2018). Recognizing growing pressure on ambulance trusts to meet response time targets (Wankhade, 2018), the stark reality of only one ambulance service in the UK meeting call targets since 2013 (National Audit Office, 2017, p. 9) and limited improvements achieved by subsequent, dashboard measures (Heath & Wankhade, 2014), it is clear that negative behaviours pose a direct risk to employees, operational services and patient safety (Kline & Lewis, 2018).

Nevertheless, bullying behaviours do not occur in isolation and can be enabled, even amplified by the organizational context (Ågotnes et al., 2018). In this sense organizational change, hierarchy, destructive leadership styles, lack of autonomy, insufficient resources, ineffective and non-existent management/colleague support are all potential contributory factors for ill-treatment (Baillien et al., 2011; Fevre et al., 2012). In line with established research (Einarsen & Hoel, 2008; Jenkins et al., 2012), managers/supervisors are often cited as the originators of the behaviours many employees label as 'bullying' (Fevre et al., 2012). Evidence also shows that effective leadership and management, along with a spectrum of employee support, buffers bullying while their absence exacerbates it (Lewis et al., 2017). Thus, despite a dearth of studies on bullying in an ambulance services context, ambulance personnel continue to report higher rates of bullying compared to other NHS workers (NHS Staff Survey, 2018 and 2019). Yet, when ambulance service staff are studied, links to bullying are often tangential, see, for example, Sterud et al. (2008) who indicated that job-related factors like emotional exhaustion and bullying may be important contributors to suicide ideation. Alternatively, short reports by bodies such as NHS Employers have used case studies of other UK ambulance services, for example the London Ambulance Service (NHS Employers, 2017), to indicate evidence of perceived good practices.

The revised job-demands resources model (JD-R) (Schaufeli & Bakker, 2004) provides a practical framework for the study of negative behaviours in an organizational context and builds on Karasek's (1979) original framework which placed individual working experience at the cross-section of job demands and job control. Consequently, the JD-R model starts with the necessary balance between the availability of resources to successfully meet the all the demands of a given job, without specifically discussing resources available (Schaufeli & Taris, 2014, pp. 43–44). Although this endows JD-R with a practical flexibility appealing to researchers and practitioners alike, it presents a challenge to operationalization since there is no set JD-R model but, rather, varieties and adaptations pertaining to the particular organizational context. As an example, Lee and Ashforth (1996, p. 123) include 'role ambiguity, role conflict, stressful events, heavy workload, and pressure' among job demands and counteract them with autonomy and scope for decision-making. Demerouti et al. (2001) expand the job demands element to include both social (for example colleagues, customers) and organizational elements, thus accounting for physically demanding activities (heavy lifting, dealing with bodily fluids), as well as the overarching precarity of work such as insecurity and contractual duration. Subsequently, job resources can both reduce the pressure of job demands on workers, promote wellbeing and personal development or simply have a functional role in enabling the worker to achieve their targets (Schaufeli & Taris, 2014, p. 45; Demerouti et al., 2001). Critically, peer and management support are listed as examples of a job resource which, when present positively impact a worker (Richter & Hacker, 1998).

In line with the JD-R model, when the workplace balance is upset by placing unmanageable job demands on workers, or

providing them with insufficient job resources to ameliorate the negative impact of job demands, burnout is likely to occur (Bakker et al., 2005). Given the negative impact of burnout on both physical and psychological wellbeing (Melamed et al., 2006), it is necessary to consider its emergence as the result of JD-R tensions. Specifically, we studied the double-whammy of high job demands through ambulance target pressures (National Audit Office, 2017) and limited resources due to the proliferation of ill-treatment behaviours in the wider social care sector (Kline & Lewis, 2018). In order to do so, we focused on two NHS ambulance trusts with a recent history of reported high levels of bullying and in the next section we provide an overview of our selection and methodology.

Case study methodology

Our research was based on a mixed-methods, case study analysis (Stake, 1995; Thomas, 2014) of two UK ambulance trusts (Blue Light and Green Cross). The Blue Light study took place over a three-month period in 2018. We performed a pilot study by selecting locations from the organization's own staff survey data to receive a draft survey instrument. We then followed a mixed-methods research design of a remotely controlled and executed online survey methodology based on the British Workplace Behaviour Survey (Fevre et al., 2011) and using the survey platform Qualtrics. All members of staff, irrespective of their management or front-line role at Blue Light and Green Cross were eligible and were invited to take part. Weekly reminders were sent to all staff across the six-week period in which the survey was open. This was done to account for sickness absences, annual leave and in order to maximize response rates. All staff received a personal email weekly from the researchers and there was a general introductory message sent out by the director of workforce/HR prior to the study commencing. In line with case study methodology (Swanborn, 2010, p. 2), we adopted an 'intensive' and inductive approach, which focused on collecting as much information about the phenomenon as possible. We wanted to hear about the issues of concern for all employees around ill-treatment at work and thus did not categorize the respondents as managers or non-managers. This was because the work was couched in terms of culture audits, rather than studies of bullying and harassment. The main survey response rate for Blue Light was 28%, whereby 1100 (out of approximately 4,000) employees completed all questions. The response rate was thus deemed 'low' (Bryman, 2016, p. 224). The Green Cross study was carried out over a four-month period in 2017 with an acceptable response rate of 50% ($N = 2093$) (Bryman, 2016, p. 224). However, a number of limitations to our approach must be noted. We were unable to capture socio-demographic data because one of the conditions for access and a stipulation from both Blue Light and Green Cross and trades unions was the ability to ensure the full anonymity of respondents. Thus, it was necessary to forego the collection of what would have been useful data, to reassure participant employees/members that they could not be identified, for example by their ethnicity, as there were relatively small numbers of certain demographic groups in both organizations. We return to this limitation in the discussion section.

A tale of two trusts

There is evidence from successive NHS staff surveys in England (see NHS staff surveys online, 2003–2019) that the UK ambulance service suffers from high incidences of perceived bullying and harassment. Wankhade (2018) and Wankhade et al. (2018) warned against oversimplified conceptualizations of culture, and distinguished two broad categories: culture being something an organization has, versus it being a metaphor of what the organization is (Wankhade, 2018). The need for a nuanced investigation which takes into account the wider, socio-economic environment (Wankhade, 2018; Wankhade & Patnaik, 2019) was our reason for our indepth investigation into Blue Light and Green Cross. Table 1 provides an overview of historic levels of bullying in both organizations, using the NHS staff survey conducted at each location. It is particularly noteworthy that, despite the slight reduction of reported bullying levels across Green Cross, levels of negative experiences have remained fairly stable across both organizations, thus necessitating our study.

Accordingly, each of the two case studies provides an overview of the tensions and workplace experiences of ambulance staff, starting with available participant demographics (noting the limitations outlined above), and then combined evidence from the survey and interviews comprising negative behaviours and management issues against the JD-R model (Schaufeli & Bakker, 2004).

The Blue Light ambulance trust

Of the 1100 respondents who completed all the questions in the survey, there was an approximately even split of genders: 43.2% female, 56.1% male and 0.6% indicated they wished to be considered in another way. The mean age for Blue Light respondents was 42.6 years, which correlated with indicated lengths of service with three to five years and six to 10 years jointly accounted for approximately 38% of participants. Some 76% of respondents worked full time on a rota line; 6.7% being full-time relief workers, 12% part time (between eight and 29 hours) and 2% employed part-time pattern but as relief. The remaining 3% indicated their contractual arrangements to be 'other', for instance agency staff. Respondents were first provided with the following definition of bullying in order to minimize ambiguity:

Table 1. Historic reports of bullying experiences at Blue Light and Green Cross based on the NHS surveys conducted at each location.

	Percentage of Blue Light staff reporting bullying/harassment/abuse experiences in the past 12 months			Percentage of Green Cross staff reporting bullying/harassment/abuse experiences in the past 12 months		
Year	From managers	From other work colleagues	Total	From managers	From other work colleagues	Total
2017*	13.6%	16.8%	30.4%	31.3%	23.6%	54.9%
2018**	16%	18.2%	34.2%	23.7%	21.2%	44.9%
2019	15.2%	20.2%	35.4%	19.2%	19.6%	38.8%

*Green Cross data collection. ** Blue Light data collection

Bullying at work involves repeated negative actions and practices that are directed at one or more people. The behaviours are unwelcome and the person receiving the behaviours has difficulty defending themselves from them. Important—We do not think of one-off incidents as bullying. Using the definition above, have you been bullied at work in the last 12 months?

Of the 1035 people who responded to this question, 75% had not experienced bullying. Of the 25% who reported affirmatively, 178 (17%) stated that this was occasionally, 31 (3%) stated this was monthly, 35 (3%) stated that they experienced bullying more frequently, for instance weekly or daily, and 2% indicated a 'don't know' response. Interestingly, there was no significant correlation between bullying at Blue Light and the gender, ethnicity, religious beliefs and sexuality of its employees. Employees with a disability or chronic illness were, however, 1.4 times more likely to report bullying. In line with the premises of the JD-R (Schaufeli & Taris, 2014) model, staff who stated their disability/health condition exacerbated their experience by precluding them from fulfilling the demands of their role were a further 1.75 times more likely to report bullying.

In order to measure relationships at work and determine their role as either enablers of positive staff experience (and thus acting as job resources) or placing higher demands on staff again in line with the JD-R model, we deployed the Health and Safety Executive's (HSE) management standards for stress at work scale. Here we report on four items from the 35 measured by the full scale. The Blue Light median scores (which are unaffected by outliers) are shown in brackets where a score of 1 indicates 'high stress' experiences, and 5 indicates 'low-stress' experiences:

HSEQ.5: I am subjected to personal harassment in the form of unkind words or behaviour (4.19).

HSEQ.14: There is friction or anger between colleagues (3.18).

HSEQ.21: I am subject to bullying at work (4.40).

HSEQ.34: Relationships at work are strained (3.31).

As seen from the above data, we observed a split in responses where HSEQ.14 and HSEQ.34 provided lower median scores, and HSEQ.5 and HSEQ,21 elicited higher scores. In line with the JD-R model, we found that it is not just direct instances of negative behaviours such as bullying which need to be taken into account as detriments to employee workplace resources. Tensions in the immediate environment are also significant stressors for workers and, although there were variations in responses across Blue Light locations, between 50% and 60% of respondents reported incidences of friction or anger between colleagues (HSEQ.14), with no significant differences across demographics groups. This was also the case with HSEQ.34 where between 50% and 60% respondents across Blue Light reported strained working relationships. An overview of all participants' responses is provided in Table 2. Table 2 utilizes behaviours from the 2011 representative study of negative workplace behaviours in Britain (Fevre et al., 2011). Compared to the Fevre et al. (2011) study, Blue Light exceeded each behaviour by a considerable margin, i.e. respondents were two and three times more likely to report such behaviours compared to a representative average from British workplaces.

In interviews, staff raised numerous examples of manager behaviour which they felt was unreasonable. The theme of being treated differently compared to colleagues such as 'some staff get pulled up, others don't' was a frequent occurrence, while serious investigations (SI) were believed by some staff to be seemingly deployed inappropriately. Some staff claimed SIs were often raised in interviews (as threats) as means of control by managers, even though protestations from staff, often supported by trade unions, were ignored. This often led to threats of dismissal—'I was told I would be sacked' and 'I was told to prepare to be sacked' for clinical decisions that, when investigated, were dismissed and staff exonerated. Often, staff had taken considerable sickness absence during SIs and reported this as 'stress and anxiety'. Other Blue Light staff who had encountered SIs were reported as having left the organization or retired because 'the stress of the SI was too much to bear'.

Further to this, managers were reported as often unable or unwilling to follow up on staff well-being during periods of sickness absence due to SI or general sickness. Similarly, return-to-work protocols were not consistently followed —'when I returned to work [after suspension] I was promised monthly one-to-one chats, but nothing ever happened—not even one'. Other staff complained that injuries encountered as a result of work were not considered during sickness absence reviews which they felt breached organization policy. Confidentiality, or lack of it, was also reported by a few staff mainly around SI investigations. One staff member complained of being contacted to undertake pieces of work 'even though I was on certified annual leave'. Other examples of perceived unfair treatment by a manager concerned career development with one staff member reporting 'I was told I was too old to be considered for paramedic training'—a potential breach of the Equality Act 2010.

At the start of interviews, participants were encouraged to discuss what concerned them and so not many staff used the label 'bullying'. When bullying issues were raised by staff, they invariably related to the same named individuals in

Table 2. Experience of unreasonable treatment behaviours in the previous 12 months at Blue Light.

Behaviour—How often have you experienced:	Sometimes	Monthly	Weekly/ daily	Cumulative
Someone withholding information which affects your performance	44%	7%	13%	64%
Pressure from someone else to do work below your level of competence	33%	5%	10%	48%
Having your views and opinions ignored	50%	13%	18%	81%
Someone continually checking up on you or your work when it is not necessary	35%	7%	15%	57%
Pressure from someone else not to claim something which by right you are entitled to	20%	5%	4%	29%
Being given an unmanageable workload or impossible deadlines	42%	8%	17%	67%
Your employer not following proper procedures	40%	6%	11%	57%
Being treated unfairly compared to others in your workplace	33%	5%	9%	47%

management positions, some of whom were still employed by the organization. Staff described these encounters as 'it's like being in an abusive relationship' that it is 'generally accepted in the trust'. Different organizational sub-cultures can co-exist (Wankhade, 2018; Wankhade et al., 2018) and interviewees talked about banter being accepted as part of the culture 'but it can be malicious—it is the cultural norm'. Alongside banter, gossip and rumours was also a cause for concern which 'went on for a long time. It just got me down'. Several staff talked about behaviours being 'normalized' such that people forgot that in a 'normal workplace, these things would not be accepted, but here you keep your head down and get on with it'. Several toxic components of the trust's occupational culture (Wankhade & Patnaik, 2019) were identified, and staff frequently raised 'nit-picking' by managers which others simply described as 'organization culture' or 'the corporate bully'. Sadly, some staff talked about suicide ideation and even having made suicide attempts. These were not isolated and conversations took place with several interviewees who had attempted suicide as a result of workplace experiences.

The Green Cross ambulance trust

We had 2093 Green Cross employees taking part in the survey and, as with Blue Light, males (53.47%) and females (46.01%) were equally represented, while 8% did not indicate a gender preference. At 40, the mean age of Green Cross employees was comparable, albeit negligibly lower than Blue Light, while 83.87% were in full-time employment, 11.61% worked part time (between eight and 29 hours) and the remainder 4.5% worked less than eight hours a week as agency staff.

Some 42% of Green Cross employees stated that they had experienced bullying in the previous 12 months (more than double than in Blue Light) and, when it occurred, 24% of respondents stated that bullying was occasional, 7% stated it was monthly, 11% stated that it was more frequent (weekly and daily), while the remaining 3% stated they were unsure. Once again, we were unable to find any statistical correlation between exposure to bullying at Green Cross and the demographic characteristic of participants such as gender or ethnicity. As with Blue Light, we wished to test the JD-R dynamics through the role and impact of workplace relationships as part of the resources available to ambulance trust staff. The results of the same four HSE measures were:

> HESQ.5: I am subjected to personal harassment in the form of unkind words or behaviour (3.75).
>
> HESQ.14: There is friction or anger between colleagues (2.89).
>
> HESQ.21: I am subject to bullying at work (3.84).
>
> HESQ.34: Relationships at work are strained (2.76).

Interestingly, it was once again questions 14 and 34, directly dealing with workplace dynamics, which produced the high-stress scores (as a reminder, this is a five-item scale where scores closer to 1 indicate high-stress factors, and scores closer to 5 suggest lower-stress factors). Our findings suggest that Green Cross employee encountered similar but higher tensions and toxicity at work than their Blue Light counterparts. HSEQ.21 showed bullying was a regular occurrence for 63% of respondents, while 27% reported strained relationships at work and 26% suggested there was tension between colleagues. We then examined the same unreasonable treatment behaviours as we had with Blue Light and these are presented in Table 3. As with Blue Light, Green Cross employees were up to three times more likely to report negative behaviours than the representative British workplace average.

Table 3 results reveal that between 40% and 70% of respondents indicated exposure to 'unreasonable treatment' behaviours on an occasional or more regular basis. The detrimental impact of JD-R tensions was most prevalent around 'unmanageable workloads', 'Having your views and opinions ignored', 'Your employer not following proper procedures' and 'Someone continually checking up on you or your work when it is not necessary'. These behaviours were clearly evidenced in conversations between the researchers and employees where 'unreasonable treatment' emerged as a 'managers know best' culture where when challenged, managers are perceived as knowing 'what's best for you'. Employees attending focus groups and interviews often expressed the view that such behaviours arose from a lack of proper management training and/or because managers lacked the requisite skills to manage staff properly and with sensitivity. As an example, there were concerns with Green Cross operating a 'boys club' culture. Individuals reported dissatisfaction with inappropriate behaviour, which when reported met with a common response, namely that it is 'that's just the way they are'.

Such views were reported in both interviews and focus groups where cliques and favouritism were perceived to exist, extending to social settings where groups of male managers, whose careers had progressed together, upheld a culture that was stubbornly resistant to change (see also Wankhade & Patnaik, 2019). This not only undermined employee resilience and wellbeing but was accepted as a *fait accompli*, a persistent issue which 'cannot be broken internally'. The researchers were also told regularly that 'one's face has to fit in order to develop one's career', while

Table 3. Experience of unreasonable treatment behaviours in the previous 12 months at Green Cross.

Behavior—How often have you experienced:	Sometimes	Monthly	Daily	Cumulative
Someone withholding information which affects your performance	36.78%	11.78%	10.34%	59%
Pressure from someone else to do work below your level of competence	27.63%	9.77%	10.15%	47.5%
Having your views and opinions ignored	36.97%	20.05%	17.54%	74.6%
Someone continually checking up on you or your work when it is not necessary	21.74%	10.9%	16.35%	49%
Pressure from someone else not to claim something which by right you are entitled to	21.8%	11.15%	6.33%	39.3%
Being given an unmanageable workload or impossible deadlines	29.01%	11.97%	18.55%	59.5%
Your employer not following proper procedures	31.27%	16.17%	19.36%	66.8%
Being treated unfairly compared to others in your workplace	24.81%	12.09%	12.59%	49%

several employees felt there was little point in reporting bullying issues because managers would default to supporting each other rather than taking a complaint seriously and acting on it. This led to a sense of unease and even dread for employees at Green Cross and even during interviews, some employees continued to question researchers what the data would be used for and sought on-going reassurance that they could not be identified, because: 'Standing up against bad behaviour puts you on a manager's radar—excessive monitoring, more work, more pressure'.

Similarly to Blue Light, staff felt the need to cope with day-to-day working pressures, internal tensions and negative behaviours through recourse to what was termed 'gallows humour'. However, this could overspill into the frequent use of inappropriate bad language, disrespectful behaviours towards women and student paramedics and 'cavalier and bullish management'. Staff told us that 'shouting', 'swearing in front of others', 'demeaning' and 'belittling' behaviours were commonplace. Banter, although seen by many established Green Cross employees as the cultural norm was practiced through teasing among colleagues about being overweight, too short, hard of hearing and so forth, whereby 'if you can't take it, you're not tough enough' prevailed.

Discussion

Our study sought to provide insights into pressures and risks to the resilience and wellbeing of staff in the ambulance service, with a particular focus on bullying as an under-researched area in the UK's emergency services. Increased scope for worker precarity in atypical and non-standard roles (Standing, 2014; Savage et al., 2013), such as shift-work representative of the UK's emergency services, has been identified by a number of studies (Bo, 2020). Researchers have also commented on the 'layering' of insecurity (Manolchev et al., 2018) on account of workers' subordinate positions in the employment relationship (Braverman, 1998) and use technology-enabled methods of managerial control in order to reach targets and achieve efficiencies. The academic literature has identified the incidence of bullying behaviours as part of this process of managerial control (Beale & Hoel, 2011), which can limit worker autonomy (Schaufeli & Bakker, 2004) and perpetuate the contexts in which bullying occurs (Baillien et al., 2011). In turn, studies (Fevre, et al., 2013; Beale & Hoel, 2010) have shown that exposure to negative behaviours such as bullying is likely to have a range of detrimental outcomes not only for the victims of bullying and harassment but for the organizations themselves (Vartia, 2001; Matthiesen & Einarsen, 2004; Niedhammer et al., 2006).

Given the overall precarity of the UK labour market context (Standing, 2014), and the emergency services context in particular, it is necessary to recognize scope for management malpractice in ensuring services are delivered on target and efficiencies are achieved. This could be explained through the unique 'layering' of structural (organizational constraints and pressures), cultural (stress-coping behaviours by staff) and individual (singular instances of negative behaviours) factors which jointly contributed to the bullying experiences of employees at Blue Light and Green Cross. Therefore any failure to address malpractices by the management and senior management teams at Blue Light and Green Cross placed direct pressure on employees, who discussed their growing mistrust of each organization in our follow-up, qualitative interviews. With regard to the structural constraints introduced above, we heard testimonies from ambulance workers who felt they had been overlooked for promotion, were without managerial support in time of need, or were threatened and intimidated by those from whom they sought support. This was the case in both organizations and employees discussed the normalization of negative behaviours and their acceptance as part of the working environment. This was particularly concerning given the routine narration of inappropriate gestures, actions and comments by managers and senior staff towards those lower in rank. Paradoxically, rather than serve as a catalyst for recognizing such behaviours as bullying and harassment, their routine occurrence led to lack of willingness (and, at times, fear) of taking a stand against workplace toxicity both on account of lack of trust that comments would be taken seriously and concerns of potential reprisals.

In recognition of the cultural factors discussed above, and although having potential utility for the individuals engaging in it, dark humour was only a short-term fix for a critical situation and served to further add to the pressures, challenges, stressors and ill-treatment (Fevre et al., 2011) of employees at Blue Light and Green Cross, thus harming resilience and wellbeing. The unchecked use of banter by staff appeared to be not so much part of the solution as part of the wider problem of bullying each of the trusts faced, yet curbing offensive and risqué comments seemed no less challenging than stopping the negative behaviours that our survey uncovered. Custom and practice had led to a wide range of inappropriate actions—from bullying, favoritism and inappropriate behaviours becoming embedded in the organizational every day at Blue Light and Green Cross and with both organizations failing to address that which was hidden in plain sight. These types of issues further help to potentially explain the consistently high incidence of sickness absence and stress among ambulance staff, as reported by NHS Digital (2019). Finally, given the absence of managerial support (perceived and actual) and lack of adherence to workplace policies and procedures at both organizations, it was not surprising that workers sought out unconventional ways to cope with stresses, and pressures—whether caused by workload targets, or bullying behaviours.

The striking of a balance between available (material/support) resources and work demands is of paramount importance both for the JD-R model and earlier frameworks on which it is based, for instance Karasek's (1979) job demands–job control approach. Thus, since expected 'resources' such as managerial support, guidance, mentoring and often collegiality (on account of the high incidence of between-staff complaints at Green Cross) were absent, employees drew on banter and gallows humour as a way of connecting with others and destressing. When this happened, colleagues could be *both* viewed as stressors *and* sources of tension release, rather than regarded as one or the other. This is significant in showing that, when organizations fail to regulate open spaces of interaction through suitable guidance and support, employee wellbeing and resilience are undermined. This is especially

so, and likely to continue in the pressured and efficiency-driven context of UK's emergency services, which has recently been exacerbated by the pressures imposed by the Covid-19 pandemic. As a result, staff either leave, or go underground to create a counter-efficient sub-culture (Wankhade et al., 2018) which challenges practices perceived as unfair or illegal.

Conclusion

The pressures on UK ambulance staff outlined in this article are not new. From a labour process theory perspective, these problems are both historic and systemic, caused by employee exploitation with the precarious and uncertainty of the UK labour market. However, they are also emergent and exacerbated by the emotional, mental health and physical risks placed on front-line workers by the Covid-19 pandemic. Therefore, our study extends the literature by identifying some of the causes for such tensions in the UK ambulance service. We show, that if allowed to diminish, resilience and the interplay between demands/resources pressures will cause staff to either leave or seek to resolve tensions through counter-organizational means. We encountered a number of limitations which future research could strive to address. We were unable capture bullying behaviours by worker demographic, which would have added an additional dimension to our case studies. It would have been preferable to gain access to existing data such as sickness absence, grievance and disciplinary data to see if there were patterns across different socio-demographics (for example over/under representation of trade unions, BAME and disability).

Nonetheless, this should not be regarded as a *carte blanche* for managers to achieve efficiencies by any means necessary, or for ambulance trusts to outsource day-to-day management to its workforce. Bullying and harassment, grievances, sickness absence levels, and high staff turnover rates are indicators of failing management, and poor or weak managers must be held to account. The systemic nature of emergency sector precarity and resultant structural, cultural and individual causes for bullying suggest that all employees, but particularly managers, need a heightened awareness of negative behaviours that lead to perceptions of bullying and harassment. This requires specific interventions into preventative measures that enable managers to challenge their own and each other's behaviours, as well as of those they manage. Maintaining employee resilience requires a culture of openness, and a willingness to speak out without fear of retribution and reprisal, which in turn requires effective leadership. Managers must be aware of the corrosive impact which stress and burnout have, and the HSE offers a free, online instrument for individuals in authority to self-assess their effectiveness in preventing and reducing stress at work. The instrument also enables the identification of professional development needs and can be delivered internally or by an external provider, tested and re-tested at least bi-annually.

The inherent complexities of the triadic, i.e. structural, cultural and individual causes of bullying in Blue Light and Green Cross, points to the need to adopt an internationally-agreed definition of bullying to help workers understand the complexities of bullying and arrive at an informed response position. The current NHS staff survey does not provide a definition, leaving it up to employees to decide on what bullying is, or is not. If ambulance service organizations, or indeed the wider NHS, fail to define bullying in their own workforce surveys, it should come as no surprise that results may be skewed and thus greater effort is required to orientate employees as to what bullying and ill-treatment constitutes. We believe it is important for staff to understand the boundaries of their own behaviour and the importance of speaking out when they encounter such experiences, either as recipients or as witnesses. Although very difficult to organize in the operational environment of 24/7/365 of ambulance services, team meetings are key to tackling the fundamentals of bullying. In a caring-led environment, such as emergency care provision, it is fundamental that the embedded and historical inappropriate behaviours are recognized, named and openly addressed.

The incidence of negative behaviours in the UK's emergency services is a matter demanding investigation. In the meantime, the experiences of workers at Blue Light and Green Cross continue to raise concerns about who watches the watchers.

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