Cultural characteristics in the ambulance service and its relationship with organisational performance: evidence from the UK

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Note: Please do not quote without the permission of the author
I don’t think it really matters whether you work in ambulance service I or II or III; there are different variations on culture but it is still an ambulance culture.

Senior Corporate Manager, Delta ambulance trust

Introduction and background

For all the interest in defining and assessing cultures, the important question of whether and how organisational culture impacts on organisational performance remains “empirically poorly explored” (Davies et al., 2000, p.114). Dingwall and Strangleman (2005) argue that from the perspective of organisational analysts, ‘culture’ has been more widely used in other disciplines like anthropology (Bittner, 1965) and literary studies (Clifford and Marcus, 1986; Geertz, 1973). The concept of culture is one of the most fascinating and yet elusive topics of management research. Brown (1995) identifies fifteen different descriptions of culture. Like performance, it is also a contested phenomenon. Harris and Obgonna (2002, p.32) argue that despite lack of unanimity about the concept of organisational culture, its popularity over the past few decades has established it as the dominant concept in organisational theory. There is a growing body of work by commentators, academics and practitioners who have tried to find a relationship between organisational culture and quality of healthcare (Scott et al., 2003a, 2003b; Mannion et al., 2005). Within such larger debates, this paper attempts to address a smaller but specific question of whether organisational culture bears any influence on healthcare performance within the specific context of the ambulance service in the UK. Systematic research and development in ambulance services is a growing phenomenon in the rapidly changing environment of ambulance care (Siriwardena, et al., 2010; Snooks et al., 2009).

There is also a growing international interest in using organisational culture as a means to improve health care and changing organisational culture is now a familiar prescription for health sector reform. Organisational culture and its management are increasingly being viewed as a necessary part of health system reform (Scott et al., 2003a). This follows an assumption that the NHS and its constituent organisations possess a discernable culture and the nature of such cultures has some bearing on performance and quality (Department of Health, 2001, p.2; Mannion et al., 2005; Wilkins, 1984). This interest has also been renewed in the wake of some high profile failures in professional practise, and in particular the Bristol Royal Infirmary case (Kennedy, 2001); the high profile report of medical errors in the US (Institute of Medicine, 1999) and the Shipman case (Shipman Inquiry, 2005). Key findings from Bristol inquiry suggested that cultural characteristics of the NHS fostered a climate where dysfunctional behaviour and malpractices were not effectively challenged (Kennedy, 2001). It also highlighted the collection of fragmented, loosely coupled, and self-contained sub-cultures existing at Bristol Infirmary (Weick and Sutcliffe, 2003).

Ambulance Service has often been referred to as having a ‘command and control’ culture accompanied by a tendency to blame (Commission of Heath Improvement, 2003) and are thought to be risk averse (NHS Modernisation Agency, 2004).
Improving the culture of the service is also one of the major recommendations of the national ambulance review (DoH, 2005) and recent published evidence (Wankhade, forthcoming; Radcliffe and Heath, 2010; Heath and Radcliffe, 2007). It has been also argued that that a major cultural transformation needs to be secured alongside structural and procedural change to deliver expected improvements in performance and quality (DoH, 2000). Cultural change is high on the Government agenda and involves all elements of cultural and organisational changes with key elements including amongst other things, empowering front line staff to use their skills and knowledge to develop innovative services with more say in how services are delivered and resources are allocated, and changing the NHS culture and structure by devolving power and decision-making to frontline staff led by clinicians and local people (DoH, 2001a, p.2). This paper argues that this case study adds to the evidence about the relevance of the culture-performance debate for the ambulance service and also questions the adequacy of the current performance assessment in the UK.

The paper is structured as follows. The first section reviews the literature on organisational culture in general and explores the empirical link between culture-performance debates including Schein’s analysis of the three cultures of management (1996). The second section explores the different cultures of management in the ambulance service and how it impinges on their performance and service delivery. The third section details the research methodology adopted for this study. The fourth section evaluates the evidence from the research and highlights the cultural assumptions of each of the different groups and how it impacts on its performance. This is followed by some concluding remarks.

1. Empirical evidence linking organisational culture and organisational performance

Various studies have suggested that effectiveness of a wide variety of organisations including healthcare might be linked with the culture of the organisation (Cameroon and Freeman, 1991; Wilderom et al., 2000; Driscoll and Morris, 2001; Ferlie and Shortell, 2001). While there is some intuitive appeal in the proposition that organisational culture may be a relevant factor in health care performance, the relationship between culture and performance is not conclusive since both ‘culture’ and ‘performance’ as variables are conceptually and practically distinct (Scott et al., 2003a). Mannion et al., (2005) reviewing the evidence from studies in health care organisations in the US and UK highlighted difficulties concerning methodological limitations and mixed evidence regarding the relationship between organisational performance and organisational culture.

Defining culture is not easy and culture has been the subject of considerable academic debate (Alvesson, 1995; Cameroon and Quinn, 1999; Martin, 2002; Schein, 1985). Most definitions recognise the socially constructed nature of a phenomenon that is expressed in terms of patterns of behaviour. Allaire and Firshtrotu (1984) compare organisations to mini-societies so as to highlight the interpretation and expression of the role of the participants within the socio-political and technical world of the organisation. Out of the plethora of definitions available, one which is helpful is that developed by Schein (2004, p.17) who defines organisational culture as a “pattern of shared basic assumptions that was learned by a group as it solved its problem of
external adaptation and internal integration; and that has worked well enough to be considered valid, and therefore-to be taught to new members as the correct way to perceive, think, and feel in relation to those problems”.

For all the disagreements over the precise definition of organisational culture discussed above, it is generally agreed that culture operates in layers and Schein’s identification of the three levels of cultures is a widely acknowledged and useful framework of analysis (Scott et al., 2003). At the first level are the ‘artefacts’ which are the most visible manifestations of culture, including the rewards, rituals and ceremonies and are concerned with the observational patterns of behaviour. In the health services, it may include dress codes (green uniform for ambulance crews and white coat/tie for doctors). It is however both easy to identify and difficult to decipher. At the next level are the espoused ‘beliefs and values’ which may be used to justify particular behavioural patterns like the Hippocratic Oath of the doctors to put the interest of the patient first or in the case of the Ambulance Service, speed of response to an emergency. At the third level are the ‘assumptions’ are the real and largely unconscious beliefs and expectations held and shared by individuals. A shared value or belief is transformed into a shared assumption. For instance, medical research is believed to be dominated by the use of rational scientific quantitative methods over qualitative inquiries to generate knowledge (Mannion et al., 2005). This pluralist view of culture finds support in the academic literature (Morgan, 1986; Sackman, 1992).

Different levels of cultures can exist in an organisation that may seek to differentiate themselves from one another by their cultural artefacts and values (Martin, 1992). Rivalry and competition between these groups may then appear to be a key feature of the overall organisational culture (Harrison and Nutley, 1996). Such subcultures can also be associated with different levels of power and influence within the organisation. It can be observed, for instance that a medical culture dominates in the NHS over a management culture (Scott et al., 2003). But the evidence base linking culture and performance in healthcare organisations is suggestive but not definitive. But such ideas form major strands of both policy stipulations and managerial action (DoH, 2000; Scott et al., 2003a). A further understanding of the nature of organisational culture and its expression within a healthcare organisation such as the ambulance service will be useful. It will further help to identify methodological lessons for those interested in developing further empirical work.

1.1 The different cultures of management

Different classifications have been discussed in the literature to understand and measure cultures notwithstanding the suggestion that the search for an ‘ideal’ instrument could be a frustrating exercise (Scott et al., 2003b; Lim, 1995). Schein (1996) analyses and describes the issues of subculture in an organisation by arguing that there are three different, important occupational cultures which often work at cross purposes and are often in conflict with each other. He calls them as (1) the culture of engineering, (2) the culture of Chief Executive Officer (CEO), and (3) the culture of Operators. These cultures often cut across organisations and are based upon what Maanen and Barley (1984) have described as ‘occupational communities’. The Operator culture that evolves locally in organisations and within operational units is
the most difficult to describe. The other two cultures, the engineering culture and the culture of the CEOs cut across organisations and the shared assumptions are derived from a common educational background. For instance, sales persons, accountants, assembly line workers, and Engineers all share the same tacit assumptions about the nature of their work regardless of who their current employers are. Such similar outlooks across organisations also apply to Executive managers, particularly chief Executives. CEOs face similar problems in all organisations and in all industries throughout the world. Executives form a common worldview about the nature of business and what it takes to run a business successfully (Schein, 1996, p.13). A brief discussion of the shared assumptions of each of the three cultures will be useful before further discussion.

The Operator culture

Being local in origin, this is perhaps the most difficult culture to describe. An Operator culture can be identified in a chemical plant, in a hospital, a pharmaceutical company or even in an office. But what elements make this culture broader than the local unit are not very clear. In order to focus on this issue we can consider the fact that the operations in different industries reflect the broad technological trends in those industries at some functional level and how one does things in them reflects the core technologies that created them. And, as those core technologies themselves evolve, the nature of operations changes. For example advances in information technology have rendered the manual process of painting in the automotive industry or detecting leaks in a chemical plant obsolete (ibid, p.13). Since this culture is based on human interaction and communication, Trust and teamwork are essential in getting the work done efficiently. If the operations are complex, Operators learn that they are highly interdependent and must work together as a team, especially when dealing with unanticipated events. Rules and hierarchy often get in the way when unexpected events occur. Operators become highly sensitive to the degree to which the production process is a system of interdependent functions, all of which must work together to be efficient and effective.

The Engineering culture

In every organisation, there is one group that concerns itself with the basic design element of the technology that is the basis of the work of the organisation and has knowledge of how that technology is to be utilised. Schein (1996) describes this occupational community as the one representing engineering culture. It is likely to be most visible in traditional engineering functions, but it is also apparent among the designers and implementers of all kinds of technologies such as information technology, market research and healthcare organisation. In the design of complex systems such as jet aircraft or nuclear plants, the engineer prefers a technical routine to ensure safety rather than relying on a human team to manage possible contingencies. Engineers recognise the human factor and design for it, but their preference is to make things as automatic as possible. Safety is built into the designs themselves. Engineers, in the broadest sense, are designers of products and systems that have utility, efficiency and safety and which are designed to require standard responses from their human Operators (ibid, p.14).
The Executive culture

Both Operators and Engineers often find themselves in divergence with the third culture, the culture of the Executives. The Executive worldview is built around the need to maintain an organisation’s financial health and is preoccupied with boards, investors, and the capital markets. In a healthcare organisation, the Executive has in addition to the above, to deal with greater conceptual challenges, multiple objectives (sometimes contradictory), and various stakeholders (citizens, Government, patients, regulators and taxpayers). Managing financial health and the growth of the organisation become important management tasks. Schein’s assumptions of the Executive culture apply more to CEOs who have risen from the ranks within the organisation through promotion. The Ambulance Service is a good example where most of the senior Executives have traditionally come from within the service.

As Executives rise in the hierarchy, their level of responsibility and accountability increase, they become preoccupied with financial matters and find it harder to observe and influence the basic work of the organisation. The need to manage from a ‘distance’ forces them to devise control systems and routines that become increasingly impersonal. This need for information and control requires them to develop and implement elaborate information systems alongside the control systems (routines, rules and rituals). They also feel increasingly alone in their position at the top of the hierarchy. Schein also argues that both the Executive and the engineering cultures tend to see people as impersonal resources that generate problems rather than solutions and view people and relationships as means to the end of efficiency and performance (productivity) and not as an end in themselves (ibid, p. 16).

2. The three cultures of management in the ambulance service

Based upon the above classification, we argue that there are three distinct management cultures within the ambulance service and would include:

- The Operator culture represented by the frontline crews (paramedics and technicians) who respond to all emergency 999 calls

- The engineering culture represented by the Emergency Medical Dispatch Centre staff (Call takers and Call dispatchers) where all 999 calls are received and vehicles dispatched to the scene of the emergency

- The Executive culture representative of the Chief Executive and the senior Executive team.

We further argue that there are not three cultures as described by Schein, but a fourth culture that of the ‘managers’ which sits rather uncomfortably at the periphery of the Executives (Wankhade, 2007). These are significant findings in terms of classifying the different subcultures in the service. Each of these is explained in some more details in the subsequent sections.
The paramedics as the Operators

The paramedics form the backbone of any ambulance service. A paramedic is a senior healthcare professional who works in an ambulance service and travels to the scene of an emergency. Paramedics assess the patient and initiate any specialist pre-hospital medical treatment and care. Besides administering life-saving procedures, paramedics are also qualified to use a range of clinical techniques and have to deal with a wide range of patients including those suffering from traumas such as road traffic accidents (RTA) or suffering from some other trauma.

There are two categories of emergency crews who attend to 999 calls in an ambulance trust. These are (a) paramedics with certain higher skills in terms of the clinical intervention they can give to the patient and (b) technicians with fewer clinical skills. There are also two categories of vehicles that can attend to a 999 call. The first is a standard two-crewed emergency ambulance whilst the second is a rapid response vehicle (RRV) which is usually a car driven by a single paramedic (and called ‘solo-responders’ in ambulance jargon). For the double crewed ambulance, the usual practice is to have a paramedic-technician or paramedic-paramedic combination. Usually two technicians are not put together for the safety of the patients but for operational exigencies it is not unusual to have two technicians in an ambulance. Rees (2007) reported a story about the death of a 999 caller that was attributed to delay in dealing with the emergency since the first responder was a technician and had to wait for the arrival of a paramedic to administer the relevant drug for which he was not authorised.

As the performance of the ambulance service is ultimately dependent on the performance of the paramedics in hitting the response time targets, especially the headline target of Category ‘A’ response of eight minutes, the success of the enterprise depends on their knowledge, skill, and commitment. The required knowledge and skills are “local” since each ambulance trust organises its own training programmes and differs in the local geographical knowledge of the area they serve based on the organisation’s core technology. Although the workload for any particular day or hour is predictable and is based on the IT systems used, the exact level can never be known in advance. This requires Operators to be constantly vigilant and prepared and they must have the capacity to learn and to deal with the unexpected.

The EMDC staff as the Engineers

The EMDC is the focal point of the Ambulance Service and its effectiveness is critical to achieving ambulance performance standards mentioned earlier in this section. It provides a 24-hour service and often involves dealing with highly stressful and emotive situations. The EMDC utilises either the Advanced Medical Priority Dispatch System (AMPDS) or the Criteria Based Dispatch (CBD) versions of the medical dispatch systems that enables trained staff (Call takers) to categorise emergency calls in an objective and logical manner by asking the caller structured questions. These questions identify the presence or absence of ‘Priority Symptoms’ like chest pain; breathing problems; change in level of consciousness and haemorrhage, etc.
The EMDC is the hub of all the ambulance activities and control. The time taken to answer a 999 emergency call and that to dispatch an appropriate vehicle and mobilise crews efficiently counts towards the overall efficiency of the Engineers (and the organisation by implication). A typical shift runs with approximately 8-10 Call takers; 5-6 Call dispatchers, and a supervisory officer (called performance managers) with an overall manager in charge for the EMDC. Assisting the Engineers is an impressive array of technology; the AMPDS that guides the response of the Ambulance Services; and satellite navigation and radio paging systems used for determining the exact location of an emergency vehicle and communicating with the crews.

Two categories of staff work in the EMDC; the ‘Call takers’ who receive the 999 calls and then talk to the callers; and the ‘Call dispatchers’ who assign a team of Operators and an appropriate vehicle for each call. The Engineers receive training in first aid and life saving techniques which means that, when required, they will stay on the line and provide instructions and support to the caller to enable them to assist the patient until the ambulance arrives. There have been instances when Engineers have given instructions over the phone to distraught mothers that enable them to deliver babies whilst they wait for the ambulance and the Operators to arrive.

The management information tends to be restricted to the data that the main control room system can provide for the monitoring of performance. Management of resources (distribution of vehicles) is the sole responsibility of the EMDC staff and they do not seek interference from others. The constant pressures of time and resources require the Engineers to keep a close track on the Operators’ performance for each job. This requires defining when meal breaks can be taken by the Engineers or for which calls the paramedics can be sent, etc. often leading to conflict.

**The Executive culture**

A majority view amongst senior management in the ambulance service is to be seen as an integral part of the NHS network rather than being viewed as an emergency service. The need for better cooperation and sharing of resources was widely acknowledged by the senior Executives across the trust. The Executive vision is to forge close partnerships with other emergency and other healthcare services which will enable the ambulance trusts to quickly develop their role within the NHS network and enhance their clinical skills and allow them to carry out their tasks more efficiently through improved planning and coordination.

Executives focus on financial survival and growth so as to provide adequate returns to their shareholders (Primary Care Trusts, Strategic Heath Authority, Department of Health) and to society (patients, public at large). Obtaining funding from the PCTs that commission the services of individual Ambulance Trusts is considered a top priority. The economic and political environment is perpetually competitive and potentially hostile, so the CEO is isolated and alone, yet appears omniscient, in total control, and feels indispensable (Schein, 1996, p.15). Raising the profile of the Ambulance Service within the wider NHS network is seen both a responsibility and a challenge. The need and desire to be heard and noticed by external stakeholders and Commissioners (PCTs) weighs heavily on the minds of Executives. There is also a clear hierarchical, task and control focus of this culture. Meeting performance targets
and hitting the national headline target of eight minute response (Category ‘A’ call) is seen as a barometer of Executive success- the difference between a good Ambulance Trust and that of a bad one. Failure to achieve Category ‘A’ targets and poor performance ratings is seen as a stigma and personal failure.

This analysis makes a significant contribution in understanding and classifying the different subcultures in the ambulance service. Schein’s (1996) conceptual framework is further expanded by the empirical evidence from the case study in identifying his three subcultures. Having discussed the assumptions of these three cultures within the ambulance service, the next section details the methodology adopted in this study.

3. Research methodology

This study was part of the research conducted by the author in a large ambulance trust (hence referred to as Delta trust) in the North of England. One of the key research questions was to explore and classify the organisational culture (s) and explore the links between organisational performance (measured and unmeasured) and organisational culture in the given organisation. Semi-structured interviews and non-participant observations were used in the study. Seventy-two interviews were conducted in this study between January 2006 and June 2008 exploring the individual perception of performance of different occupational groups and its implication and relationship with organisational performance. Non-participant observation was used as the second main data collection strategy in this study. Performance review meetings in the trust were observed. Following a multi-level approach, these observations were conducted at three vertical locations within organisation: the Executive (corporate) level at the trust headquarters; area management level (middle executives and managers level); frontline paramedics and Emergency Medical Dispatch Centre (EMDC) staff (micro) level. The advantage of this approach is that it allowed for an analysis of the interdependence between these organisational dimensions (Currie et al., 2008). In total around 150 hours of observation took place.

All interviews were tape-recorded with prior consent to facilitate subsequent analysis using QSR NVivo Version 7.0 to facilitate the analysis of data. Following initial scrutiny of the transcripts, the responses to the key themes were analysed repeatedly to further explore the linkage between performance measurement and culture. This followed the principles of grounded theory where prominent and emergent issues inform subsequent sampling and research activities while also providing a framework for interpretation and content analysis (Charmaz, 2002). The first level codes and the second level codes (thematic codes) were derived from the reduction of field notes and interview accounts. Through coding of relevant passages of transcribed text, from observations and interviews, it was able to identify detailed descriptions, accounts, beliefs and shared assumptions within the case study data.

Ethical approval for the study was obtained from the local NHS research ethics committee.
4. Finding and discussion

The exploration of the individual understanding of performance by the different actors in the Delta trust was guided initially by their immediate response to the creation of their new organisation from the amalgamation of four erstwhile ambulance trusts as part of the national restructuring of ambulance trusts in July 2006 in England. Beyond the broad consensus on the difficulties surrounding the merger, it soon began to emerge that the impact of merger on the organisation was felt differently by each of the different occupational groups, identified as, senior executives, managers, paramedics and EMDC staff, rather than as employees of legacy trusts. Senior executives were positive about the benefits of the merger and thought it would give the organisation a strategic capacity in a way the service had not had before. Middle managers clearly talked about difficulties in getting to grips with new organisational structures which largely affected the operational managers in terms of their relocation and job roles with few respondents expressing difficulties in ensuring safe and satisfactory service delivery. The attitude of frontline staff towards reorganisation was mixed. Many paramedics questioned the impact of merger as they had not noticed any real difference in terms of working conditions or service delivery. Views of EMDC staff broadly echoed the views of the paramedics in so much as that it had not made any noticeable difference.

One common theme which emerged during initial observation and first round of interviews across the organisation was the repeated mention of words like ‘culture’, ‘cultural challenge’ ‘ambulance culture’ ‘command and control culture’ in response to questions concerning individual understanding of performance. It began to unfold that these cultural challenges were not simply due to differences in the individual organisations but concerned the assumptions and values held by the different categories of staff. As our understanding of the organisation grew it emerged that there is no ‘single’ ambulance culture but instead there are ‘multiple’ cultures within each category of staff. A key concern of this study then was how to analyse the meaning which members of these different groups of staff in the service assign to their social world as they seek to cope and maintain membership in the face of attempts of different groups to exert influence. In order to understand as fully as possible the dynamics of the culture of an organisation, it is vital to develop an appreciation of the perspectives and interpretations of individuals and groups of individuals within it (Harris and Obgonna, 1998). This view is consistent with Smircich (1983) who argues that researchers attempting to understand culture should be concerned with learning the consensus meanings ascribed by a group of people to their experience and articulating the thematic relationship expressed in its meaning system.

It soon began to unfold that these cultural challenges were not simply due to differences in the four merged organisations but concerned the assumptions and values held by the different categories of staff identified above. Senior Executives were positive about the benefits of the merger and thought that the ambulance service reorganisation was a really positive move and one that would give the organisation a strategic capacity in a way the service had not had before. Some Executives also talked about the new capabilities on issues concerning performance and interaction with commissioners and other stakeholders to do things differently:
“I think the jury’s out in this regard. But I think there is certainly a view that things are changing because they’re actually seeing new ambulances, new equipment, new technology that's brought them in line with other places. They’ve not had that before.”

Senior Board Executive I

Further down the organisational hierarchy, the experience of the managers was not as positive. Many respondents expressed their difficulties in ensuring safe and satisfactory service delivery. New roles were created (that also displaced many staff) and new arrangements for relocation of jobs and staff took place. Comments made by some respondents towards the merger and management response included ‘takeover’, ‘faceless organisation’, and ‘inconsistent’:

“I think the senior executives above me should be a lot more visible than what they are. I think there's a horrible feeling that this is a faceless organisation and that the people who are making decisions and making some quite unpopular decisions were never around to have anybody to speak to them.”

Senior Manager, Area I

“I don’t think it increases performance since we struggled to meet our targets and we still deliver the service the way we always did.”

Corporate Manager I

To further strengthen corporate accountability, many area managers were given additional corporate responsibilities and were required to divide their time between the corporate headquarters and their respective local areas. Some of the managers interviewed during the study spoke about lack of executive understanding of the concerns of other sub-cultures and also their contribution towards the success of the organisation. Some respondents blamed poor communications in the new bigger organisation for not getting the right message across. Communication in the Delta trust was a function of the Corporate Communication team, the head of which worked directly under the chief Executive without a vote in the Trust board:

“I think we’re made some bad mistakes over the last few months with things that should have been quite smooth and should have been seen as benefits to staff or to patients. The way it’s been communicated has basically turned that upon its head.”

Communication Manager

The attitude of frontline paramedics towards reorganisation was mixed. One respondent talked about opportunities for new job roles emerging and a chance to work in different locations within the bigger organisation as a positive outcome of the
merger process. Many however questioned the impact of merger as they had not noticed any real difference in terms of working conditions or service delivery:

“I always think of my own little regime, my own little station and my own little city and my own little rack on my car. I don’t think of the wider issues because I can’t impact on them.”

Senior Paramedic I (emphasis added)

One respondent also raised concerns about the delays it added to making decisions in a big organisation.

“Where we used to be able to get decisions made quite quickly and be able to act on those decisions the whole thing has slowed right down.”

Paramedic II

Views of staff working in the EMDC that receives the emergency 999 calls and dispatches vehicles broadly echoed the views of the paramedics. Comments were made that it had not made any noticeable difference:

“No it is just the same. No different…Nothing has changed”

Call handler I, EMDC

Concerns were raised of the bigger ‘cultural’ problem of doing things differently in an organisation born out of four totally different organisations with different organisational, clinical and performance ethics:

“They don’t seem to accept that there are four services here that have got four different ways of working and theirs might not necessarily be the best way of looking at things.”

Call dispatcher I, EMDC

Few of the paramedics were frank enough to admit their lack of awareness of the changes being carried out and that they were not bothered about them either. One senior paramedic told that they wanted to see real changes and the organisation had not made enough progress on issues like uniforms, vehicles, stations, equipment, working practices and career development. But not everyone agreed with this assessment. One member of the other occupational community was quite dismissive of these concerns:

“The issues that they whinge about is exactly what they’ve always whinged about which is new vehicles, new equipment, and at the moment, well what are they changing now? Are they going to take this off us or whatever and
that's always the same. I don’t think from a staff perception, apart from the upheaval that they see, the day to day work hasn’t changed at all.”

Senior Corporate Manager II

One specific issue referred to by many participants was the ‘power issue’ in which executives and senior managers of one particular legacy organisation were appointed (after due process of selection though) in the new Trust. Some respondents who previously worked in the other three legacy Trusts referred the management structure of the Delta trust as an ‘Area I takeover’ and felt that all the good things achieved by them earlier were lost:

“Perception of most of the lads here in this area is that it’s an Area I takeover. People in higher jobs are from Area I. None of our senior managers have been given a job. At the grass root, they think that they have not integrated with Area I, but been taken over. It’s 4-0 when we checked last time when four jobs were lost to Area I.”

Senior Station Manager, Area III (emphasis added)

The above discussion reflects that the intended gains from restructuring are not universally accepted and appreciated by different categories of staff and importantly that it would be a mistake to judge organisational response from the standpoint of any one category of staff. The views of senior executives reflect a more strategic view about the gains of this reorganisation. Managers clearly talk about difficulties in getting to grips with a new organisational structure which largely affected the operational managers in terms of their relocation and job roles. Comments from frontline paramedics suggest that they do not see much change happening at an operational level but that they now have to deal with a bigger organisation. The EMDC staff also point out that no benefits have accrued to them as a result of the restructuring process. These comments highlight the fact that respondents across the new organisation spoke not as members of their erstwhile organisations, but as members of their occupational ‘tribes’, each with its own assumptions, values and beliefs. This is further reinforced with their specific beliefs on performance.

4.1 Attitude towards performance of the three occupational cultures in the ambulance service

The executive view towards performance and targets remains focussed towards organisation’s vision and mission and bears characteristic assumptions of this culture as evidenced from the comments of the senior management team:

“We need to measure our performance around the three key elements that any business would do really and that is around quality, cost and volume. The way I view this tension is that it’s like when an organisation’s being managed well as a creative tension...That’s how I see it and that’s how I try
to encourage a manager to view that tension and to build it as a force for positive change.”

Senior Board Executive II

Views expressed by another senior executive are also similar:

“Like it or not, performance targets are here. And although there is an awful lot to do in terms of Taking Healthcare to the Patient, we can’t ignore the fact that we need to meet our 75% Category ‘A’ target.”

Non Executive Director I

The views expressed above reflect the basic assumptions of the Executive culture detailed in the previous section. A clear emphasis on financial health along with clear lines of hierarchy and control is indicated in the remarks of the senior executives. What also emerges from these views in terms of the focus on performance and targets is that the challenges of the job and the sense of achievement take precedence over the relationship aspect (with the other occupational cultures). It is easy to identify these comments with traditional executive prerogative about vision of the service and the direction of travel for the organisation. The drive to perform can be seen as a strong need of executives within the challenging and often unstable environment of the NHS where failure and non-performance often results in loss of jobs. In these circumstances, the views expressed above may not be too surprising.

The Engineers deal with the actual handling of 999 calls and dispatch of the vehicles in the ambulance service. But to meet the performance targets of the organisation, they need the cooperation, active support and commitment of the Operators to go out to the scene of the emergency in the fastest time possible. The crucial role played by the Engineers is also acknowledged by the Executives:

“From the point of view of delivering performance, the first point of call has to be the control room. If you get the control room right then the rest will fall into place. If you haven’t got your control room processes, procedures right, you haven’t got a cat in hell’s chance of getting your road staff sorted in that respect. It has to start from the centre and move its way out.”

Senior Board Executive III

During the period of this study, there were three EMDCs in the Delta trust covering Areas I, II and III. A considerable time was spent in each of them, watching with interest, the working of the Engineers and the way the business was conducted and talking to the Operators informally as well as in formal interviews. Given its important role as indicated by the previous respondent, we were struck by the lack of Executive and Operator influence and interference on a day to day basis. There is no outside control regarding the way in which each 999 emergency call is answered or an appropriate vehicle is dispatched:
“All senior operations managers have access to the ‘Alert System’ where they can see live where their vehicle is. But they do not have access to the mapping system which would allow them to track their vehicles. There is a pressure on sector managers to ensure performance in their area is as high as possible and they attempt to talk to us. But we fight them. We are very clear that we will distribute the resources to the best of our ability and not what the individual sector manager wants.”

EMDC Manager I, (emphasis added)

The Engineers use their skills, training and experience in dealing with their work. While they are generally conscious of targets and performance, the impression gathered by the researcher suggests that they do not like to rush into answering one call and moving on to another reflecting their basic belief of safety first:

“For me the time taken to answer the call, which at times is quite challenging, is not really important. Rushing to finish the call would distract me in assessing the call correctly, which for me is a bigger priority.”

Call taker II, EMDC

The views expressed above reflect the basic beliefs detailed in the previous section. This can be related to their safety orientation and over-design for safety of the patients. The Operators on the other hand, wish to balance the clinical care given to patients with that of speed of response. The most common comment from the Operators concerned the paradox of reaching to the scene of emergency quickly and being unable to make any clinical intervention:

“As an ambulance service if you get to a patient in 8 minutes and if they die, you succeed; but if you get there in 9 minutes and the patient survives, you fail.”

Paramedic III

“There is a paradox between good performances; how to get the vehicle as quickly as possible at the incident to the quality of care provided to the patient; and the focus is mostly on the former.”

Senior Paramedic IV

Another Operator who responded to emergency situations as a solo responder moaned about the constant pressure exerted by Engineers about the targets:

“When we get a job, it is like how long it takes to get there to the patient’s benefit. In Control, it’s all about time, targets, everything else. But for the practitioner on the road, it is more about just getting to that patient safely.”

Senior Paramedic V
It is not being suggested here that the Operators are not serious about their jobs. The time spent by the researcher with them showed their total commitment. Travelling as an observer with them during actual 999 emergency calls showed their skills and focus. What these comments suggest is the pressure to meet the target on a continuous basis. While it may appear that there is some initial alignment amongst the needs and task as defined by the operators, the need of the engineers for efficient operations through optimal resource utilisation and the need of the executives for minimising cost and providing vision and direction to avoid any problems pulls the organisation in different direction. When the new organisations reinvent themselves due to changes in environmental factors such as merger, targets and technological factors, there are signs of collision amongst the three cultures which is reflected in the way the three cultures perceive their respective roles. The executive perception of the operators (and engineers) is quite forthright in this regard:

“I think, certainly within the executive team, we’ve got that focus and we’re building a strong team as we get to know each other better. I am very much aware that operational staff now know that they’ve got an executive team up which is of high calibre and they know that they’re being lead by minds and not monkeys and I think that’s quite a powerful message really.”

Senior Board Executive V (emphasis added)

“One big challenge before Ambulance Service is how to professionalise a blue collar trade.”

Senior Board Executive II

Another executive put it rather bluntly:

“If you talk to road staff about achieving Category ‘A’ performance they just laugh in the sense of well that’s your problem and it’s your problem to get the ambulances in the right place, to make sure we can get there within the time.”

Senior Area Executive III

Some Engineers complained about lack of education on the part of the Operators to understand the working of the control room. Visit by an Operator into the EMDC Control room was a rarity. There was no formal procedure in place in the Delta trust for meetings between these two groups though individual Operators would drop in for a ‘brew’ sometime:

“There must be a system in place where they come here and we go out to see mutual problems. If they spend a day with us, then they can see our problems as to why they were given a job or why they took more time at the hospital. This will improve relationship.”

Call dispatcher II, EMDC
If the Operators assume that the Executives and Engineers do not appreciate their views, they can resist and covertly do things their own way. The comments by the Engineers about the unnecessary delay on jobs by the Operators or by the Executives about the need to bring a cultural change to professionalise the service confirm this proposition. The comments of Engineers about the freedom in running the EMDC and the Executive approach of laying down guidelines and lines of hierarchy support this view. The comments by the Executives about professionalising a ‘blue collar trade’ and those by the Engineers about trying to control every aspect of the Operator’s working pattern (meal breaks) support Schein’s (1996) hypothesis about the implicit Executive and engineer’s assumptions of people being the problem or source of error. But the Executives and the Engineers often disagree on measures to be adopted in increasing efficiency. Engineers seek permanent solutions in terms of more resources which are guaranteed to work and be safe in all the circumstances but would cost more. This is suggested in the comments made by the Engineers about more staff, better vehicles and latest technology needed to carry out their work. The Executive concern is usually about minimising the cost while attempting to maintain a strategic focus.

Views expressed above by representatives of the different sub-cultures and policy experts bring out the difficulties in understanding the multiple subcultures and their interactions in the ambulance service (Schein, 1985; Davies et al., 2000). Assumptions of these subcultures were also guided by the functional groupings, trade union membership (a real issue for the Service), length and terms of working in the service, individual loss/gain due to restructuring or a combination of all these issues. It is also relevant to note that these comments have come from respondents who have worked in all the four legacy organisations. But they bear greater significance in terms of their assumptions as a separate occupational community irrespective of the organisation of their previous employment. There are several other implications about these subcultures. One implication of the different sub-cultures concerns the validity of their basic assumptions which was discussed earlier. It then becomes not a case of “who is right” but of creating enough mutual understanding among the parties so that solutions can be understood and implemented. These findings also suggest how the basic assumptions and characteristics of these three cultures can have implications for organisational performance. The next section examines the fourth culture of management, namely that of middle managers in the Delta trust and its attitude towards performance.

4.2 Managers as the fourth culture of management

There is inconsistency in the literature regarding the definition and nomenclature of managers. Currie and Procter (2005) use the nomenclature of ‘middle managers’ with operational responsibilities rather than from the corporate functions, which are positioned in the organisational hierarchy so that at least two levels of staff were below them. Watson (2001) finds this classification rather restrictive and argues for the use of the terms as it is understood in the organisation. In this study, managers have included all individuals who were understood as managers in the Delta trust (see Figure 1). This helped to avoid any pre-judgement of the roles of managers and allowed a greater understanding of the fourth subculture in the ambulance service.
Findings from this study represent the views from a cross-section of respondents who were officially called managers in the organisation having either operational responsibilities or corporate job titles.

Figure 1: Organisational Chart of the Delta trust

The organisation was structured around seven directorates headed by a board Executive reporting to the Chief Executive. The area directors were considered as the part of executive team in terms of their employment conditions. They have been referred to as junior executives in this study. The managers were organised around these directorates. There were three area directors who were responsible for the overall management of the local functions of service delivery. The deputy/assistant directors were based at the corporate headquarters which on average was between 30 and 50 miles from the area offices. All individuals below the level of Assistant Directors and Area Directors were called managers in the organisation having both operational and corporate responsibilities. Following Watson (2001), they have been referred to as middle managers but only as managers.

One revealing aspect of this investigation was the role played by middle managers in matters concerning both operational and strategic aspects of performance management of the service. Speaking to a range of managers having either operational duties or corporate responsibilities suggested acknowledgement of less important roles being played by the managers and also a general desire to be more strategic in
their behaviour. Several factors appear to have contributed to this perception. Traditionally, most of them joined the service as frontline paramedics and worked their way through to managerial/Executive positions. Many managers stated that it was not uncommon to find that senior executives including chief executives on the trust boards come from the ‘ranks’. To an outsider it might give the impression that the performance measurement (and management) of the eight minute response ends too soon to allow any managerial intervention in ‘real time’. This means that the whole process of deciding on an appropriate response to an emergency call is completed within a few minutes of an emergency 999 call hitting the switchboard of the EMDC Control after being answered by the Call taker and Call dispatcher assigning a particular vehicle/crew to attend it. This results in little scope for the managers for dealing with performance issues of the organisation as they occur.

The lack of opportunities for management training and clinical education which are often sidelined because of operational exigencies was an issue highlighted by many managers. It has a bearing on the managerial response to organisational change. The Executive focus on performance targets further affected the personal development of this group. The Executive attitude towards managers did not help either. One senior board Executive expressed his ‘frustration’ about the lack of managerial skills in communicating the message of the management team to the frontline staff. Some managers on the other hand complained about the ‘lack of genuineness’ of the Executive intention to involve them in the actual decision making and developing strategic thinking of the organisation.

The views expressed above by some of the managers can be ascribed to what is described in the literature as either ‘reluctant managers (Scase and Goffee, 1989) or those who seem unsure of their own capacity and capability (Dopson and Stewart, 1990). Such a reluctance or inability could be assigned to the geographical distance of the corporate centre from the operational managers, the size and spread of the Delta trust (one of the largest trusts in England), and their own position in the organisational hierarchy. Moreover, the assistant directors tended to remain at the corporate headquarters and the way the organisation was structured around different directorates further prevented a greater interaction amongst corporate and area/operational managers. Operational managers were isolated due to the shift patterns of frontline staff and from each other due to the distances involved which resulted in their engagement in the organisation in an implementation role. This is in conformity to the literature which argues that strategy is formulated by those at the corporate centre and implemented by the operational managers at a local level (Currie and Procter, 2005).

This is not to suggest that there were no positive developments witnessed during the period of this study. The development of the managerial strategic function was recognised by senior executives including policy experts. Training programmes were given a boost. Investment in management education through workshops, seminars and ‘away days’ facilitated lateral interaction between managers, that had been previously difficult to achieve due to the hierarchical organisational structure. There were several indications in this regard. It was emphasised that all proposals for additional resources should be produced in a business case following detailed analysis and evaluation of the merits of the proposal. This helped managers formulate the details of the contents of the strategy by spanning the boundary between the organisation and its external environment. One manager explained there were better opportunities to interact with
the Commissioners and outlined that one of the initiatives concerning ‘Stroke Services’ in which he was involved was helped by early engagement with the PCTs.

However such initiatives had their own unintended consequences. Such business cases often had to go through multiple layers of decision making: through local area management committees; through programme boards; and finally to the Board of executives. This often led to delays. One manager spoke about how one proposal discussed with the PCT Commissioners had taken nearly a year to be cleared. Another respondent complained:

“We used to be able to get decisions made quite quickly and be able to act on those decisions. Up until last year, we used to look after our own workforce planning and didn’t end up getting to a situation where we’d got excessive numbers of vacancies. We used to order our own vehicles so we didn’t get undue delays with vehicles coming through. The Legacy Trust was the last time I had any new vehicles or new staff.”

Senior Manager II, Area III

There was a general consensus amongst managers that they had the potential to play a strategic role in making the transformation of the organisation from a transport service to professional healthcare provider. However several challenges to their ability to play an increased strategic role were mentioned by respondents. It was argued that the organisation was too focussed on operational performance and had to deal with the historical and legacy factors of command and control culture of a uniformed service in which there was a culture not to question the decisions made by seniors (Floyd and Wooldridge, 1992,1994).

One senior manager of more than fifteen years of service narrated his own experience. He explained that traditionally ambulance services had promoted and recruited from within their own ranks and that this was a typical uniform service approach in which if one worked for it long enough, one would get promoted because it’s his/her turn. This has resulted in a lack of ownership, understanding and accountability at all levels in the organisation and where the senior executive team were viewed as ‘Generals’ and lots of time is spent in looking ‘upwards’ for directions. Another manager who had, earlier, worked outside of the ambulance service suggested that the inability of ambulance frontline managers to make a strategic contribution was due to their lack of external exposure:

“I think without that external exposure, that sort of business acumen, that awareness of marketing and financial strategies to support decision making, it is all about operational service delivery. As an organisation we put in place business plans, we put in place strategic objectives and cascade down through Personal Development Plans {PDPs} and individual objective settings. But what we miss is that we don’t have any accountability with it and when it comes to the crunch, we avoid dealing with the underperformer.”

Senior Corporate Manager III
However, the Executive expectations of the managers were not always as positive. Many senior executives mentioned factors like lack of confidence and unwillingness on the part of managers to gear up to the new challenge posed by *Taking Healthcare to the Patient* (DoH, 2005):

> “Actually there's a culture in certain parts of the organisation and probably this part, in the middle management, where managers believe that they know all the answers what they're saying it’s the endpoint of everything, they'll have to have the last say in everything.”

Senior Area Executive II

The underlying conservatism within the service was mentioned by several participants in this study and has been referred to earlier in this thesis. Despite the essential nature of service delivery remaining largely the same during the past 20-30 years, ambulance trusts have generally struggled to meet the required standards (Heath and Radcliffe, 2010). Some respondents stressed how important it was to take into account the sensitivities of managers in the newly restructured organisation and how vital it was for the organisation to implement the new vision of the ambulance service as envisaged by policy makers:

> “Managers are very, very influential, you know. If they say to the staff that things are rubbish out there, the staff don’t tend to go and look too far. Equally if they say ‘things are really improving out there’ the staff takes it from them. The staff will buy into it. So by having a de-motivated middle management workforce couldn’t have been worse. They’re just switching off themselves.”

Senior Manager III, Area I

It is not being suggested that managerial contribution is not being appreciated by the senior Executives in the service. Many senior Executives acknowledged the crucial role of the managers in driving forward the new clinical agenda before the frontline staff. One executive acknowledged that there were signs suggesting that the middle managers were beginning to act in a way that they would be expected to do and were at least talking the language and debating and discussing issues within the new culture. Few new appointments had individuals arriving from outside of an ambulance background.

New job-roles were designed during the first year of the new Trust that left some of the managers without proper job descriptions. Such job insecurities and the consequent competition for the new posts caused a number of existing relationships to break down between managers in the three areas of the new Trust.

> “I need a job. I mean I’ve got a post, I’ve been appointed to a post with due process but for a year I’ve been doing nothing. The merger was in July 2006 and we are now nine months on and I’m having my first one to one meeting with the Executive Director this Wednesday, the first since July. And I don’t know what the content of the meeting will be and I don’t know
whether I will have any either strategic role or even tasks in simple terms at the end of that meeting.”

_Senior Manager IV (May, 2007)_

These job insecurities appeared to make some managers insensitive and to pay only ‘lip service’ to their strategic role. Some confusion amongst managers was also created by the dual roles (area and corporate leads) given to many managers for the stated objective of developing a corporate identity of the new organisation and devising a directorate structure. Many managers however argued that it was done to provide greater Executive control over managerial actions and for reasons of parsimony. This often led them to working in little boxes- what Kanter (1983) describes as ‘segmentalism or compartmentalisation’ of actions, events and problems from one directorate to another.

Some respondents further felt that the HR issues were not a management priority and managers were not involved in discussions which had happened at a very late stage in the new organisation. Some of them were also critical of the management practice of communicating to its staff through the corporate communication team. Some managers were also not happy with the management policy to distribute resources across the whole organisation:

“In this area, this year, we got over £6½ m of additional funding and we saw just over £2m of that and we haven’t even seen the return for that yet because having been given the £6½ m in March/April time this year nobody allowed us to spend it. Where our Commissioners have got high expectations having given us the money, we have seen less than a third of that money in area but the Commissioners believe that we've got all £6 ½ m. You certainly don’t want to lie to the Commissioners.”

_Senior Manager IV, Area III_

It was noticed in our study that attention to the symbolic dimensions of these sub-cultures also played some part in shaping the attitudes of these groups towards one another. Discussions with paramedics and other frontline staff showed how passionate they were about the working conditions and how they valued the facilities made available to them. They were quick to compare how things had changed between their original organisations when compared with their new organisations:

“When you consider what matters to operational staff, they want to ensure that they’ve got quality vehicles, quality equipment, that they get regular meal breaks and receive a reasonable remuneration for what they do and they’re well trained. Now if you crack those few things off you've got a fairly satisfied workforce. We've put in no new vehicles, hardly any staff, which has led to extra pressures on existing staff.”

_Senior Area Manager V_
The impact of these symbolic actions in the Delta trust was also noticeable during the attendance of the performance review meetings at the level of Executives and managers within the organisation. The trust internal executive meetings usually took place every week in elegant suite rooms at the trust headquarter building. Other than the executive team, only the three area directors were invited to such meetings. The meetings tended to last between 3 and 5 hours. Tea/Coffee and juice; nice crockery and cutlery were always available in the room. The nature of the paperwork was very detailed running to 75-100 pages on average. One regular agenda item in each of these meetings was a report by the operations director detailing previous week’s overall response time performance for the Trust as a whole and individual performance figures for each of the three areas. Having some understanding of the culture of the organisation, it was not surprisingly, usually the first item on the agenda. Confidential information was also discussed during these meetings in presence of the researcher. Though the overall nature of these meetings was very formal and business like the atmosphere of these meetings was pleasant in these meetings.

The experience of the attendance of the meeting of the managers in the three areas was quite contrasting. The Delta trust had three area management teams. Each of them carried out a separate meeting with their own team of managers with similar designations as that of the corporate executive team. These meetings usually took place every fortnight in the office of the area director which had a desk for the occupant and a big table in the front of the desk that allowed the room to double up as a meeting room. The walls were simple and the floor also had a simple carpet. The meetings tended to last between 2 and 3 hours. Tea/Coffee was available in the room using assorted mugs. Sometimes attendees carried their own cups. The format of the reports submitted unlike those from the executive meetings was not uniform. Separate templates were used by individual managers. The nature of the paperwork was considerably less than half that compared to that of executive meetings. The level of discussion and questioning was generally good but not as detailed as that of the executive meeting. There were more agenda items on average when compared with that of the executive meeting. Again, one of the first agenda items for these meetings was a detailed update of the previous week’s overall Category ‘A’ performance for the area. The usefulness of response time targets in the new scheme of things has been a matter of recent academic debate (Mason et al., 2009; Wankhade, forthcoming; Radcliffe and Heath, 2009).

Contrary to the impression gathered from attending executive meetings, the responses in these meetings seemed guarded. This could be due to the fact that the permission to attend such meetings came from the ‘top’ and there was some apprehension about what was said during the meeting might be reported back. But the overall nature of these meetings was more relaxed including the length of the social small-talk (holiday plans were also discussed). On quite a few occasions the conversation drifted to social matters and the chair had to intervene to bring some order. These meetings had an understandably local flavour and references and jokes were made about the other two areas in terms of that area’s performance and the behaviour of senior executives. One such meeting in Area II which the researcher attended shifted at the last moment to the Trust headquarters but in a very small and cramped room with insufficient chairs and space. But it did not stop one senior manager commenting about the ‘opulence’ of
the building in comparison to the poor state of the control room in his area and the lack of financial support from the corporate office.

These observations are interesting as they highlight not only the difference in the social settings of the different occupational cultures, they also the symbolic behaviour of these different groups within the organisation. In particular, for those areas in the Delta trust where the procurement of new vehicles was delayed, it took on a symbolic meaning. Views were quickly disseminated through informal channels of communication and respondents pointed out how such things were dealt with much faster previously. Many individuals started to question the benefits of the restructurering. This is not to suggest that the senior management showed any discrimination in making new vehicles available to a particular area. But in the new bigger organisation, such decisions were based on balancing the needs of all the three areas subject to financial resources being available. This obviously meant a certain time-lag in the actual delivery of the vehicles. Nonetheless, it remained a rather emotive issue for frontline staff:

“They’re not going to get any more performance since all the time the staff are being asked for more and more and more. They can’t give no more! Staff is fed up to death. What they would like is twice the amount of vehicles on the road.”

Senior Paramedic IV

The success of Taking Healthcare to the Patient (DoH, 2005a) largely depends upon the active participation and motivation of the frontline paramedics who deal with 999 emergencies. A de-motivated workforce can seriously impinge on the success of any culture change programme:

“We see non-core activity being ruled down to help to balance the operational resource. What matters is delivering the bottom line performance target. So we might get there very quickly but will do in a kind of poor vehicle, poorly trained and poorly motivated staff that would have the negative impact on the organisation.”

Senior Area Executive I

Concluding discussion

NHS Ambulance Trusts in England were reorganised from 32 to 11 in July 2006 (DoH, 2005a) and are currently witnessing a process of culture change in the light of the new direction of travel envisaged by the policy makers (Siriwardena et al., 2010a). The increasing importance given by the Government to bring cultural change to the NHS shows the relevance of this study in highlighting some of the issues concerning culture in an ambulance service. What it implies is that the concept of culture needs to be taken more seriously than has been done in the past. There is a greater need to recognise the deeply embedded shared tacit assumptions of the various subcultures
within an organisation. Instead of superficially manipulating a few priorities, it is important to acknowledge the contribution of each of these subcultures.

Unless the implications of these occupational cultures are understood, recognised and confronted, organisations will not function effectively. Poor communication between the different subcultures can adversely impact the ‘learning’ in the organisation. As a consequence of technological advances and the interdependent nature of business, none of these cultural communities can alone solve the problems that a complex healthcare organisation like an ambulance service generates. For instance, use of satellite navigation and tracking technology has made it possible for Engineers to effectively use their resources but has also resulted in the Operators being ‘tracked’ on a continuous basis and the Executives being put under greater financial pressures to modernise their fleet and technology. Communication between the different occupational cultures will stimulate mutual understanding rather than mutual blame and will move away from the culture of ‘us’ versus ‘them’ (Schein 1996). The complexities of different aspect of organisational culture can perhaps never be fully captured. However, this study has contributed to the body of knowledge by bringing into focus the various challenges faced by senior managers in the Ambulance Service to become significant drivers of organisational cultures as a significant separate subculture in the organisation. This in itself is a significant finding. Schein’s (1996) theoretical framework has been strengthened by identifying and classifying the four subcultures in the ambulance service, each with its own beliefs, values and attitudes.

The lack of the strategic role being played by the managers in the ambulance service is revealing and the dominance of their implementation function pointed in this study is in conformity with the literature (Currie, 2000; Floyd and Wooldridge, 1997). In particular, the potential of managers to make an enhanced contribution in strategy is also illustrated in the case of changing the culture of the ambulance service. This happens in two ways. As long serving members of the service, they know the ‘pulse’ of the organisation and can ‘sell’ their views to the executive management (Dutton et al., 2001). The resultant realised strategy is then one which will be sensitive to the local context and mediates local problems such as more staff, vehicles, etc. in addition to meeting the requirement of Government policy. The findings highlighting the lack of strategic role played by the managers are significant to our understanding of this important emergency service. It adds to the present body of knowledge regarding the role of managers in other public sector organisations and makes contribution to that effect.

In conclusion, it will be fair to comment that the complex grouping, layering and complexities that exist in organisations can never be fully captured. This in-depth case study has helped to uncover rich descriptions of organisational life in one ambulance trust in England, a service which is relatively neglected in management research. Attention has also been drawn to the ways in which performance and culture interact in an iterative manner, and such links can be varied, many, contingent and multidirectional (Mannion et al., 2005).

Notwithstanding the contribution made to strengthen the link between organisational performance and culture, there are few limitations to this analysis. The behaviour of staff could be construed as an artefact of the organisation’s culture (Jackson, 1997).
Such an ambiguity complicates the search between culture and performance as such a
link is based on a premise that these concepts are formally distinguishable from one
another. Further research in this area would be valuable to assist these findings.
Despite such methodological reservations, these findings do indicate that
organisational culture may indeed be a significant consideration in deciding how a
high level performance can be achieved within a healthcare organisation.

These views expressed by different sub-cultures confirm the overall perception from
the other occupational groups in the Delta trust regarding the usefulness of response
time targets as a true measure of performance (Wankhade, forthcoming). But the
insights gained from this research also show frustration on the part of large number of
respondents, who participate din this study for not being able to make a significant
contribution towards organisational performance for reasons of operational
exigencies, lack of funding and due to the need to complete the eight minute cycle on
a 999 call. It implies that the performance management process should be a holistic
one in which the contribution of all the occupational groups that are critical to its
success are clearly recognised. The current eight minute headline target has a very
narrow focus and is a bad ‘proxy’ for reflecting the service performance and interplay
between different occupational groups within the organisation.

There is a universal appeal of getting a fully loaded double crewed ambulance that
usually arrives on scene within a few minutes of an emergency. But its relevance in
every response remains to be studied. There appears to be a genuine need to initiate
new methods of communication and mechanisms to take on board the views of these
different occupational communities in the ambulance service to inform policy
decisions.
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