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ABSTRACT

Purpose- The purpose of this paper is to analyse the culture change management programme in one UK NHS ambulance service, documenting various perverse consequences of the change management and suggest further research implications.

Design/methodology/approach- The paper reviews the literature on ‘culture’ and ‘culture change’ and identifies several perverse consequences of a culture change management programme through an in-depth case study analysis, based on interviews with trust staff and policy experts along with non-participant observation. Study was given ethical approval by the local NHS research ethics committee.

Findings- Significant negative consequences of the culture change management programme in the ambulance service are systematically documented. The paper argues that any worthwhile study of organisational culture change management must take into account the perverse consequences of such a process and its overall impact on employees.

Research limitations/implications- These findings come from detailed investigation from only one large ambulance trust in the UK. However they have significant implications for the organisational ‘culture-performance’ debate.

Practical implications- The paper draws out several policy and practice implications from this empirical study. Any meaningful evaluation of culture change initiatives should be seen not only in relation to success in achieving planned objectives, but also by keeping in mind negative consequences of culture change programmes.

Social implications- The concept of unintended consequences has a long history in organisational theory, but there have been relatively few empirical studies recognising the importance of unintended consequences of cultural management efforts. The impact of cultural change programmes in different organisational settings, including the ambulance service, remains under-researched.

Originality/value - This paper makes an original contribution in identifying and systematically documenting the disjuncture between stated and unintended consequences of ambulance culture change management programme, which will be of value to academics, practitioners and policy makers including theory building.

Key words- ambulance, culture, sub-cultures, culture change, perverse consequences, culture-performance link, NHS

Paper type- Case study

The negative consequences of culture change management: evidence from a UK NHS ambulance service

Introduction and background

Organisational culture and its management are increasingly being viewed as a necessary part of health system reform (Scott *et al.*, 2003; Ferlie and Shortell, 2001). There is a growing international interest in using organisational culture as a means to improve health care. The Bristol Royal Infirmary case (Kennedy, 2001), the high profile report of medical errors in the US (Institute of Medicine, 1999) and the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2010) have renewed the interest surrounding dysfunctional behaviour and self-contained sub-cultures and pressures of meeting government targets (Weick and Sutcliffe, 2003). Despite the acknowledged significance of organisational culture to the theories and practices of management, the complexities and consequences of cultural interventions remain comparatively understudied (Diefenbach, 2007; Bititci *et al.*, 2006; Harris and Ogbonna, 1998, 2002). Commentators argue that attempts to manage culture are frequently characterised by perverse consequences that can impede or even prevent the desired culture change (Akroyd and Crowdy, 1990; Legge, 1994).

Though the concept of unintended consequences has a long history in organisational theory (Merton, 1936; Ridgeway, 1956; Caplow, 1994), there have been relatively few studies recognising the importance of unintended consequences of cultural management efforts. The impact of cultural change programmes in different organisational settings remains an under-researched area (Harris and Ogbonna, 1998, 2002; Diefenbach, 2007; Dingwall and Strangleman, 2005; Dutton *et al.*, 2001). Given much of the early literature on culture change is either prescriptive or managerial in orientation (see Peters and Waterman, 1982; Deal and Kennedy, 1982), assumptions on cultural change recommendations often assume employees as willing agents to such management initiatives; without revealing much about the consequences of these changes on the employees and the human dynamics (Austin and Currie, 2003).

Development of scholarship in emergency services, especially the ambulance service, is a growing academic endeavour (Wankhade and Murphy, 2012). Management research about the nature and role of the ambulance services within the wider health economy is a relatively recent phenomena (Heath and Radcliffe, 2007, 2010; Bevan and Hamblin, 2009). Recent published evidence suggests that some of the issues concerning ambulance performance targets and their unintended consequences might have their origins in the underlying occupational cultures in the ambulance service (see Wankhade, 2011, 2012; Radcliffe and Heath, 2009).

Despite the methodological and conceptual limitations of any such analysis, the exploration of the culture change process with respect to organisational employees in the ambulance service is an important topic for academic enquiry. This will improve academic and practitioner understanding of the culture change process in an emergency healthcare organisation that has been relatively neglected, notwithstanding the abundance of literature on organisational culture. The article addresses this imbalance in the literature and will focus on the exploration and documentation of the unintended consequences of a cultural management programme in a NHS ambulance trust in the UK, evaluating the impact of cultural change on its employees. It is recognised that unintended consequences may be positive as well as negative; but in this study it is largely perverse outcomes which are identified.

This paper is structured as follows. The first section reviews the literature on culture and the management of culture, including the unintended consequences of such initiatives. Section two discusses the contextual dimension of such change programmes for the ambulance service in England in the light of current direction of travel (Department of Health, DH, 2005). The third section details the research methodology adopted for this study. The fourth section presents evidence about the various unintended consequences of the culture change initiatives documented in the study. Section five has a discussion and analysis of the findings. This is followed by concluding remarks.

Literature review

Before dealing with managing organisational culture, it will be useful to understand what organisational culture is. Defining culture is not easy, and 'culture' and 'culture management' have been the subject of considerable academic debate (Alvesson, 1995; Cameron and Quinn, 1999; Martin, 2002; Schein, 1992). Most definitions recognise the socially constructed nature of 'culture' as a phenomenon that is expressed in terms of patterns of behaviour. Allaire and Firsirotu (1984) compare organisations to mini-societies, highlighting the interpretation and expression of the role of the participants within the socio-political and technical world of the organisation. For all the disagreements over the precise definition of organisational culture amidst the multitude of such definitions available, it is generally agreed that culture operates in layers, and Schein's (1992) view of organisational culture as a 'layered' pattern of shared basic assumptions manifested in shared values and organisational artefacts is quite popular. Though a fuller discussion is beyond the scope of this paper, this pluralist view of culture finds support in the literature (see Smircich, 1983; Martin, 1992), but different perspectives on studying culture are also available.

Several studies have suggested that the effectiveness of a wide variety of organisations, including healthcare, might be linked with the culture of the organisation (Cameron and Freeman, 1991; Wilderom *et al.*, 2000; Davies *et al.*, 2000). While there is some intuitive appeal in the proposition that organisational culture may be a relevant factor in healthcare performance, the possible relationship between culture and performance is not conclusively established since both 'culture' and 'performance' as variables are conceptually and practically distinct (Scott *et al.*, 2003a, b). Mixed evidence has been reported from international studies linking culture to organisational effectiveness (Mannion *et al.*, 2005; Gerowitz *et al.*, 1996). It has been further argued that a major cultural transformation needs to be secured *alongside* structural and procedural change to deliver expected improvements in healthcare performance and quality (DH, 2000).

Cultural change is high on the government agenda and involves all elements of cultural and organisational changes. Key aspects include 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 (DH, 2001a, p. 2). It may not be enough to know whether culture is linked to performance, but also to know how and why it is linked. Considerable conceptual and empirical work remains to be done to provide better substantiated articulation of these links and their implication for healthcare policy and management and how cultures can be managed (McNulty and Ferlie, 2002).

A critical review of literature suggests several distinct strands in relation to managing culture. The first approach is that of 'natural evolution' whereby new

members in an organisation are socialized and inculcated with the organisational culture, which is further reinforced as dynamic interaction occurs (Harris and Obgonna, 2002, p. 33). This model is supported by Sathe (1983) and Harrison and Carrol (1991), who focus on the means through which culture is disseminated. A more revolutionary approach is also advocated (see Bowman and Falkner, 1997; Brown, 1995), encouraging a generalist approach to culture management through a use of taxonomy or typology of organisational culture (Harris and Obgonna, 2002). The picture is further confused due to the differing perspectives on culture change. Kondra and Hurst (2009) present compelling arguments for an institutional perspective on culture change in organisations. The limitations of the excellence literature have been highlighted earlier in the paper. Critical writers (see Martin, 1985; Obgonna, 1993) argue that culture is both complex and differentiated and any attempt to manipulate it might generate ethical issues and perverse consequences (Harris and Obgonna, 2002, p. 34). That is also the view taken in this paper.

Discussion of unintended consequences in the performance literature is well documented. The Minutes and Memoranda accompanying the Public Administration Select Committee Report (2003) contain a wealth of information about past attempts at performance measurement; including accounts of perverse behaviours which had been anticipated by practitioners but were ignored in their design. Bevan and Hood (2006) identify 'reactive subversions' (p. 521) in three of the targets in the English NHS. Wankhade (2011) documented a range of unintended consequences of the ambulance performance targets in the English NHS. Given the importance of recognising perverse consequences, empirical investigations of unanticipated consequences of culture management are surprisingly few. Understanding the unintended consequences of cultural intervention also has an implication for the organisational culture-performance debate referred to earlier. Unintended consequences of culture change initiatives could offer some explanation for the weak evidence of empirical relationship between performance and culture in the literature (Harris and Obgonna, 2002, p. 46).

Harris and Obgonna (2002), identify the following unintended consequences in their study.

- 'Ritualisation' of the culture change effort to an annual/periodic ritual;
- 'Hijacked process' which results in the change of founding ideals of the change programme;
- 'Cultural erosion' in which the espoused ideals are eroded by subsequent events;
- 'Cultural reinvention' denoting espousal of attitudes and behaviours which, while appearing new, merely camouflage continued adherence to the old culture;
- 'Ivory tower' cultural change reflecting cultural change plans which are either divorced from organisational reality or cannot produce meaningful implementation;
- 'Inattention to symbolism' that is inherent in that organisation;
- 'Behavioural compliance' with the long-term aim of changing the values, beliefs and assumptions of the employees who go through the emotions but their basic attitudes remain unchanged.

Culture change management in the ambulance service

The desired purpose of such changes was the development of a 'new' culture focussing on the direction of travel set out by national ambulance policy review (DH, 2005). Recommendations from the review required a quantum culture leap for the ambulance service in transforming itself from a simple transport organisation to a clinically driven emergency service. In addition, the review proposed major structural reorganisation of the ambulance service in the England which saw the merger of the thirty-three ambulance trusts into twelve in July 2006. This involved developing new management structures, development of a new culture of treating a greater number of patients in the community and performance of an enhanced clinical role by the ambulance personnel (often referred in the ambulance jargon as the 'see and treat' as against the 'scoop and run' model). By implication, it also prepared the way for performance management to move beyond the stringent response time targets.

Such culture change initiatives and the process of change during our study were also affected by various contextual factors. The understanding of the alignment between a culture and the wider environment is important if we are to make a realistic assessment of 'cultural lag' or 'strategic drift' (Scott *et al.*, 2003b). There was growing recognition that the biggest facilitator for bringing cultural change to the ambulance service has been the recommendations contained in the national review:

Whilst clinical and emergency planning roles are seen to require professional qualifications, management is often perceived as something that can be learned on the job. Leadership and organisational management expertise must receive an increased level of attention and investment if the ambulance service is to fulfil its potential (DH, 2005, p.11).

The national ambulance review built upon the previous efforts to modernise and professionalise ambulance service education (through paramedic degrees), regulation (Health professional Council) and streamlined performance management; thus presenting a 'pivotal moment' to the ambulance trusts in becoming a clinically professional service within the NHS. Despite the pressure of meeting more stringent response time targets, the issue of upgrading paramedic skills and clinical education was put in the spotlight for the ambulance service as a whole. A visit to the websites of many ambulance trusts revealed the emergence of a espoused new professional culture, with the increasing use of organisational change vocabulary such as vision, mission and value statements, business plans, etc.: notwithstanding the well-documented dysfunctional consequences from the restructuring of organisations (Fulop *et al.*, 2002; Pollitt, 2007). The stated mission and values of the newly formed Delta trust included ensuring that patients received the most appropriate care, acknowledging the need for investment in fleet, on equipment and the workforce in building a truly modern and forward thinking healthcare service (Annual Report, 2007-08). There was a growing consensus that it gave ambulance trusts, which were small organisations historically, greater strategic capacity and capability to interact within the local health economy as a more equal partner.

Despite the efforts made by ambulance trusts to culturally transform themselves into a clinically driven workforce, they are still perceived as a uniformed service since the training and service provision have been organised around managing major trauma such as road traffic collision, severe breathing problems or cardiac arrest (Lendrum *et al.*, 2000). Non-achievement of targets is still considered a taboo for senior executives. Vestiges of the old command and control culture, accompanied by tendency to blame (CHI, 2003) hierarchical and top-down management style, and resistance to change and being risk-averse (NHS Modernisation Agency, 2004) are some of the factors cited historically within ambulance service. It might be argued however that clinicians in

other parts of the NHS often complain that services are ‘hierarchical and top-down’ in management style, and ‘resistance to change’ is cited as a barrier in a variety of settings; so these issues are not unique to ambulance services.

Research methodology

This study was conducted by the first author in a large NHS ambulance trust in England (referred to here as the Delta trust to protect anonymity and confidentiality). This trust had been restructured in 2006 into one large organisation by merging four previous organisations, each with different organisational/management cultures and different performance histories (see table 1). The new trust structure consisted of three areas which coincided roughly with the geographical boundaries of the four legacy organisations, except that two old organisations were merged internally to form one new area. Each of the three areas was run by an area management team headed by an area director and had local responsibility and a loose operational accountability to the corporate executive team.

Table 1: Background details of the restructured Delta Ambulance Trust

Background Characteristics	Trust I	Trust II	Trust III	Trust IV
Rural or Urban	Urban	Rural	Rural	Urban
Approx. size of the area served	550 Sq. Miles	1,100 Sq. Miles	6,824 Sq. Miles	1,150 Sq. Miles
Resident Population	2.3 Million	1.4 Million	492, 000	2.4 Million
Staff strength (2004-05)	1600	1100	400	1100
Number of calls received (2004-05)	326, 939	142,000	33,149	274,900
No. of incidents attended (2004-05)	245,921	112,183	34,879	220,000
No. of patient journeys (PTS)	763,838	245,000	229,652	621,000
Cat. 8 minutes performance 2004-05 (target 75%)	82.5 %	76.7 %	75 %	73.7 %
Performance Ratings-2004-05	3 Stars	3 Stars	1 Star	0 Stars

Performance Ratings-2003-04	3 Stars	3 Stars	2 Stars	2 Stars
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The main research question in this study was to explore the key objectives of the culture change initiative, documenting the perverse consequences of the culture change programme in the given organisation. Seventy two semi -structured interviews (see table 1) with 100 hours of non-participant observations during January 2007-June 2008 informed the study findings.

Due to the exploratory nature of this study, the primary aim was to access the different experiences of a range of staff within the organisation in understanding their social settings (context) and their perception of culture change management. A ‘stratified purposeful’ strategy (Miles and Huberman, 1994, p.28) was considered to be most effective method to recruit the participants in this study. The research participants included senior board executives, managers, and frontline staff representing paramedics, the 999 call handlers and dispatchers working in the Emergency Medical Dispatch Centres (EMDC) from all the three administrative areas of the Delta Ambulance Trust (see table 2). The selected sample helped to illustrate various sub-groups within the organisation and facilitate understanding of the social dynamics underlying the case. The principal inclusion criterion of the research participants was based upon their professional role and their relevance to the aims of this study. To further improve the validity and reliability of the findings, policy experts from the Department of Health (DH) and Audit Commission were also interviewed.

Non-participant observations (see table 3) were conducted at three levels within the organisation: at the corporate level (trust headquarters); area management level (middle executives and managers level); and frontline paramedics and the EMDC staff (micro level). This allowed for an analysis of the interdependence between these organisational dimensions (Currie et al., 2008). At the corporate level, ten open Trust board meetings and internal executive meetings were observed. Four area management team meetings, to understand how these groups were responding to culture change initiatives, were also attended. At the micro-level of frontline staff, operations in the three EMDC control rooms were observed and time was also spent in the ambulance stations, travelling with ambulance crews and in the canteen where managers, junior executives, and frontline staff took breaks. In total, around 100 hours of observation inform this study. Observation was complemented with informal conversations in the ‘corridors’ with staff. Conversations typically related to specific issues observed in meetings and discussion of the context that framed the decision on the matters (Currie et al., 2008).

Table 2: Sampling Strategy for Recruitment of Research Participants

First phase interviews (2007)
Senior board executives (including non-execs) x 17
Managers (including corporate & operational) x 27
Paramedics x 3
EMDC (Control room staff) x 9
Total interviews: 56
Second phase interviews (2008)
Senior board executives (including non-execs) x 6

Managers (corporate & operational) x 5
EMDC (Control room staff) x 1
Professional experts (including Ambulance Trust specialist, Audit Commission) x 4
Total interviews: 16

Table 3: Non-participant observation at Delta ambulance trust

Details of observation and time spent
Executive and trust board meetings (including legacy trusts) x 10 (41 hrs)
Area Performance meetings (managerial) x 4 (11hrs)
EMDC control room visits x 8 (18 hrs)
Ambulance ride-ons & station visits x 6 (19 hrs)
Canteen & small talk (15 hrs)
Total observation: 104 hrs

The evidence of these sources has been triangulated to build a rich understanding of the functioning of the performance framework in one ambulance trust in UK. Such an approach is in conformity with the use of multiple data collection strategies to build the in-depth case and improve the quality of the case study research (Currie et al., 2008; Miles and Huberman, 1994, Yin, 2003).

The interview data were transcribed and the responses to the key themes were analysed repeatedly to further explore the understandings of the culture and the impact of the culture change initiatives. Using the conceptual framework of Harris and Obgonna (2002), the interview analysis informed by observation, helped to highlight prominent and emergent issues which provided a framework for interpretation of the data (Rhodes and Brown, 2005) and content analysis (Boje, 1991; Sayer, 2000; Watson, 2011; Charmaz, 2003). Quotations have been used from the analysis of the interviews unless explicitly attributed to the observation data. Ethical approval for the study was obtained from the local NHS research ethics committee.

Findings and results

Employees of the Delta trust were exposed to the cultural change initiative that was championed by a senior and experienced member of the executive management team. There was no formal internal document/paper within the organisation but interviews with senior executives revealed four key objectives of the culture change programme in the organisation. They included:

1. Developing a more clinically trained workforce by providing clinical leadership and governance aligned to the challenges imposed by Taking Healthcare to the Patient (DH, 2005);
2. Changing the overall attitude and behavioural characteristics of the staff in helping them to engage in evidence based practice;
3. Improving the staff-management relationships in the new organisation to address the concerns of the legacy organisations and staff welfare; and
4. Addressing the current value and beliefs in the organisation to raise the overall profile of the service within the wider NHS.

In dealing with these objectives, senior executives largely viewed this as comprising changes to staff values and behaviours in the light of the challenge posed by the national ambulance review (DH, 2005):

Setting up the medical directorate around clinical performance indicators is perhaps one of the areas which excite me most about being the unfulfilled potential of the ambulance service around its performance area (Senior Board Executive I).

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 and what hasn't happened is the staff. I am not saying they are to blame for this at all, it's partly down to the way the organisations and managers have not necessarily communicated it very well, but what the staff don't take on board is that the Category A 8-minute standard is actually reflective of patient care (Senior Board Executive II).

And one of the things my top team will be talking about at the moment as we sit here, is about how we identify what is good clinical care in a remote rural area, what's good clinical care in a rural area, what's good clinical care in an urban area and how we put together the performance framework clinically which ensures that the clinicians understand where they are in terms of the patch and what is good clinical care where they are. (Senior Board Executive III).

A number of techniques were employed by the senior management team to this effect. Such methods included series of meetings with all staff in all the three areas of the trust; attendance at 'visions and values' workshops; using the staff intranet to promote and publicise the organisation's vision and values statement; communication of espoused beliefs during visits by senior managers; symbolic gestures and actions etc. The desired purpose of the change was the development of culture and was focussed on the direction set out by the government. The strategy for cultural integration adopted by the trust management was designed to change the accountability lines for the area heads directly back to the executive directors. Senior executives argued that it was necessary to set up the new trust with some geographical continuity from the old organisations, so as to ensure the service was delivered without any interruption until the new organisational structures were put in place. 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. Senior members of the executive team were quick to point out the signs of change and how the things were going in the right direction.

Yes I can see signs. We've got senior managers and some middle managers who are beginning to act in a way that we would expect within the new culture. We've got members of staff and members of the trade unions who are at least now talking the language and are debating and discussing the points. There are signs that people even if they don't agree or accept them, at least understand and acknowledge where we're trying to go (Senior Board Executive IV).

Initial interviews with frontline staff including managers revealed some differences with the desired objectives and change strategies. There was a lack of consensus on issues involving management and clinical practices. There was also a perceived grievance about the style and pace of culture change programme undertaken:

We've now got to consider the whole area and we've now been basically told clinically this is what your performance measure should be and what we're measuring against and I don't necessarily think that that is the best way of doing it. I still think that there's quite a lot of this corporate central urban view that seems to be pushed out to everywhere else that I don't think's always appropriate (Senior Manager, Erstwhile Trust II, May 2007).

And later:

I don't think culturally we've changed at all, apart from maybe what we're saying there's maybe a little bit of an understanding there that we've got to believe in what we're saying now where I think there's less negativity there before, so culturally that may be changing but I think we're a long way from changing fundamentally. (Senior Manager, Erstwhile Trust II, June 2008).

Senior managers and experienced staff raised issues of symbolic importance:

I see that we meet with the commissioners on a regular basis and since we've become NWAS in this area, this year, we funded 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 (Manager, Erstwhile Trust IV, December 2007).

There was also no unanimity in respect to improving the clinical training and governance mechanism which was one of the stated objectives of the culture change programme. Staff raised variance in practise across the new organisation:

I think that there are some frustrations amongst the paramedics sometimes that they feel that they are deployed inappropriately for they say that the training is in some way not reflective in way they are asked to do (Senior Area Executive).

I think staff is finding it hard to understand the transition from trade to profession. They don't realise that some of the practices they perhaps got away in the past, they can actually be under an enquiry from the Professional Council for some of these practices (Senior Manager I).

Our study revealed that many of the cultural change objectives cited in the beginning of this section have not been fully achieved. The culture change interventions identified in our study appeared to be 'top-down,' 'invasionary' in approach, with a very hierarchical understanding of how change has to be managed (Diefenbach, 2007, p. 130; Clegg and Walsh, 2004). Furthermore, the desired changes were undermined by perverse consequences that were accepted by the respondents as having slowed or even halted the change programme. Some of these effects, discussed later in the paper, could well be due to lack of understanding of the distinct occupational sub-cultures within the ambulance service and their different assumptions on issues relating to organisational performance and culture (see Wankhade, 2012 for details).

Acknowledging that no change programme can be perfect, it is equally important to document any dysfunctional behaviour arising out of such programmes, so as to minimise the effect of such unintended consequences for the organisation. Using the conceptual model developed by Harris and Obgonna (2002), six unintended consequences of culture management have been documented which are based upon the

four stated culture change initiatives observed during the study and are dealt with at some length, as follows:

Hijacked process

The first issue relates to the extent to which the founding ideals of the change programme were maintained throughout the process of change. The unintended effect of the change centres on the creation of an opportunity to hijack the process of change. The change initiatives began with relatively clear aims and objectives:

I think that high investment in clinical leadership and management is going to be the most important thing that we can do to deliver good performance (Senior Board Executive I, January 2007).

But later:

My biggest challenge is really continuing to keep clinical leadership and management at the top of the agenda. This is because it's going to require effort from the managers; it's going to require change and it's going to require money and none of those things have been mandated by political or local targets (Senior Board Executive I, December 2007).

Recent evidence (Wankhade, 2011; Radcliffe and Heath, 2009) suggests that the issue of clinical education and workforce training in the ambulance service in the UK has been hijacked, to an extent, by the operational exigencies of meeting performance targets. This pertains to the first objectives of the culture change programme discussed earlier in this section. This hypothesis is confirmed by the views expressed by many participants that training and staff development were sacrificed and staff were re-deployed to meet performance targets. The need for a stronger clinical leadership was identified as one of the key recommendations in a recent report published by the Association of Ambulance Chief Executives (AACE, 2011, p.76).

The impact of such interference was either the subversion or camouflaging of the process. As a result the original aims were either lost or downgraded (Harris and O'Connell, 2002, p. 39):

If I'm honest, everyone says training is very important and everyone probably does think it very important. In practice it's sacrificed to meet targets and we've done that here. So, unfortunately, training is one of the first sacrificial lambs when it comes to meeting targets... Convincing colleagues is more difficult. Training staff is easy (Senior Training Manager).

Thus this important facet of the cultural change programme can be subject to the vagaries of operational exigencies, the rationale of which can often be couched in organisational efficiency jargon.

Cultural erosion

The second management action resulting in unintended effects centred on the extent to which the espoused ideals were eroded by subsequent events. In some cases, indications are found of seemingly successful changes in employee behaviour and values in the short term, but such behaviour tended not to persist (Harris and O'Connell, 2002). One of the stated objectives for cultural change was to culturally integrate the four legacy

organisations into the new organisation. However, there were signs that other factors were impinging on the change:

A lot of that happened in the first few months when the chief and other executives were everywhere and I think we've probably covered it too much then and not enough now. I think when he's out and about, people warm to him, and he can easily explain things that people will accept (Senior Executive Erstwhile Trust I).

Well most of the senior executives have shown their face, but they don't get out and see the staff when they come to this building. It's not about coming to HQ and going into control and talking to the control staff. It's being seen out and about so the staff get the understanding and the belief that they've got a team (Senior Manager II Erstwhile Trust IV).

In another example of cultural erosion, it was seen that strengthening the clinical governance capability was also part of the change management programme, but that with the passage of time, management attention was diverted by other equally powerful forces:

I think it's a good opportunity to start afresh... We will bring in a much stronger clinical management structure at an operational level. I will now have the structure to push clinical governance forwards right down to patient level (Clinical Governance Manager, March 2007).

But later:

The lack of clinical governance is still there. There is a clear divide between operational management versus clinical direction. The organisation is still run very operationally (Clinical Governance Manager, June 2008).

In both cases, early changes in line with the official position of increasing the visibility of the senior management team in all areas and of improving the clinical governance structures in the new trust were eroded. Such erosion appeared to be linked to the extent to which the desired change is reinforced and rewarded as well as the degree to which behaviours and values are aligned (Harris and Obgonna, 2002, p. 40). This relates to the second objective discussed at the beginning of this section.

Ivory tower culture change

Unintended consequences also emerge when cultural change initiatives are designed without sufficient awareness of the diversity of views throughout the organisation. One of the stated objectives of the cultural change programme was to upgrade clinical skills and the knowledge of the workforce so that they felt sufficiently confident to make clinical decisions at the scene of emergency:

It's not easy to get the individual to understand what the organisation is about and what their roles are. When you are saying to someone, who may have been working in a factory making a widget, but now is actually going to go out there and save someone's life and meet them at the most vulnerable point in their lives. It's a stark reality (Training Manager).

It appeared that the development of the cultural change plans did not take the organisational reality into account or were incapable of meaningful implementation.

Thus the individuals and groups involved in the planning of the cultural change programme were not fully aware of 'ground realities' ranging from educational and motivational levels through to practices and procedures (Harris and Obgonna, 2002). It was assumed a majority of the staff would be keen to accept the new challenge envisaged by the policy makers. The unintended consequences of the change programme varied with the individuals and the scale of challenge involved in making the 'leap'. For example, two respondents from different occupational groups in the new organisation raised doubts about such high ideals:

We have made paramedics professionals, but that was just a piece of legislation that was passed that protected the title. Historically it's a blue collar service. It's been run similar to the police and fire service – very operationally – and it's about bringing that clinical focus back in to run it as a clinical service as opposed to an operational one. But you've got a huge workforce there that is set in their ways (Senior Area Executive II).

They don't care at the end of the day what those figures say... No they don't really give a monkey because the minute they come here for a 12 hour shift, whether it be a day shift or a night shift it's job, after job, after job (Senior Paramedic I).

The impact of this unintended side-effect of change is that clinical educational and training of the workforce still remains a big cultural challenge for the ambulance service in the UK (Siriwardena, 2010; Snooks *et al.*, 2009). Observations of staff suggest that while the organisation is moving ahead with the clinical training of the workforce, it doesn't necessarily register across the organisation and the canteen culture still plays its part. Thus it is important to involve all members of staff in some level of consultation and organisational analysis prior to the change management process. As such the cultural intervention effort studied in this case remained painfully distant to the desired objectives two and three as discussed earlier.

Inattention to symbolism

A few of the managers and staff interviewed during this study spoke about lack of management understanding of the concerns of other sub-cultures and also their contribution towards the success of the organisation. This relates to the third objective stated earlier in this section. But despite the challenges in developing a new culture, there were a few positive signs emerging in that respect:

I think it is a power issue. They don't seem to accept that there are four services here that have four different ways of working and theirs might not be the best way of looking at things (Senior Manager III Erstwhile Trust I, May 2007).

But later:

I think what has been quite good is the way that the recognition by the trust that things maybe haven't gone as well as they expected. From my point of view there seems to be a little bit of recognition. I think there's a lot more understanding out there and people do seem to be making more of an effort now and that's good because that has eased this corporate area off a bit as well (Senior Manager III Erstwhile Trust I, June 2008).

In contrast, a few of the frontline staff, including the paramedics and EMDC control room staff, frankly admitted their lack of awareness of the changes being carried out

and how they were not bothered about them either. This might not be too surprising (see Willmott, 1996; Beer *et al.*, 1996). One dispatcher argued that he 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 and a few participants were rather 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 I).

Another factor which was peculiar to the given case and having a bearing on the cultural integration in our study was the impact of the merger on different staff. 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 (although after due process of selection) to the new trust. Discussions on outcomes of such power relationships and struggle for supremacy are well documented in the literature (Diefenbach, 2007, p. 135; Walsh, 1995, Humphrey, 2005; Grant *et al.*, 2005). Some respondents who previously worked in the other three legacy trusts referred to the management structure of the Delta Ambulance 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 II).

Another factor which gave some credence to the power issue referred to earlier was the perception of some members of staff that the operational practices, reporting systems and drug protocols followed by the new organisation were largely adapted from the practices followed by the former trust now representing Area I. Thus, by implication, evidence of good practice existing in the then legacy organisations was perceived to be ignored:

We've got some excellent reporting systems here in terms of performance management, better than any of the other areas. When you speak to a couple of assistant directors and executive directors they accept that the reporting systems are better here than anywhere in the (Delta) trust and yet they don't seem to get adopted by the trust. They want us to try and use the Area I model which is flawed and is proven to be flawed at the moment (Senior Manager IV, Area II).

We noticed some further evidence about lack of attention to symbolism during the change management process. Pondy *et al.* (1983) observe that symbols are key components of culture but often get ignored by practitioners, who concentrate only on the layers of culture and miss this important aspect in culture change programmes. Discussions with paramedics and other frontline staff showed how passionate they were about their 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 during change also appeared to have a profound impact on the change process. 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 restructuring. This is not to suggest that the management team showed any discrimination in making new vehicles available to a particular area. However 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 impacting the relations between staff and senior management. As summed by one participant:

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 so in a kind of poor vehicle, poorly trained and poorly motivated staff that would have negative impact on the organisation (Senior Area Executive II).

It thus appears that attempts to bring cultural change in ambulance trusts will need to consider cultural sensitivities of different subcultures within the organisation (Wankhade, 2012). Without the appreciation of this 'symbol dilemma' (Harris and Obgonna, 2002), such an intervention programme may not meet with the expected success. Further research on this issue may improve our understanding of cultural strength and may be helpful in explaining the management of culture in different contexts. A meaningful staff engagement programme was further highlighted in the recent report cited earlier (AACE, 2011) which acknowledged the progress made in the areas of education and training but highlighted the need to engage with the workforce that "by and large feels undervalued and wants more support" (ibid, p. 76).

Ritualisation of culture change

Few of the managers sounded supportive of the concerns of the frontline staff and spoke of different challenges due to moving to the new, centred approach. Issues relating to increased workload, delays in decision-making, lack of new vehicles, absence of direction from the centre, and non-availability of senior executives in the areas, were some of the things mentioned in this regard in relation to the third stated objective of the culture change initiative:

I haven't up to now seen a great deal of encouraging signs that things are really moving on and improving. I'm normally one of those people who will say, "Well

look, you know these things take time to settle down guys, give it time and be reasonable.” A lot of my colleagues just think it’s awful, absolutely awful, but it is sometimes difficult to stay out of their negative views because there hasn’t been a great deal to shout about (Senior Area Manager VI).

Some support of the views expressed by the manager above came from a junior executive who called for greater visibility of the senior executives and talked about tensions between local practices and the corporate centre:

I think it’s a horrible feeling that this is a faceless organisation and that the people who are making decisions clinically and making some quite unpopular decisions are never around to speak to (Senior Area Executive III).

Some respondents blamed poor communications in the new bigger organisation for not getting the right message across. Communication in the chosen organisation was a function of the Corporate Communication team, the head of which worked directly under the chief executive but without a vote in the trust board:

I think we’ve 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 (Senior Communication Manager).

However some participants highlighted peculiarities of the ambulance culture and how it impacts on any cultural change programme:

I don’t think it really matters whether you live in area I or II or III; there are different variations on culture but it is still an ambulance culture. I am being realistic and it is very unionized making it much more difficult to make changes (Senior Corporate Manager II).

One expert agreed to the above assessment of the Delta ambulance trust staff

There have been a lot of arguments, national appeals about meal breaks, grading and things like that, but it has revealed, I think, something more fundamental. There is a certain conservatism, a certain unwillingness to change. You can’t push anybody to be flexible and adaptable so far. Sooner or later they step back to what they are familiar with (Ambulance trust specialist, Audit Commission).

Senior executives were quick to dispel this perception on the part of some of the staff and emphasised that only the best people were appointed in the new organisation, with merit being the sole criterion for their appointment. The exact truth may be difficult to ascertain and some of it can be traced to the vagaries of human nature and the individual’s role in the new organisation. Interestingly, performance in Area I started to dip whilst other areas tried to catch up during the first seven months of 2008. In its own peculiar way this factor helped to ease out some of those feelings. One executive summed it up quite well:

I think there’s been some interesting dynamics being developed because of what was seen as an Area I takeover. I think it is still being viewed as that in big chunks of the organisation. But increasingly we’re seeing people from other areas say well actually we are better than that (Senior Area Executive, Area III).

Our study revealed that employee response to change differed widely, depending on the enthusiasm of individuals to participate in or implement espoused changes and the strength of the existing subcultures to which they belonged (Sackman, 2002; Wankhade, 2012) thus impacting the staff-management relationships. Assumptions of the subcultures were also guided by the functional groupings, trade union membership (a real issue for the ambulance service), length and terms of working in the service, individual loss/gain due to restructuring or a combination of all these issues. Evidence presented here suggests the potential impact of the strength of each sub-culture as a crucial factor in changing the culture in the ambulance service. This is supported in the literature as one of the reasons for the failure of organisational change initiatives (see Sathe, 1983, who describes it as ‘thickness’; and Schall, 1983, who refers to strength as ‘congruence’).

Behavioural compliance

The final unintended outcome documented in our study is related to behavioural compliance in relation to the fourth stated objective mentioned earlier in this section. Harris and Obgonna (2002) note that many culture interventions fail in their objective of value change but do influence the behaviours of organisational members. In our study, the designers of the change were quite explicit in their long-term aim of changing the values, opinions and beliefs of the employees. For instance:

We don't want to merge the four previous cultures into the new one; we want to create a whole new culture that actually doesn't take on any of the baggage from the four previous ones (Senior Board Executive IV).

I think what we actually need to do is we need a take a non-professional blue collar workforce and migrate it into being a professional workforce (Senior Board Executive V).

Mixed evidence was reported in the study as to whether real managed value change emerged. This is not to suggest that beliefs and values remained constant or there was no impact of the efforts to bring about culture change. It appeared though that any observed change in values was evolutionary rather than the result of management initiative. On the surface, it would appear that senior managers were quite optimistic about change:

We are now in that stage and we have to move to the next level making that change happen (Senior Area Executive IV).

But interviews with frontline staff revealed a somewhat different viewpoint. Concerns were expressed about tensions arising due to uncertainty and confusion regarding structures and roles; the corporate centre versus local identity issue; the challenge of convincing staff that this was a merger and not a takeover; and the recognition that corporate challenge exists rather than pretending it does not. But there was also a growing recognition, especially during the second year of the new trust that things needed to be done differently in light of the policy initiatives and the management response towards such changes. Some respondents agreed a change was warranted:

Those of who I would have classed as disinterested have taken an interest and have suggested, “Oh we'll have a go at that because that's the future. That's the way we want to go (Senior paramedic II).

We are accepting that we have to do things differently... You know when you get your head around it and you think, 'Yeah okay' then I accept that I've had to change as well (Senior Area Manager VII).

Behaviour compliance is a well-documented phenomenon in the literature (Legge, 1994; Obgonna and Wilkinson, 1990). Our evidence suggests that the unintended effects of behavioural compliance by staff can overshadow the expectations of value change during a culture change programme. A mixed picture thus emerged about the impact of the fourth change objective, varying with the levels of individual engagement, length of service, prior contact with the senior management team and impact on individual roles.

Discussion and analysis

It is worth emphasizing the context of the study, that a change in culture was sought at a time of major reorganisation involving merger of four trusts into one, and is a critical factor in the negative consequences described in this study.

Since their re-organisation in 2006, NHS ambulance trusts in England are witnessing a process of culture change in the light of the new direction of travel envisaged by policy makers (NHS Confederation, 2008; National Audit Office, 2010). The increasing importance given by the government to bringing cultural change to the NHS shows the relevance of the evidence presented in this paper, highlighting some of the issues concerning cultural change in one large ambulance trust in England. Findings discussed in this paper bring empirical evidence from a systematic exploration and description of a range of perverse and unintended consequences of culture initiatives in an emergency health service in the UK, helping to address a clear research gap. The difficulties in conceptualizing culture change have been discussed earlier in the paper. Our study has documented several perverse consequences of the culture change objectives in a large ambulance trust in England. These findings shed additional light on the ongoing debates about culture interventions being seen as a "continuum" in which the extent of planned change is gauged in different shades rather than in definitive terms (Harris and Obgonna, 2002, p. 45; Alvesson, 2002). These findings have brought out the impact of the cultural interventions not only on the frontline staff, but also on the managers who were subjected to change and who are also prone to unpredictable consequences – a theme we identify as currently 'under-studied' (Balogun and Johnson, 2004).

A central implication from these findings is that any meaningful evaluation of culture change initiatives (like the success of the performance framework) should be considered not only in relation to the achievement of pre-planned objectives but also by dysfunctional effects of such change initiatives. These findings have further implications for the organisational 'culture-performance' debate, which is relevant for understanding the link between organisational performance and organisational culture (Mannion *et al.*, 2005). The weakness of the empirical evidence suggesting links between the two has been raised before. Harris and Obgonna (2002, p. 46) argue that "where evidence of a culture-performance link is found, it seems likely that either the unexpected effects of culture change were positive or that the negative effects were negligible or minimized by astute management. Where no link is found, the moderating effect of negative unintended consequences is likely to have been especially profound." We tend to support this hypothesis.

It is worthwhile noting some of the limitations of this analysis. We do not intend to generalise these case study findings. Though Eisenhardt's (1989) view is that more than four cases are desirable, Dyer and Wilkins (1991) cite some of the more important single case studies that have advanced the knowledge of organisations. Thus we provide a thick description of the settings, so that readers are better able to assess how well our findings may apply in other contexts (Wilkins, 1984; Lincon and Guba, 1985).

The importance of timing is crucial in studies of organisational culture. Although this study was carried out over a period of two years, it is emphasised that any culture change is a dynamic process and it could have different effects over time (Jackson, 1997). Another limitation of these findings relates to the diversity of existing perspectives on culture change (Pettigrew *et al.*, 2001). Any finding of no culture change could be an artefact or overemphasis on pervasive side effects, whilst any evidence of culture change can be attributed to the actual experience of the participants (and researchers) of weak unintended effects (Harris and Obgonna, 2002). Further research into the perverse (and unintended) consequences of culture change initiatives in different ambulance settings will uncover additional insights into the nature and dynamics of these changes.

Conclusion

We have argued in this paper that existing and past efforts on the part of the ambulance service to fully integrate within the wider NHS have been hindered by the confusion which still prevails within its members about the core value and mission of the service (NHS Confederation, 2011, 2011a). Being part of the NHS, ambulance services have made a huge progress towards their transformation from a patient transport organisation to a clinically trained workforce in the last ten years (NAO, 2010; DH, 2005). The historical perception of judging them as a health arm of the emergency services as opposed to the emergency arm of the health service has changed considerably but the need to create organisations that 'look, feel, behave and deliver differently' is still being debated by the ambulance chiefs (AACE, 2011, p. 77). Issues surrounding the cultural transformation of the service into a professional clinical workforce form an ongoing agenda for current debates (Cooke, 2011; Wankhade, 2011a).

There are several policy and practice implications from this study. One central implication from our findings is that any meaningful evaluation of culture change initiatives should be seen not only in relation to the success of the planned objectives, but also registering the perverse consequences of culture change programmes. Thus, it would be important to have meaningful results for efforts to bring about cultural change along with structural and procedural reforms. There is a case for a systematic identification and evaluation of such effects during the planning stage, as well as during and after the culture change initiatives by individual organisations (Hatch, 1993). Given the profound nature of these perverse consequences, it would be useful for the organisation to develop realistic expectations regarding the consequences of cultural change. The evidence cited in the paper is specific to an English ambulance setting but there is a value in the lesson drawn from this study for future attempts at culture change in other ambulance trusts and potentially other healthcare organisations including international settings. Further research will be valuable to test the generalisability of these findings.

We thus argue that any worthwhile study of organisational culture change management must take into account the perverse consequences of such a process, the preparation and implementation experience along with its overall impact on the employees. Within complex and dynamic environments such as the NHS, issues

pertaining to performance measurement might also be better understood with reference to organisational sub-cultures (Wankhade, 2012). By examining and observing the diverse and often conflicting cultural perceptions, values and practices of different sub-cultures in a given organisation, implications for culture change initiatives can also be considered. In conclusion we agree with Alvesson (2002, p. 186) that “culture change calls for receptiveness amongst the collective for new ideas, values and meaning and without such an openness, radical, intentional cultural change is very difficult.”

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