Re-Imagining Ambulance Services through Participation and Deliberation

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ABSTRACT

Purpose

This chapter identifies the serious issues of mental health and wellbeing of English paramedics working in the emergency ambulance service. It identifies the case of top-down performance measures and absence of indicators of wellbeing in ambulance performance reporting. It also documents the impact of such measures on frontline staff and its implications for their motivation and commitment. The chapter advocates a more decentralised, open and discursive approaches on performance management packages in the public sector, as key methods, for re-imagining the ambulance and wider public services in a global context.

Design/Method

The chapter first provides the context of the English ambulance service and the challenges it faces within the context of the New Public Management (NPM) and New Public Governance (NPG) literature. Key issues concerning performance metrics and staff wellbeing and welfare are identified and discussed. The notions of communicative rationality, deliberative democracy and agonistic pluralism are then introduced as a framework for analyses of the state of both wellbeing and resilience and the performance regime within the English ambulance service. The chapter then integrates the themes to the re-imagining of public services discourse internationally, suggesting a more participative approach.

Findings

We have been arguing for inclusion of the wellbeing of the healthcare provider, as well as the public service recipient in the evaluation of public services. The chapter makes a case for a greater participative and dialogic engagement to address the intertwined relationship of ambulance staff wellbeing within the performance management regime of the service. We re-imagine the process to take into account the wellbeing of ambulance staff as an integral and intrinsic part of the delivery of a service and that deliberative methods of participation are deployed in the reimagining of ambulance services and the public services more generally.

Originality

The challenges facing ambulance services and more generally the health services globally continue to proliferate and intensify, and are exacerbated by foreseeable contextual challenge such as the demographic profile of patients and service users and budgetary cuts. Traditional and more recent NPM approaches are proving inadequate for this challenge and appear unsustainable in practice. The lack of acknowledgement of welfare indicators in the performance metrics will make them not fit-for-purpose. Our suggested approach will help to re-imagine the service by improving the sustainability and resilience of the service in parallel with the improved wellbeing and personal resilience of the people who provide the service.

Key Words

deliberative democracy; agonistic pluralism; ambulance services, wellbeing, performance management ; reimagining performance management systems, public values, sustainability and resilience

1. Introduction

In this chapter, we identify the serious issue of paramedics' wellbeing in the English emergency ambulance service and provide some relevant evidence. It is then argued that the salience of the issue could be raised by including indicators of wellbeing in performance reporting. However, previous experience of imposed, top-down performance measures in the ambulance service suggests they meet resistance and fail to achieve commitment from staff. Therefore, theories of deliberative democracy and agonistic pluralism are explored and more participative and dialogic methods of re-imagining the performance management package are advocated.

Moreover, we suggest that addressing these issues in one of the UK's national ambulance services could act as an exemplar for re-imagining public services internationally; as the fundamental issue of centralised decision-making and imposed performance measures versus more decentralised, open and discursive approaches is relevant to such services generally. In this regard, our stance is consistent with international texts on performance management in the public sector, such as de Bruijn (2002), who holds that interaction between managers and professionals is a main design principle for performance management systems, and Van Dooren et al. (2015), who propose performance management across the public sector should become more agile and closer to the action.

The chapter proceeds as follows. Section two describes the context of the English ambulance service and the challenges it faces; then links these to the concepts of New Public Management (NPM) and New Public Governance (NPG). Section three explores deliberative democracy and agonistic pluralism as a framework for analyses of the state of both wellbeing and resilience and the performance regime within the English ambulance service, which form the next two sections. This is followed by discussion integrating the themes of the chapter and relating them to the re-imagining of public services internationally, with some concluding remarks.

2. Context and Challenges facing English Ambulance Services

English Emergency Ambulance Service

Ambulance services act as a first point of contact in most health services, often dealing with urgent and emergency calls as part of pre-hospital care networks. In England there are ten National Health Service (NHS) ambulance trusts and along with one each in Wales, Scotland and Northern Ireland, they deal with over 12 million 999 calls every year. Structured regionally, these thirteen services cover sizeable geographical areas and employ over 33,000 full-time employees. The College of Paramedics acts as the professional body for paramedics, supporting the clinical practice and professional standards of its members (Association of Ambulance Chief Executives AACE, 2020).

Although ambulance services play an important role within the urgent and emergency healthcare network, their contribution is under-appreciated and public perception of a patient transport service

still persists in some quarters (National Audit Office, NAO 2011; 2017). When the NHS was established in 1948 "...ambulances provided the most basic of facilities for patients… in a vehicle which was a converted van and driven by a man with only a first-aid certificate and a clean driving licence" (Pollock, 2015, p. 24). Ambulance services have made huge progress, particularly over the past decade, towards becoming professional pre-hospital care providers. However, several challenges threaten this process and these need to be addressed in re-imagining ambulance services.

Challenges facing the service

These challenges include: the role of the performance management regime (Heath et al., 2018); an assumed heroic style of leadership with an associated command and control culture (Wankhade et al., 2018); high levels of mental health illness, sickness absence, presenteeism, and poor wellbeing of staff (Heath et al., 2021); and slow progress in the use of technology to share patient information with hospitals. The COVID-19 pandemic, over the last two years, is having a considerable impact on the operational capacity and resilience of staff (Greenberg et al., 2020; Lawn et al., 2020). Moreover, this impact is on a service which was already experiencing substantial deterioration in resourcing due to the UK government's austerity policies since 2010 and growing emergency 999 call demand, which is associated with continuing demographic trends, such as the increasing proportion of elderly people in the population (NAO, 2017; Granter et al., 2019; Wankhade et al., 2020).

The additional issue of interoperability presents an interesting dilemma to ambulance leaders. Less than 10% of 999 calls pertain to life threatening situations and less than 50% of journeys to hospitals result in admissions (Wankhade et al., 2020). Consequently, national and local NHS leadership now perceives ambulance services less as a 'blue light' service (with fire and police) and increasingly as a pre-hospital care provider and an integral part of the urgent and emergency care network. However, there are situations where interoperability remains essential and the three 'blue light' services "need to re-engage at both a national and local level" (Stephenson 2015, p.107).

A detailed analysis of all of these issues is beyond the scope of this chapter and instead we shall focus on two of them, namely the role of performance targets and the psychosocial wellbeing of ambulance staff, both of which have the potential to derail the reforms and progress achieved so far. Rather than providing precise and definitive prescriptions, we suggest solutions might best emerge from increased participation and greater deliberation by stakeholders. In this way, we present the case of the English emergency ambulance service as an example of how public services could be re-imagined which is relevant to an international audience. This contrasts with the top-down imposition of performance measures *a la* NPM which has characterised the service.

New Public Management and New Public Governance

Pollitt and Bouckaert (2000) neatly summarise the characteristics of NPM into '4Ms':

- **Minimisation** of the state through privatisation and outsourcing;
- **Maintenance** of tight controls on public spending;

- **Modernisation** of public services through the adoption of private sector management practices;
- **Marketisation** of public services through contracts (often in quasi-markets).

NPM is a technocratic approach which incorporates both marketisation and managerialism while reinforcing bureaucracy (Gregory, 2007). There are many different definitions of the NPM, it was not adopted universally and there are significant differences in emphasis where it has been taken up (Christensen and Lægreid, 2007). It is based on contradictory conceptual frameworks (Aucoin, 1990) and favours managerial over democratic reforms, privileging efficiency over equity (or effectiveness) and contrasting with the political and social ambiguity which characterises public sector organisations (Gregory, 2007).

Some political scientists have claimed that the NPM has been superseded by the NPG, which is said to better reflect the pluralistic nature of modern societies (Christensen and Lægreid, 2007; Osborne, 2010); although here too there are many contradictory definitions. NPG is often taken to imply networks of stakeholders or citizens working together to determine and/or deliver public policies. Governance networks can facilitate collaborations between citizens and managers of public services, although networks of elite stakeholders may disregard the interests of the wider citizenry. Networks may also encounter difficulties around power, trust, co-ordination and accountability (Liddle, 2018). Nevertheless, and significantly, NPG can potentially offer scope for participative and discursive approaches (Lynn, 2010).

3. Communicative Rationality, Deliberative Democracy and Agonistic Pluralism

Communicative Rationality

The concept of *communicative rationality* emerged from the multiple crises of the state in the 1970s. At that time, a fiscal crisis of the state was identified, following the 'long boom' in 'western' economies after the Second World War and its sudden demise; when a number of shocks, most notably oil price rises, impaired the ability of welfare states to fund public spending (O'Connor 1973). Habermas (1976) diagnosed four related crises: the fiscal crisis; a crisis of rationality; a crisis of legitimacy; and a crisis of motivation. Under fiscal stress, piecemeal instrumentally rational solutions to apparently discrete problems are no longer as effective.

The route out of the quadruple crises is either a slow transformation of the social order by participation and deliberation or a government combining economic liberalism and political authoritarianism (Held, 1987). The latter may be identified with *neo-liberalism* which is "… a theory of political economic practices that propose that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong property rights, free markets and free trade" (Harvey, 2005). NPM can then be seen as a neo-liberal and instrumentally rational response to the crises.

However, as Held suggests there is an alternative. Habermas regards instrumental rationality as unhelpfully separating competitive markets, hierarchical bureaucracies and public policy from the everyday world (Schipper, 1996) and advocates establishing a public realm where matters of general interest can be discussed and differences of opinion settled by sustained argument (Held, 1987). In open debate, priorities for collective action can be set through collaboration, reflection and reciprocity (Healey, 1997). This is the logic of communicative rationality.

Deliberative Democracy

Notions of *Deliberative Democracy* have been developed out of the communicative rationality concept, whereby the common interest emerges through discourse and debate; thus reconciling rationality and legitimacy in collective decision-making through an appropriate public process of deliberation (Benhabib, 1996a). For Benhabib (1996a), the deliberative model is proceduralist, recognises both conflicts of values and conflicts of interests and privileges a plurality of modes of association. Similarly, Dryzek (2000) contends that the essence of democratic legitimacy lies in the opportunity and ability of all individuals subject to a collective decision to participate in authentic and effective deliberation about that decision.

The concept of the *Ideal Speech Situation*, in which decisions are reached through dialogue without coercion may be related to communicative rationality (Pallerm, 2000). Here decisions are made on the basis of consensus arrived at through reasoned argument alone. Consensus, in this sense, requires a very high level of agreement; not just accepting a decision but also the reasons for that decision. From this point of view, even voting to short circuit debate is seen as coercive. This position can be criticised for 'assuming away' power and hegemony and for assuming that there *is* a common interest, which will emerge via dialogue and consensus (Pallerm, 2000).

Curato et al. (2017) argue that some advocates of deliberative democracy are nuanced rather than naive about power. For example, Mansbridge held that it is unhelpful to set reasoned persuasion against power (which is identified with coercion) in democratic life. Instead, democracies must have both, as different material interests and competing values may be irreconcilable. Therefore, equal voting where each participant is regarded as being of equal worth is acceptable (Mansbridge, 1996). Hendriks (2009) adds to this by distinguishing between 'power-over' and 'power-with'/'power-to'. 'Power-over' refers to situations where the powerful exert domination over the powerless. Power in this sense is clearly inconsistent with authentic deliberation. 'Power-with' or 'power-to' develops through communal activity and seeks empowerment rather than domination. Deliberative forums can promote 'power-with' through communication, especially when trust is built up over time (Hendriks, 2009).

Habermas came relatively late to developing a theory of deliberative democracy (Dryzek, 2000). Initially, for communicative rationality, especially in "its counterfactual extreme of the 'ideal speech situation'" (Dryzek, 2000 p.24), the only force to count was "the force of the better argument" (Elster, 1998, p.103). Habermas's eventual conception of deliberative democracy recognised the pluralistic complexity of the modern world and was more concerned with how the communicative practices of

civil society could influence the legislative and policy processes of the state (Dryzek, 2000). Dryzek then criticises this position for its emphasis on laws, constitutions and voting, rather than the further democratising the administration or economy; as more critical proponents of deliberative democracy would advocate.

Critique of Deliberative Democracy

Benhabib (1996a, p. 74) notes that 'institutionalists' may "consider the discourse model to be hopelessly naive, maybe even dangerous, in its seemingly plebiscitary and anti-institutionalist implications…". They argue that complex and highly differentiated modern societies cannot be organised along deliberative lines. However, Benhabib cites attempts to investigate the institutional possibilities of public deliberation against this. More recent studies illustrate the variety of ways in which such initiatives can indeed be implemented successfully (Curato et al., 2017).

According to rational choice theory, individuals act out of self-interest, acquire an optimal amount of information and their preferences are not open to change through debate. Sen (2009, p.179) argues, however, that individuals have good reasons to act on values broader than narrow self-interest and the assumptions of RCT "reflect an extremely limited understanding of reason and rationality". Moreover, as Benhabib contends, "... the formation of coherent preferences cannot precede deliberation; it can only succeed it" (Benhabib, 1996a, p. 71). Similarly, Dryzek (2000) argues that preference change is not only possible, but that values like equality, integrity, reciprocity and accountability, which support rational decision-making, are best learned through debate and deliberation.

Difference democrats and accommodationist models of democracy stress the need for democratic politics to recognise the legitimacy of the perspectives of historically oppressed groups. They oppose, therefore, what are seen as the ostensibly neutral rationalistic practices in deliberative democracy (Benhabib, 1996a; Dryzek, 2000). These are said to assimilate and/or marginalise minority groups, favour the articulate and well educated and, therefore, discriminate against the oppressed; thus disregarding the pluralist nature of modern societies (Young, 1996). Some supporters of deliberative democracy require certain kinds of speech (i.e. 'reasoned argument'), but other forms of communication are favoured by difference democrats, including "greeting, rhetoric and storytelling" (Young, 1996, p. 129).

Dryzek argues that deliberative democracy can acknowledge plurality and that authentic deliberation exists if communication leads to reflection on preferences in a non-coercive way. If so, a variety of ways of communicating can be accepted. Curato et al. (2017, p. 5) believe that deliberative democrats "have conditionally embraced greeting, rhetoric, humor, testimonies, storytelling, and other sorts of communication". Similarly, it is increasingly accepted that 'strong sense' consensus is unnecessary in practice. Instead there may be workable agreements where different participants accept an agreed course of action for different reasons, as long as these reasons have received deliberative scrutiny (Dryzek, 2000). The charge raised against both deliberative and difference democrats, that they have no mechanism for arriving at collective choice and decision-making, may be addressed practically through bargaining or voting following rational debate. Curato et al. (2017) claim

that some of the controversies around deliberative democracy, such as these, should be set to rest now because "the practical uptake of deliberative ideas in political innovation provides a rich source of lessons from experience" (p.2).

Agonistic Pluralism and Deliberative Democracy

Mouffe (1999), regards the aims of deliberative democracy as commendable in that questions of morality and justice are held to be the central issue of politics. However, she argues that deliberative democracy omits the political dimension; leaving no place for politicians and politics. Moreover, the Ideal Speech Situation is invalid because, without some constraints on public deliberation, no communication could ever take place and there needs to be an authority to enforce the rules of debate. Instead, the ineradicable nature of conflict, power, hegemony and passion must be acknowledged and forms of authority devised which are compatible with democratic values. She thus advocates *agonistic pluralism* which recognises that antagonism is inherent in all human society but conflict is contained by the exercise of legitimate power. Democracy needs clearly differentiated positions, dissent and choice between real alternatives. Mouffe (1999) claims this is more receptive to a pluralist society than deliberative democracy.

Agonistic pluralism is admirably anti-utopian and recognises the role of conflict, power and emotion in decision-making, but downplays the consent and co-operation that also characterise organisations and polities. Kapoor (2002) argues that Mouffe's unwillingness to adopt some form of communicative rationality leaves unresolved the question of how to adjudicate between competing 'pluralisms'. Recently, Mouffe stated that agonism is not antagonism and adversaries are legitimate opponents within "the conflictual consensus that constitutes the basis of a pluralist democracy" (2018, p.91). She proposes "a combination of different forms of democratic participation" where "direct forms of democracy might be suitable in some cases and a variety of participative ones in others… in conjunction with representative institutions" (Mouffe, 2018, p. 69). As we have seen, there are versions of deliberative democracy which do not seem too far from this.

Indeed, deliberative democracy "comes in many shapes and sizes" (Hendriks, 2009, p.175) and there has been increased use of different kinds of deliberative processes by governments and others since the 1990s. Public deliberation takes place in many ways in many venues with different modes of discourse being variously appropriate. Moreover, 'deliberative pluralism' (p.176) recognises not only that there are different forms of deliberation, but that other forms of decision-making are sometimes more appropriate, because research shows deliberation does better in certain procedural conditions and contexts than in others.

4. Wellbeing of Ambulance staff

Staff wellbeing

The impact on paramedics of heavy workloads, emotional and physical trauma and associated issues around post-traumatic stress disorder (PTSD), mental health, wellbeing and welfare of ambulance

staff is notable. Concerns have also been expressed about the stringent performance management regime, the role of response time targets, the intensity of ambulance work and its impact on individual and organisational resilience (Granter et al., 2019; Wankhade et al., 2020). In their case study of two ambulance trusts, Manolchev and Lewis (2021) found that efficiency targets, increased job demands and reduced resources contributed to increased claims of bullying and harassment, while reducing staff resilience and wellbeing.

Ambulance services consistently have the highest sickness absence rates amongst NHS organisations in England (NHS Digital, 2020) and there is a reported 10% shortage of ambulance paramedics nationally (NAO, 2017). The issue of 'presenteeism' (staff reporting to work while being sick) is also widespread within healthcare settings (CIPD, 2019).The preparedness of staff to deal with traumatic events, including threats of physical assault and abuse (Furness et al., 2020) and the level of support available to frontline crews (Nelson, 2020) are problematic. Furness et al. (2020) highlight the cultural valuing of a 'stoical devotion to duty' as exacerbating the situation.

The NHS Staff Survey (2020) showed ambulance services performing worse than the NHS as a whole in numerous aspects of wellbeing. These include the proportion of staff who said that their trust "definitely" takes positive action on health and wellbeing; who would recommend their organisation as a place of work; and who said that the team they work in often meets to discuss its effectiveness. Staff working at ambulance trusts experienced bullying, harassment and abuse from members of the public on a significantly higher scale than the national average, as did those reporting physical violence.

Effects of the COVID 19 Pandemic

COVID-19 has severely tested the mental and physical resilience of ambulance staff around the world. Some recent accounts have shown vividly how the cumulative effect of lack of personal protective equipment, sickness, and death of colleagues resulted into heightened levels of emotional distress and anxiety (Lawn et al., 2020; Nelson, et al., 2020; Heath et al., 2021). This unprecedented situation resulted in increased risk of 'moral injury' severely impacting the psychosocial wellbeing of ambulance personnel (Greenberg et al., 2020).

During 2019-20, NHS ambulance trusts in the UK received a total of 12.4 million contacts to their Emergency Operations Centres (EOC), which included 9.2 million 999 calls resulting in 8.2 million face-to face incidents (Association of Ambulance Chief Executives, AACE, 2020:7). Inevitably, a higher proportion of paramedics worked on a Covid-19 specific area than clinical staff generally and a lower proportion worked remotely/from home. This has undoubtedly exacerbated the already disturbing situation described above and has been described by ambulance staff as a 'journey of personal and professional emotions' (Wankhade, 2021).

Management and Policy Implications

Consequently, protecting the emotional and psychological wellbeing and resilience of staff, including the increased risks of psychological distress or 'moral injury' to frontline staff, should be a key organisational priority (Greenberg et al., 2020). Building systems and networks to support staff resilience has been identified across global systems as an important ingredient in supporting staff wellbeing (Santarone et al., 2020). Organisational and professional support, including training for ambulance staff and managers, within a nurturing organisational culture is needed (Wankhade et al., 2018) and this has been one of the most important lessons taken from the fight against the global pandemic (College of Paramedics, 2020; Wild et al., 2020).

Incorporating measures of staff wellbeing and resilience into the official English ambulance 'dashboard' of performance indicators would raise the salience of these issues. Thus, the authors have proposed the development of "wellbeing scorecards, including narrative as well as numerical accounting" (Heath et al., 2021, p.8). A question which then arises is how participative can, and should, the process of developing such indicators be.

5. Paramedic Roles, Performance Indicators and the Ambulance Service

Previous Performance Management Regime

Traditionally the role of emergency ambulance staff was seen solely as transporting patients rapidly to hospital Accident and Emergency (A&E) units, with response time targets used to measure ambulance performance: the key measure in England being the 8-minute response time target for patients with life threatening conditions (Heath et al., 2018). However, more recently, it has been policy and practice to promote an enhanced role for paramedical activities at the scene, in terms of providing care and giving advice, drawing on a wider range of skills, experience and expertise, and to reduce significantly the number of patients taken to A&E departments by ambulance crews (Wankhade et al., 2020). This was accompanied by growing recognition of their contribution to the urgent and emergency care agenda in several official publications (NAO, 2011; 2017; Carter, 2018). Consequently, the clinical education and training of staff has been transformed over the past decade, culminating in a university-level entry qualification for paramedics (Newton and Harris, 2015).

However, the performance management regime, which before 2010 concerned only response times, conflicted with this change (Heath et al., 2018), as did the prevailing culture within ambulance services (Wankhade et al., 2018). Moreover, the narrow range of indicators became notorious for enabling gaming, as the regime fell into many of the pitfalls identified in the literature regarding the potential of some performance measures to promote dysfunctional behaviour (Bevan and Hood, 2006; Wankhade, 2011; Heath et al., 2018).

Current Regime

Consequently, a wider range of 'clinical' quality indicators for ambulance services, which became known as the dashboard, was introduced in 2011. The new approach was generally welcomed, but concerns persisted that some indicators, most notably response times, would be stressed at the expense of others. Cultural resistance to the imposed nature of the approach was also anticipated

(Heath et al., 2018; Wankhade et al., 2018). The NAO supported the broader performance regime but cautioned that improvements to the whole urgent and emergency care system depended on it working more coherently (NAO, 2011). In its follow-up report in 2017, the NAO highlighted the potential financial benefits of new models of care, but also expressed concerns about "continuing variations in operational and financial performance" (NAO, 2017, p.10) and suggested that "commissioners, regulators and providers still place too much focus on meeting response times" (p.8), even though the additional performance measures had been introduced. The Ambulance Response Programme (ARP), rolled out nationally in 2017, did give ambulance staff more time to assess 999 calls, so that patients could get the right care response first time (Turner et al., 2017). However, the extent to which ambulance trusts have shifted their attention beyond the narrow concern with numbers of call outs, rapid responses and transportations to A&E identified by Radcliffe and Heath (2009) over a decade ago, is perhaps less than might have been expected.

Notwithstanding the efforts to refine the performance regime, ambulance services are grappling with ever increasing 999 call activity and have been struggling to meet these new standards (Nuffield Trust, 2021). Moreover, the impact of the Covid-19 pandemic has severely tested the resilience and response capability of ambulance staff, further jeopardising the progress achieved so far.

5. Discussion

Earlier in the chapter a number of issues, which are expected to challenge ambulance services in the future were set out. (No doubt other matters will take us by surprise.) In this chapter we have chosen to focus on the intertwined issues of wellbeing and performance management. The case for addressing the serious and increasing concerns around ambulance staff wellbeing has been clearly established. Absence, sickness and vacancy rates, together with allegations of discrimination, bullying and harassment, all provide evidence of poor physical and mental health and low self-esteem and morale amongst paramedics (Heath et al., 2021).

It was also suggested that the salience of issues around staff wellbeing could be enhanced by including appropriate indicators in the ambulance service dashboard or by developing wellbeing scorecards, which could be published separately. However, in order to facilitate this, it seems desirable to involve a wide range of stakeholders (e.g. ambulance professionals, service users and representatives of the community) as well as managers, politicians and experts. Furthermore, it is suggested that these matters should be resolved via processes involving participation, dialogue and transparency. Previous reforms of the ambulance service, whilst welcome in themselves, have lacked such a transparent process and, as a result, the imposed, top-down regimes have failed to achieve commitment from ambulance service staff (Heath et al., 2018; Wankhade et al., 2018).

A theoretical discussion has been presented, which advocates the need to develop participative and dialogical approaches to decision-making, while acknowledging the agonistic nature of political life. Thus, it is recognised that participants in decision-making have different and potentially clashing views, interests and values; but it is held that they can still come together to reach agreed decisions through communication and debate in appropriate circumstances. The position taken here on par-

ticipation and deliberation is in line with Benhabib's contention that it is desirable to adopt "a deliberative vision of democratic politics which can also do justice to the agonistic spirit of democracy so well-articulated by its defenders" (Benhabib, 1996b, p.9). It is also compatible with 'deliberative pluralism' (Hendriks, 2009) and allows for a mix of representative and participatory democracy within decentralised polities as advocated by Pont (2004). However, the nature of that mix and the form of participation and deliberation may vary according to contingency and, ideally, would be shaped by the participants.

Thus, the appropriate scope and degree of participation can differ significantly. Experiments with participatory democracy, internationally, in Porto Alegre (Brazil), Kerala (India) and elsewhere, demonstrate empirically the viability of institutions combining representative and deliberative democracy. In Participatory Budgeting (PB), local populations, not local government professionals or councillors, draw up the priorities for the municipal budget and review subsequent achievement. PB can be intensive in terms of the degree of participation, therefore, while encompassing both discursive and representative approaches (Passos Cordeiro, 2004). Since it was introduced in Porto Alegre in 1986, PB has spread, first in South America and then to other parts of the world (Cabannes, 2004; Cabannes and Lipietz, 2018; Sintomer et al., 2013); often leading to improvements in governance and service delivery (Cabannes, 2015). However, it was introduced into a specific context in Brazil and the approach has varied as it has been adopted more widely (Cabannes and Lipietz, 2018; Sintomer et al., 2008; Sintomer et al., 2013).

At other times and in other places, suitable approaches may be closer to consultation or somewhere in between. Skelcher et al. (2005, p. 579), for example, hold that "particular manifestations" of participatory democracy "include a variety of collective decision-making forums such as citizens' juries, community forums and neighbourhood committees". Similarly, Dent and Pahor (2015) present varied examples of patient and public involvement or engagement in health care. There are many mechanisms for facilitating successful participation; but, of course, at times they may be ineffectual or inauthentic. For example, there is a risk that patient involvement forums could be used "to legitimise policies rather than engage in participative decision making" (Dent and Pahor, 2015, p.551) and that bodies set up to represent the public's views be incorporated "into the system they are expected to hold to account" (Carter and Martin, 2016, p.4).

Turning more specifically to participation in public service performance management, Barbera et al. (2021) identify three different possible types of relationship between citizens and governmental agencies. Firstly, there is the 'traditional model of public service delivery' where citizens and other stakeholders are passive recipients of performance information. Secondly, there is 'collaborative assessment' where citizens are actively involved in performance assessment working with public authorities. Thirdly, there is 'assessment driven by citizens' where they act more autonomously. Barbera et al. (2021) further refine this analysis by referring to the performance measurement cycle; i.e.

1. Targeting the measurement effort.
2. Selection of indicators.
3. Data collection.
4. Data analysis.

5. Reporting (and accountability).

It is possible for citizens and other stakeholders to be involved passively, collaboratively or autonomously at all of these stages or for there to be a hybrid model where they may be, say, involved collaboratively at some stages and passively or autonomously at others. In the case of ambulance service performance evaluation, practicalities might lead to active participation at stages 1, 2 and 5 and passive participation at stages 3 and 4 (although ideally also collecting and analysing alternative data autonomously).

The challenges facing Ambulance services, the NHS more generally, and health services internationally, continue to proliferate and intensify and are exacerbated by foreseeable contextual changes; such as the demographic profile of future patients and service users. Traditional and more recent NPM approaches are proving inadequate for this challenge and appear unsustainable in practice. The challenges and inadequacies have been articulated and demonstrated in the performance management system for the English emergency ambulance service which, despite reform, does not appear to be 'fit for purpose'; still less 'fit for future purpose'. A new and alternative approach is required.

Conclusion

We have argued in the past that the wellbeing of the provider, as well as the public service recipient, should be considered in the evaluation of public services articulated through its performance management regime (Heath et al., 2021). In order to address the intertwined relationship of ambulance staff wellbeing within the performance management regime of the service, we suggest that more participative and dialogic engagement should be included, and the process reimagined

a) to take into account the wellbeing of ambulance staff as an integral and intrinsic part of the delivery of a service seeking continuous long-term improvement; and that
b) deliberative methods of participation should be deployed in the reimagining of ambulance services and the public services more generally.

In this way the sustainability and resilience of the service could be improved in parallel with the improved wellbeing and personal resilience of the people who provide the service, which we have demonstrated is much needed.

Moreover, there are many ways in which this could be done, depending on contingency, and such experiments could be examples of how public services might be re-imagined more widely in other contexts.

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