Chapter 1
Introduction: Understanding the Management of Ambulance Services

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Context and Background

The origins of the ambulance service as a public service can be traced back to the late nineteenth and early twentieth centuries with the development of a horse-drawn service that was set up in Liverpool in 1883; the city of London Ambulance Service in 1906; and the introduction of the 999 service in 1937 (Ambulance Service Association 2000). When the National Health Service (NHS) was created in 1948, the ambulance service was a function given to the local authorities. Unlike the police and fire services, there was no accompanying legislation to provide structures and operational arrangements for the new ambulance services that were classified as 'essential' rather than 'emergency' services (IBID, p. 7). With a further absence of any infrastructure for leadership or training, individual services found their own ways of operating. Uniforms and rank structures emulated the established emergency services and a basic first aid certificate was all that was required to work in the services.

Since becoming a part of the wider NHS in 1974, ambulance services have made huge progress to develop from a simple transport service into a pre-hospital healthcare service. During the 1990s, ambulance services became NHS trusts. Prior to reorganisation in 2006, there were 31 ambulance trusts in England. Reorganisation created 11 trusts organised around government offices of the region boundaries

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(DH 2005, p. 10). All of these trusts provide both emergency and non-emergency services. Emergency transport is provided by individual ambulance trusts in response to 999 calls and urgent requests from general practitioners and clinicians including inter-hospital transfers using an emergency vehicle. The patient transport service (PTS) provides pre-booked carriage of patients to hospital, for example, to outpatient appointments and to daycare centres.

The ambulance service is the first point of access for a wide variety of health problems and is a gateway to the NHS in England. The significant gaps in the healthcare literature; especially in relation to paramedic care is characterised by the fact that most documented research revolves around specific episodes of medical care in hospitals or other permanent healthcare facilities (Linwood et al. 2007). The nature of the patient care in the ambulance services is more immediate and delivered under trying, and often unstable conditions. Patient care and research into how to improve the service in such circumstances, necessitates a different but complementary approach to that of other healthcare organisations (Tippett et al. 2003; Woods et al. 2002). The pre-hospital and emergency medical systems (EMS) research lags behind other health disciplines and medical specialties, and there is a need to increase the profile, and volume, of pre-hospital research especially from a public policy and management perspective (Andrews and Wankhade 2014; Wankhade 2011a, 2012; Heath and Radcliffe 2007, 2010; Bevan and Hood 2006).

The management interest in the working of the ambulance services is surprisingly a recent phenomenon given the fact the saving and caring for the wounded or the sick and injured dates back to ancient times (Pollock 2013; Caple 2004; Wankhade and Murphy 2012). Unlike other sectors (acute trusts, primary care trusts and specialist trusts) within the NHS, management explorations about the ambulance services is a comparatively less researched phenomenon in the growing discourse around emergency management (Wankhade 2011a, 2012; McCann et al. 2013; Wankhade and Brinkman 2014; Heath and Radcliffe 2007). Historically, the ambulance services have been viewed primarily as a call-handling and transportation service, incorporating some aspects of patient care. Increasingly, their wider role as an outlet to other NHS services and in ensuring that patients can access the facilities closer to their home is being recognised (NAO 2011).

In keeping with this enhanced role of the ambulance services, the first national ambulance review (DH 2005, p. 14) provided a blue print for ambulance modernisation and future roadmap. The vision of the government was identified to improve the speed and quality of call handling to ensure consistent telephone services for patients who need urgent care. To achieve this vision, developing leadership capability—clinical and managerial—was identified to be reinforced and developed along with education, learning and development for all staff to meet the professional standards expected of them. The period from 2006 to 2010, witnessed contradictory policy objectives. Ambulance services were expected to implement the vision set out in the national review through an enhanced role of the emergency care practitioners (ECPs) but grapple simultaneously with the upheavals and challenges of reorganisation and still show performance. The reliance on the response time targets for measuring ambulance performance was also the subject of focus of some of the ear-

lier published management research for promoting gaming and manipulating results (Bevan and Hamblin 2009; Bevan and Hood 2006). In the quest for standardisation, the government introduced the new 8-min standard *Call to Connect* which further made the meeting of the target difficult (Woollard et al. 2010; Wankhade 2011b). Thus, the performance management regime for ambulance services exemplified the potential of performance measures to promote dysfunctional behaviour as it fell into many of the pitfalls identified in the literature (Heath and Wankhade 2014; De Bruijn 2002; Radcliffe and Heath 2009).

Developing general practice (GP) commissioning was the centrepiece of the reforms announced by the coalition government in 2010. This was accompanied by the introduction of a range of clinical performance indicators for ambulance services which came into effect in April, 2011. The urgent and life-threatening targets are still in practice but a set of new 11 indicators have been introduced (see Cooke 2011 for a fuller discussion; DH 2010a). Additionally, since April 2010, ambulance services like the other NHS organisations also annually publish the *Quality Accounts* intending to promote the overall quality of the service provided and benchmarking of performance (DH 2010b, 2012). Thus, the ambulance trusts are currently focussed to play an enhanced role on one hand in upskilling the staff and paramedic crews and their professionalisation (see NHS England 2013; McCann et al. 2013) and on the other hand, to confront organisational change by exploring alternate models of patient treatment at the scene or at home eliminating the need for hospital admissions (Lovegrove and Davis 2013; NHS Confederation 2014). However, ambulance trusts are still battling some of the legacy issues especially around a *'uniform culture'* which does not always sit comfortably with the core NHS values. Few of the issues surrounding occupational cultures and group identities coupled with the reliance on response time targets and options to 'treat and refer' (O'Cathain et al. 2014) on the backdrop of a growing demand of emergency 999 calls is having its own unintended consequences (Smith 1995; Wankhade and Brinkman 2014; Wankhade 2011a). This volume will explore key management issues being experienced by the ambulance trusts in the UK in dealing with some of these challenges.

Realty and Perception

In 2009–2010, the cost of ambulance services was £1.9 billion, of which £1.5 billion was for urgent and emergency services (NAO 2011). However with an annual budget of more than a £2 billion in 2013–2014 (NHS England 2013) and an overexpanding portfolio of services offered by the emergency ambulance services, their contribution is quite significant (Her Majesty's HM Treasury, 2010). The fundamental principle of providing a comprehensive service to the patients, with the access based upon clinical needs and not their ability to pay for the services offered by the NHS has been seriously tested by the urgent and emergency care in England (NHS England 2013). Several factors have contributed to the ongoing challenges faced by urgent and emergency care networks. These include, among other things,

Table 1.1 Growing demand of emergency calls in England. (Adapted from Health and Social Care Information Centre 2013)

Year	Number of calls in thousands
2004–2005	5623.8
2005–2006	5960.1
2006–2007	6333.4
2007–2008	7225.5
2008–2009	7447.2
2009–2010	7867.9
2010–2011	8077.5
2011–2012	9493.0
2012–2013	9081.0

an annual rise in the demand of emergency 999 calls (see Table 1.1) which have grown on an average annual rate of 4–6%. During 2012–2013, there was an increase of 6–9% over the previous year for the total number of emergency calls received (see Table 1.2).

Furthermore, the alternate delivery protocols and delivery are focus of current management and academic attention (AACE 2014; Siriwardena et al. 2010; Snookes et al. 2009). There have been relatively few detailed explorations of the dynamics of the ambulance services in terms of their management; the relationship between different groups of employees; and the impact of organisational culture in improving the quality of service delivery (Wankhade 2012). This volume attempts to address this gap.

Table 1.2 Key facts about the ambulance services in England in 2012–2013. (Source: Health and Social Care Information Centre 2013)

1. The total number of emergency calls was 9.08 million, a 587,972 (6.9%) increase over last year when there were 8.49 million. Of these, 2.95 million (32.5%) were category A (immediately life threatening). Of all calls, 6.98 million (76.9%) resulted in an emergency response arriving at the scene of the incident, a 268,472 (4.0%) increase over last year when there were 6.71 million
2. The percentage of category A (immediately life threatening) incidents that resulted in an emergency response arriving at the scene of the incident within 8 min in 2012–2013 was: (a) 75.5% (April–May) (b) 74.0% (Red 1, June–March) (c) 75.6% (Red 2, June–March)
3. Of the 12 NHS organisations providing ambulance services, the following number met or exceeded the 75% standard for 8-min response times. (a) 9 met or exceeded 75% (April–May) (b) 7 met or exceeded 75% (Red 1, June–April) (c) 11 met or exceeded 75% (Red 2, June–April)
4. The percentage of category A incidents that resulted in an ambulance vehicle capable of transporting the patient arriving at the scene within 19 min was 96.0% (AQI data). Last year this was 96.8% (KA34); however, these data are not directly comparable due to different clock start times

NHS National Health Service

Aims and Plan of This Book

This is the second book in a three volume series on the management of the three blue light emergency services (ambulance, police and the fire and rescue services). This volume aims to provide a broader management understanding of the ambulance services which would be of equal interest to students, academics, practitioners and professionals without compromising the rigour and scholarship of the content. We have invited experts in their particular fields to address the chosen themes, in both the theory and practice of the functioning of the ambulance services in the UK. The key thinking in this volume is to provide a broad understanding of the major management issues relevant to the operation of the ambulance services in the UK along with an international perspective. Admittedly, it is a difficult endeavour to cover all the possible management themes in a single volume such as this but we are confident that the chosen themes will give a rounded understanding and insights into the management of the ambulance services. The current available texts do not provide such an expert and balanced view on the management of the ambulance services.

This volume provides a mature understanding of an emergency service, which hitherto, is neglected in the management research. Thus, one of the aims of this volume is to invite a new generation of management scholars to explore the study of the ambulance services. This volume will also appeal to a range of students (both undergraduate and postgraduate) studying organisational theory as well as social sciences, sociology, economics and politics, public health, and emergency and disaster management. The book offers critical insights into the theory and practise of strategic and operational management of ambulance services and the related professional and policy aspects. For a large number of staff working in the emergency care settings, the growing calls for professionalisation of the service (through closer links with Higher Education Institutions (HEIs)) and the recognition to reflect on their own personal development, this volume seeks to provide an authoritative source on the management of the ambulance services addressing the knowledge gaps. To a growing audience of independent practitioners and consultants, this volume will appeal in equal measure.

More attention is being paid now to the management research on ambulance services given the policy and practice implications of the challenges to the urgent and emergency care settings. Several factors have contributed towards the need for a better understanding of the role and contribution of the ambulance services in the wider health economy. The pressures on hospital accident and emergency (A&Es) units and the resulting delays for the ambulance crews have been well rehearsed. The limited options for out-of-hours care and a growing ageing population will add more pressures on the use of the ambulance services. The Mid Staffordshire Hospital Inquiry (Francis 2013) and the Keogh Review (NHS England 2013) both highlighted a cultural transformation of the hospital and emergency/urgent care services in England. This requires a better understanding of these issues making this project particularly timely. The chosen themes in this volume will help to outline the social, cultural and political context in which the ambulance services is to be under-

stood. This volume covers issues of theory, policy and practice and raises questions, some of which are inherently controversial. Each of the chapters seeks to engage with the current debates about the direction of travel. The contributors also examine the latest development in their chosen field of enquiry. This volume thus aims to set out the management understanding of the ambulance services as a significant subdiscipline of emergency management and also provide a basis of learning and teaching in this field.

One of the other aims of this volume is to bring together top-quality scholarship using experts—academics, practitioners and professionals in the field to each of the chosen topics. Admittedly, this was an ambitious task and we have been really fortunate to have an assembly of authors who are well regarded for the expertise in their fields. They range from senior academics, chief executives and senior managers from the NHS and independent practitioners. To bring them all together is a key highlight of this volume and to this end this is a book by the people who lead and manage the ambulance services, and their opinions are important in informing the policy and guiding the practice. The contributors have written from different perspectives of critical academics to chief executives and policy experts and there is much to be gained from reading chapters in conjunction with each other, contrasting different perspectives and approaches (Newburn 2003, p. 7). We are immensely grateful to them for their untiring work that has gone to produce this volume and feel confident that it will do justice to the complexities of the chosen themes. All the chapters have been completed in 2014–2015 and hence draw upon the latest evidence and research base available on the chosen topic. The chapters are based in the practical experiences of the authors and are written in a way that is accessible and suitable for a range of audiences.

In dealing with these issues, the volume is divided into four parts. Part 1 provides the context and background to this volume. In this chapter, we have examined the state of the management research on the ambulance services and have stated the aims of this volume. In Chap. 2, Alex Pollock provides an historical context to the origins of the ambulance services. He argues that for most of human history, the care of the wounded in war or the sick and injured in the community was not of great concern to generals or those in civil authority. Exceptions existed but these did not lead to a general movement towards the provision of ambulance services on the battlefield or the street. Then in 1792, a surgeon in the Napoleonic army designed the first threefold system of good military ambulance practice, treating the wounded in situ, speedily transporting them from the place of conflict and providing a safe facility for aftercare. In 1866, a doctor in New York organised the first civil ambulance service which was summoned by telegraph, thereby completing the four features upon which modern ambulance services are based: dedicated teams, standby vehicles, reception hospitals and electronic communication. After slow and uncertain beginnings, ambulances began to save increasing numbers of lives using ingenuity and technological innovation since becoming part of the NHS in 1974.

Part 2 of this volume deals with the working of the ambulance services in providing emergency care to patients. Three key themes are examined. In Chap. 3, problematic issue of managing ‘quality’ and ‘risk’ is tackled by Mary Peters, Steve

Barnard, Michael Doorian and Kevin-Mackway-Jones. They argue that while the practice of risk management and corporate governance relates to all aspects of an organisation's business and activities, the current focus within the health service is primarily around improving quality by putting the patient first and protecting them from harm and developing a culture of transparency and openness (for instance, the NHS Outcome Framework). The measurement of quality within ambulance services has also been traditionally limited to operational activities and presents significant challenges due to the unique environment they operate within, in comparison to other types of healthcare providers. Ambulance services across England use the Clinical Performance Indicator Care Bundle to measure and monitor the quality of care given to patients. Reviewing the current state of development of ambulance quality indicators, the authors conclude that the care received by patients in the pre-hospital arena could be measured and monitored using the Clinical Leadership Education Accountability and Responsibility (CLEAR) framework.

In Chap. 4, Bob Williams examines the core but increasingly difficult issue of managing the demand for ambulance calls. He argues whether it is time to consider remodelling the English ambulance services in order to meet the competing requirements of public expectation and rising emergency demand against the backdrop of a reducing financial position and significant changes to the healthcare system and the incident mix now being attended. He further argues that the underlying increase in demand for ambulance services is universal with a number of similar themes emanating from socio-demographic changes of ageing and multiple illnesses combined with an urbanisation and fragmentation of communities. This has resulted in ambulance services starting to struggle with meeting the exacting response standards expected for potential emergencies irrespective of demographics or geography, while also providing an acceptable service in the eyes of the public to less urgent but nonetheless individually concerning health concerns.

In Chap. 5, the issue of commissioning of the ambulance service is investigated by Mark Docherty. Urgent and Emergency ambulance services are a critical part of the pre-hospital infrastructure and are held in high regard with service users and the public. These services are working in a challenging climate where decisions on priority setting have to be made within an ethically acceptable framework. Commissioners of ambulance services need to ensure that services that are in place are effective (do good) and that decisions on priority setting are fair. For ambulance services the principles of ethical commissioning will not always reach a conclusion on priority setting, and a triangulated approach that also includes clinicians, service users and the public in decision making will ensure that a decision is fair, and the process for decision making is open and transparent resulting in a more ethically robust decision that has greater legitimacy.

Part 3 of the volume explores the context of emergency care through six key themes. The issue of ambulance and professional culture(s) is examined first by Paresh Wankhade, James Radcliffe and Geoffrey Heath in Chap. 6. This chapter concerns the place of culture in ambulance services. There are issues around organisational cultures and subcultures, and the ways these are cross-cut by professional cultures. The concept of organisational culture looms large in recent literature on

organisational change, but this is problematic. It is difficult to define culture adequately and the ways in which it affects behaviour are obscure. In the case of ambulance services, for instance, does it make sense to refer to a single culture within, let alone across, organisations? Similarly, can cultures be transformed as easily as sometimes suggested? Nevertheless, governments increasingly seek to move the focus in the NHS from changing structures and systems towards changing cultures. This raises a number of interesting questions. What happens when attempts to change organisational cultures encounter professional cultures, which support power and status based on professional standing? What are the implications of attempting to professionalise other NHS occupational groups (such as ambulance personnel)? This is particularly relevant given the changing role of ambulance paramedics, which is an international phenomenon. ECPs now have the skills to carry out a wider range of activities at the scene of incidents, and there is increasing evidence of effectiveness. However, this requires services to become 'learning organisations' providing continuous training and development, but it is still questionable whether the cultures and subcultures of ambulance services support what may be seen as an imposed initiative. Thus, there are examples of variations in training and of ECPs not being utilised fully. In analysing these issues, Schein's identification of pluralistic dimensions of culture has been used. The authors conclude that ambulance organisations have multiple cultures, some of which counter change. This complexity adds to the difficulties of delivering effective reforms.

Chapter 7 deals with the issue of leadership development in the ambulance service. Andy Newton and Graham Harris make a strong case for leadership and system thinking in the modern ambulance service arguing that ambulance services remain locked in an eighteenth century mind-set that reinforces a traditional emergency care and transport focused mode of operation, which is insufficiently attuned to the changing and more heterogeneous actualities of demand of the modern world. An effective response to current rising pressures will require clear doctrine and revised concept of operation that is far more reflective of contemporary epidemiological realities and the changing role of the Ambulance Service and the Paramedics. They conclude that effecting the necessary organisational and professional changes will require both a high order of leadership and the recognition that there is a fundamental relationship between leadership and the design of the system in which leadership is being practiced.

In Chap. 8, Robert Till and Anthony Marsh explore the issue of ambulance service modernisation by setting the scene regarding the challenges the ambulance services are currently facing. The authors then goes on to discuss the ways in which the ambulance service have responded to these challenges and what methods have been adopted to improve patient care while also creating efficiencies.

Our next expert John Stephenson deals with the subject of interoperability and multi-agency cooperation in Chap. 9. He discusses how the UK emergency services have worked together for many years, but repeatedly at major incidents, they have settled back into silo working, and how a major programme to train commanders to

work differently and understand each other's issues only started in 2013. It is further argued that the issue of interoperability is very dependent on the organisational structure within each country. In the UK the police, fire and ambulance services are very separate and the armed forces are rarely called upon to support homeland activities except when a specific issue requiring their skills or manpower is identified. Outside the UK, it is common for ambulance services to be provided to some extent within the fire services, this is largely a small cadre of staff that respond to the significant traumatic incidents and very sick collapsed patients, and the broader ambulance work is often provided by private organisations rather than as an emergency service.

The subject matter of responding to diversity and delivering equality in prehospital care is next examined in Chap. 10 by our experts Viet-Hai Phung, Karen Windle and Niroshan Siriwardena. Population and workforce diversity in the NHS together with legislation and national guidance has led to equality becoming an increasingly important issue for patients, service users and staff. Ambulance services, as public sector organisations, are bound by the Equality Act 2010, and as NHS organisations are actively encouraged to implement the Equality Delivery System (EDS) and its successor EDS2, providing the local strategic context to understand and address system inequalities. This chapter examines current challenges for ambulance services in relation to equality and why this matters. It goes on to explore how services are responding to diversity, how they should embed this through engagement with both patients and staff, and how they should understand the effects of these activities through more effective data monitoring.

In Chap. 11, the problem of dealing with the massive challenges of cuts in the NHS budgets is considered by Robert Till and Anthony Marsh. They examine the challenges faced by the NHS ambulance trusts in England in doing 'more for less' and coping with the austerity. This chapter describes the difficult financial position the NHS faces and how this directly affects the ambulance services. It discusses the changing demographics and attitude of the UK and the impact of these on the ambulance services. The authors go onto discuss the innovative ideas and changes ambulance services have had to make to meet the ever-increasing demand placed upon them. Finally, the question is raised regarding the possible need for a change in commissioning of the ambulance services.

Part 4 of this volume presents different perspectives on the future of the ambulance services both in the UK and abroad. In Chap. 12, the first contribution by Mark Docherty, Andrew Carson and Matthew Ward highlights the new agenda for development of clinical skills and a new perspective on the future of ambulance services. The authors discuss how ambulance services historically and up until recently have been predominantly a transport service for sick and injured people, and the development of ambulance services for delivery of clinical services has happened sporadically and slowly during this period. They contend that pre-hospital urgent and emergency care is changing rapidly, and the twenty-first century will see the need for ambulance services to change at an exponential rate. They conclude that demand on ambulance services caused by the growing elderly population and expectations of the younger generation provide a great opportunity and a challenge

for the current service to develop into modern providers of mobile health services that have a relevance in a twenty-first century healthcare system.

Kevin Mackway-Jones and Paresh Wankhade in their piece argue the case for a sensible understanding of the challenges being faced by ambulance trusts in England in Chap. 13. They contend that the future of ambulance services raises important issues about the nature of prehospital care and the changing societal and cultural context in the UK. They highlight two core functions of the ambulance services—a means of supported transport of patients in the community and a responsive and professional outreaching emergency diagnosis and management service. Their view is that while these functions will still be integral in the future pre-hospital care models, what is likely to change is the means of delivery and the professionals that deliver the service. They conclude their arguments by making a case for an evolutionary change than rather than change by revolution which essentially centres on the 3Ss- structure, skills and science.

In Chaps. 14-16, we present three contributions addressing international perspectives for the ambulance services. Our first expert Paul Middleton reviews the provision of ambulance service delivery in Australia in Chap. 14. He argues that ambulance services by 2020 should be having the ability to analyse and measure the quality of systems and processes in relation to patient outcomes. Adherence to the current system of targets for response times based on medians from other jurisdictions remote in geography, time and design will need to be replaced with carefully analysed linked data using sophisticated statistical techniques, including regression and survival analyses as well as comprehensive health economic evaluations, to allow patient outcomes to be utilised to determine the effectiveness of ambulance practice. Based upon his analysis, the author concludes that only when the ambulance systems are joined to health services, Australian ambulance services truly will have come into the twenty-first century.

In Chap. 15, our second expert Craig Lambert analyses the pre-hospital care and ambulance service delivery in South Africa where the training and scope of practice of ambulance personal differs vastly between different regions within the country. Certain EMSs offer a doctor-based system with medical doctors responding on emergency vehicles to calls while at the other end of the spectrum are EMSs that operate with ambulance crews that have as little as 3–4 weeks of basic training. The chapter details how emergency care profession has developed away from a doctor-driven technician system towards a more autonomous profession and by implication, the responsibility for clinical decision making, interrogation, critique and development of pre-hospital medical protocol and direction is now largely driven by the paramedics. The author concludes that the extent to which this fledgling autonomous profession is capable of properly fulfilling these important functions is frequently debated.

Our final international contributors Juha Jormakka and Simo Saikko share an expert perspective on the Finnish ambulance services in Chap. 16. They begin with a short history of ambulance service in Finland and the development of educational standards in paramedic practice within the context of Europe including the continu-

ing education and professional development agenda. They provide an insight about the quality factors and risk management issues while evaluating the effectiveness of treating ring people at home sketching the future direction of travel.

Limitations of the Current Project

There were a few difficult decisions we had to take as editors of this volume; the biggest one was to decide what to include in the volume of this and what was to be excluded. We are also conscious about the possible disagreements about the final contents of the volume and what else could or should have been covered. Furthermore, even the scope of some of the chapters could have been more detailed and capable of being examined in a greater detail. The chosen themes do not claim to cover the whole gamut of issues which could be applied to the management of ambulance services. Nonetheless, they provide a fair representation of topics that concern us in our scholarly research and teaching. We firmly believe that they represent opportunities for both teaching and practice to reflect on these issues. We also seriously deliberated upon the choice of the authors and their backgrounds. In the end, we were convinced that a choice reflecting a balance between academic experts and senior practitioners would allow bringing greater criticality and reflection to understand the complexity of the chosen themes. Rather than having rigid guidelines over chapter style and structures, we saw greater relevance in a 'light touch', free-flowing style of each of the chapters in presenting contrasting perspectives from academics and practitioners. We are of the opinion that this approach worked better in a work like this though it will be for our readers to judge whether we were correct in our methodology. Similarly, we could have paid more attention to the developments in the urgent and emergency care outside England including some comparative outlooks though there remains a strong comparative element from Australia, South Africa and Finland.

Future Research Agenda

Ambulance services often provide the first point of contact in the global healthcare systems. But the context in which they currently operate within the urgent and emergency care settings is increasingly becoming fragmented, complex and politically contested. The pressures of funding, training and cultural transformation are now felt globally. The need to learn and adapt from suitable models of ambulance service delivery across the globe have never been greater. We sincerely hope that this volume will trigger greater academic and organisational interest in the understanding of one of the most important of public services. We aim to further work on a comparative element outside the UK and invite interested colleagues and partners to join the quest of the management understanding of a service we love so dearly.

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