London Ambulance Service NHS Trust

Annual Report

2010/11

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Who we are

The London Ambulance Service NHS Trust is the busiest emergency ambulance service in the UK providing healthcare that is free to patients at the point of delivery. We are also the only London-wide NHS trust.

As the mobile arm of the health service in the capital, our main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible.

However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. Often these patients will receive more appropriate care somewhere other than at hospital and so we offer a range of care to them, recognising that many have complex problems or long-term medical conditions.

We also run a Patient Transport Service which provides pre-arranged transportation for patients to and from their hospital appointments. In addition, we manage the Emergency Bed Service, a bed-finding system for NHS healthcare professionals who need to make arrangements for their seriously ill patients.

We are led by a Trust Board which comprises a non-executive chairman, six non-executive directors and six executive directors, including the Chief Executive.

As an integral part of the NHS in London, we work closely with hospitals and other healthcare professionals, as well as with other emergency services. We are also central to the emergency response for large-scale or major incidents in the capital.

We have almost 5,000 staff, who work across a wide range of roles. We serve more than seven-and-a-half million people who live and work in the London area. This covers about 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

In 2010/11 we handled over 1.5 million emergency calls from across London and attended more than one million incidents.

We are committed to developing and improving the service we provide to the people who live in, work in, or visit London.

Chairman's views

What have been the highlights from last year?

Last year we handled more 999 calls than ever before and highlights included meeting the Category A performance standard of reaching 75 per cent of seriously ill or injured patients within eight minutes – reaching 40,000 more of these patients than the previous year within the national time target – despite experiencing the busiest day, week and month in our history.

In addition, our Category B performance (to respond to 95 per cent of patients in a non life-threatening condition within 19 minutes) was our highest ever achieved.

Last year was also the first year of operation for the new London-wide trauma and stroke networks. Both are proving to be major successes, improving patient outcomes and, crucially, saving more lives.

We are also pleased that we received a European control centre of the year award and the Cabinet Office Customer Service Excellence Award, recognising the hard work of our staff who answer 999 calls and help to dispatch ambulances.

What impact will the proposed NHS reforms have on the Trust?

As we start the new financial year this will be one of the key questions. At the time of writing uncertainties remain over how some aspects of the reforms will work in practice. For example it is unclear how GPs will assume and manage the responsibility for commissioning our services and we look forward to this being clarified over the forthcoming months. However, I am confident that we will continue to focus on meeting patients' needs and expectations while responding to the reconfiguration of the NHS in London, and of course nationally, as we are required to do.

How will the Trust maintain levels of patient care when significant financial savings have to be made across the NHS?

We will not compromise our focus on patient care, even though we have to make financial savings. Quality and safety in the care we provide are at the very heart of what we do – we will do everything we can to ensure this does not change.

We are managing our approach to financial savings through a comprehensive cost improvement programme and this is monitored on a monthly basis by the Trust Board. We have a good track record of delivering savings and we fully expect this to continue.

How is the Trust's application to become a foundation trust progressing and what benefits will this status bring?

This has been a demanding project but we remain on track to become a foundation trust by early 2012. We have made considerable progress over the last 12 months, but there has been some slippage in our original timeline – due to the thoroughness of the process – which can only be of benefit in the longer term.

From our point of view, the additional freedoms to manage our affairs and to manage our funding and finances are key benefits. We are keen to ensure that our application has a trouble free route through the process, although ideally, as I write this, we would like to be a few months further ahead.

Nevertheless, we are pleased to have around 5,000 public members of the London Ambulance Service and a similar number of staff members. This will give us the opportunity to engage more directly with our potential users and ensure we develop the Service in a way that reflects patients' needs.

Chief Executive's views

What improvements have patients seen in the care they receive from the capital's ambulance service over the last year?

More patients have had their 999 call answered more quickly than ever before, and more patients have received an emergency ambulance more quickly than ever before. In addition, we have continued to improve care for our patients suffering from major trauma, stroke, heart attack and cardiac arrest. We have also continued to improve the end-of-life care for patients and our infection control procedures.

What have been the Trust's biggest challenges over the last 12 months? How did you cope and what lessons did you learn?

The biggest challenges we have faced have been the volume of demand on our service and working to a much tighter budget than in previous years, while at the same time achieving the national ambulance response target of reaching 75 per cent of seriously ill or injured patients (Category A) within eight minutes. This has been achieved by sheer hard work, determination and the goodwill of staff and managers across the Service.

The key lesson is that we have to take the pressure off our service by using the new target changes to best effect. That means providing much more clinical telephone advice and increasing our use of the community health services and referral services that are available in London.

What benefit will the removal of the time targets for responding to seriously ill and injured patients have?

The main benefit will be that we will have the flexibility to provide a more appropriate response to our patients. Rather than having to send an ambulance to every patient, we will be able to undertake a more thorough telephone assessment and then agree the most appropriate care pathway such as clinical advice over the telephone, a GP referral or an ambulance if it is decided that is the best course of action.

We will also be able to focus more on improving patient outcomes by measuring a range of clinical quality indicators and comparing ourselves with other ambulance services in England. We will now be judged on how well patients recover, rather than on just how quickly we can get to them.

What are your priorities for this year?

We need to implement our new call-handling and vehicle dispatch system safely and effectively, finalise our preparations for the Olympic and Paralympic Games, implement the new clinical quality indicators safely and achieve foundation trust status.

We have to do all this while delivering a challenging cost improvement programme and at the same time ensuring that we maintain a high level of service for all our patients.

Will the Trust be ready for the Olympic and Paralympic Games next year?

Yes we will. We have a very good track record of dealing with large scale events, whether it is New Year's Eve, G20, the London Marathon or the Notting Hill Carnival. While I recognise that this is on a much bigger scale than anything we have done before, our planning team have done a first-class job and I know that all our staff involved during the Games will show the world what a professional, high-quality service we have.

Directors' Report

Our strategic goals

Over the next five years, our strategic goals are:

- to improve the quality of care we provide to our patients
- to deliver care with a highly skilled and representative workforce
- to provide value for money.

We believe that we will be better placed to achieve our goals by becoming an NHS foundation trust.

This status will:

- make us more accountable to our patients and the communities we serve
- give us greater financial freedom
- provide us with more opportunities to lead and work in partnership across London to develop and improve healthcare services
- provide more opportunities for longer term planning through clarity of vision and strategy
- recognise us as an excellent organisation.

Strategic goal: Improve the quality of care we provide to our patients

We have an important role to play in improving the health outcomes of patients in London.

As a 24/7 pan-London healthcare provider, we are often the first point of contact for people who want medical help, whether it is an emergency or a less serious condition. Our response will determine whether they get the right treatment to meet their needs.

To achieve this goal we will:

- improve outcomes for patients who are critically ill or injured
- provide more appropriate care for patients with less serious illnesses or injuries
- meet response times routinely, and
- meet other regulatory and performance targets.

Strategic goal: Deliver care with a highly skilled and representative workforce

We know that to enable us to provide a quality service, our staff need to be highly-skilled, confident and motivated. They should also be representative of the communities we serve.

We will continue to invest in their development so that staff on the frontline have the skills to assess and treat a wide range of conditions, and those in other functions have the right skills to support them.

We will continue to improve the diversity of our workforce, and also focus on engaging with our staff more so that they are motivated and feel valued, and have a greater say in how we improve our service.

To achieve this goal we will:

- develop our staff so that they have the skills and confidence they need to do their job
- improve the diversity of our workforce, and
- engage with our staff to improve patient care and productivity.

Strategic goal: Provide value for money

It is extremely important that we provide Londoners with a service that represents value for money.

It currently costs residents £30 each per year for their ambulance service. This is less per head of population than most other ambulance services in the country, but in the future we will need to provide a better service for less money.

To achieve this goal we will:

- use our resources efficiently and effectively
- maintain service performance during major events, both planned and unplanned including the 2012 Games, and
- improve engagement with key stakeholders.

We work with a wide range of stakeholders, from local involvement networks and the London Ambulance Service Patients' Forum to the Strategic Health Authority and our commissioners. Many of our stakeholders have contributed to the development of our strategic plan and will play a crucial role in its delivery.

Achievements during 2010/11

Clinical developments

We attended more patients than ever before in 2010/11, responding to more than one million incidents.

Over the last year we have continued to improve the care we provide to our patients, whether they have life-threatening conditions or less serious illnesses or injuries.

Stroke care

The Service has continued to support the development of the London stroke networks. In February 2010, we started taking patients with very early stroke symptoms directly to one of eight hyperacute stroke units (HASUs) – specialist centres where early, consultant-led assessment, diagnosis and treatment is started within minutes of arrival. In July 2010, this was extended to all patients with a stroke, regardless of where they live or work in London. Audit data has shown our staff consistently transport over 95 per cent of suspected stroke patients to an appropriate destination.

Despite the longer distances to be travelled, the average journey time to hospital is under 20 minutes.

In November 2010, the North West London Stroke and Cardiac Network and Imperial College Healthcare NHS Trust hosted a stroke training day attended by over 80 Service staff.

Trauma care

Three specialist major trauma centres went live in April 2010, and a fourth in December 2010. The centres are equipped to deal with patients who suffer life-threatening injuries, including amputations or gunshot wounds. They have a specialist consultant on site to manage these patients 24/7. Patients with less serious injuries such as a fractured hip or ankle, or minor head injuries are treated at their local trauma unit.

Our staff have been trained in the use of a triage system that helps to ensure that the most seriously injured patients are taken to a major trauma centre. The initial results are very promising, with nearly half of all patients taken to one of these specialist centres having significant injury. This compares well with international standards. Although patients are often bypassing their local hospital, the vast majority of ambulance journey times for major trauma patients are below 45 minutes, with a median time of 13.4 minutes.

The system is already benefiting patients, with an additional 37 survivors across London in the first six months since the system went live, compared to the expected number of survivors.

Cardiac care

We have continued to improve the care we provide to patients who suffer a heart attack (caused by a blockage of blood flow to the heart) or cardiac arrest (when the heart stops beating).

More patients who suffer heart attacks are being taken to specialist centres than ever before. The latest available figures show that 1,779 patients who were diagnosed as suffering from a common type of heart attack, known as an ST-elevation myocardial infarction, were taken directly to a heart attack centre in 2009/10. This is an increase of 11 per cent on the year before. These patients were taken to specialist centres to enable them to be given primary angioplasty, a procedure which involves inflating a balloon inside an artery to enable a blockage to be cleared.

Latest figures for cardiac arrests also show that Londoners whose hearts stop beating in public are over eight times more likely to survive than 10 years ago. This survival rate of 21.5 per cent is up from just 2.5 per cent in 1998/99 and an increase from 15.2 per cent in 2007/08. The improvement in cardiac arrest survival rates reflects a wide range of developments in the care and treatment of cardiac patients in the capital.

We now have 39 community responder and co-responder schemes in place whereby volunteers are trained to attend emergency calls in their local area and provide first aid to patients until an ambulance arrives. In the last year 109 volunteers have been trained.

We also have over 500 defibrillators – machines that are used to re-start a patient's heart with an electric shock – in almost 200 public places including tourist attractions, airports and train stations. And we have trained thousands of people working in these areas in their use. In the last year 49 defibrillators have been sited and 1,080 people have been trained or re-trained.

Mental health care

There is a higher prevalence of people with mental health conditions in London than elsewhere in the country and consequently mental health 999 emergencies are jobs frequently covered by the Service. We are committed to making improvements to the quality of service we provide to this group of patients.

People with mental health conditions can have a range of complex needs and care packages are frequently dependent upon a number of different provider organisations. Some patients may be refugees and face language and cultural barriers. In addition, London's population is very mobile and mental health patients can access healthcare at any location making crisis planning extremely challenging.

In 2010/11 we explored some of these issues, holding detailed discussions with commissioners, and developed a mental health action plan that will help drive improvements during 2011/12. The action plan is broken down into a number of work streams that include areas that have a relationship with mental health such as alcohol consumption and dementia.

By offering more mental health clinical support to our staff and changing the way we view mental health, we hope to improve the overall patient experience.

End-of-life care

Supporting end-of-life care strategies across London is a growing priority for the Service and fits with ongoing strategic developments including identifying and making use of appropriate health care centres other than hospital emergency departments (alternative care pathways) and giving people a choice about where they die.

We will continue to work with both NHS and hospice-based end-of-life care providers to provide end-of-life care support that is fit for purpose. We will also continue to develop staff skills, training and competencies, the way we collate patient information and how we communicate with local providers of end-of-life care services.

We are currently working on a project with St Thomas' Hospital to make sure patients under its care on an end-of-life care programme are appropriately managed and looked after by our staff following a 999 call.

Care for patients with less serious conditions

During 2010/11 we developed our work to look at how we treat patients presenting with less serious conditions.

Our clinical telephone advisors helped 50,058 patients over the phone, an increase from 47,180 last year. Of these patients, 23 per cent were assessed as not needing an ambulance to attend them in person. We also referred 46,054 calls to NHS Direct for their advisers to call back patients and provide them with clinical help over the telephone.

As part of a wider NHS response to managing patients with less serious conditions, work has also been done to identify suitable alternative destinations where care can be provided away from the traditional hospital environment. These include minor injuries units, urgent care centres and walk-in centres, some of the latter being provided as part of the services

at some larger GP practices. Currently there are 50 of these alternative destinations, and we are working with each service provider to encourage our staff to use the facilities, as well as with the services themselves to give them a better understanding about how we work. Frontline staff are receiving training to enable them to better assess minor injuries, illnesses and conditions, and from this decide on the appropriate destination for patients.

In addition, we have started some work relating to elderly patients who have fallen with the overall aim to have a much higher level of GP engagement with us when managing their ongoing care.

Provision of pre-arranged patient transport

As well as our 999 service, we offer pre-arranged transport for patients to and from their hospital appointments. We carried out 204,454 of these journeys last year.

We delivered patients to hospital on time in 90 per cent of the journeys, compared with 92 per cent the year before, and 90 per cent in 2008/09. We departed hospital on time in 95 per cent of cases. This compares with 93 per cent in 2009/10, and 92 per cent in the year before that.

Ninety-five per cent of our patients had a journey time less than an hour. This was the same as the previous two years.

During the year, we did not commence any new contracts and stopped providing services for the South London Healthcare NHS Trust in December 2010.

Our total number of contracts at the end of the year stood at 19.

Performance against government targets

In 2010/11, we received a total of 1,494,207 emergency calls, compared to 1,480,275 in 2009/10. And we responded to 1,058,132 emergency incidents, up from 1,012,927 the year before. The total of emergency calls received per year has increased by 21 per cent over the last six years.

We conveyed 785,014 patients to a hospital accident and emergency department, compared to 740,296 the year before, and conveyed 27,578 to an appropriate care centre such as a minor injuries unit compared to 21,896 the previous year. Our staff attended 245,540 incidents but did not convey a patient for further medical treatment. We also gave clinical advice over the phone to 50,058 patients with minor illnesses or injuries.

During the year we also faced some major challenges such as the re-emergence of swine flu (H1N1) in winter along with adverse weather conditions and student protests. Despite this we achieved two of the government response time targets, and improved our performance against the third.

In 2010/11, the targets were to reach:

- 75 per cent of Category A (life-threatening) calls within eight minutes
- 95 per cent of Category A calls within 19 minutes
- 95 per cent of Category B (serious) calls within 19 minutes.

The number of life-threatening calls received during 2010/11 increased by over five per cent. We attended 347,675 of these incidents – compared to 328,616 the year before. We responded to 75.14 per cent of these types of calls within eight minutes. This is a similar achievement to 2009/10.

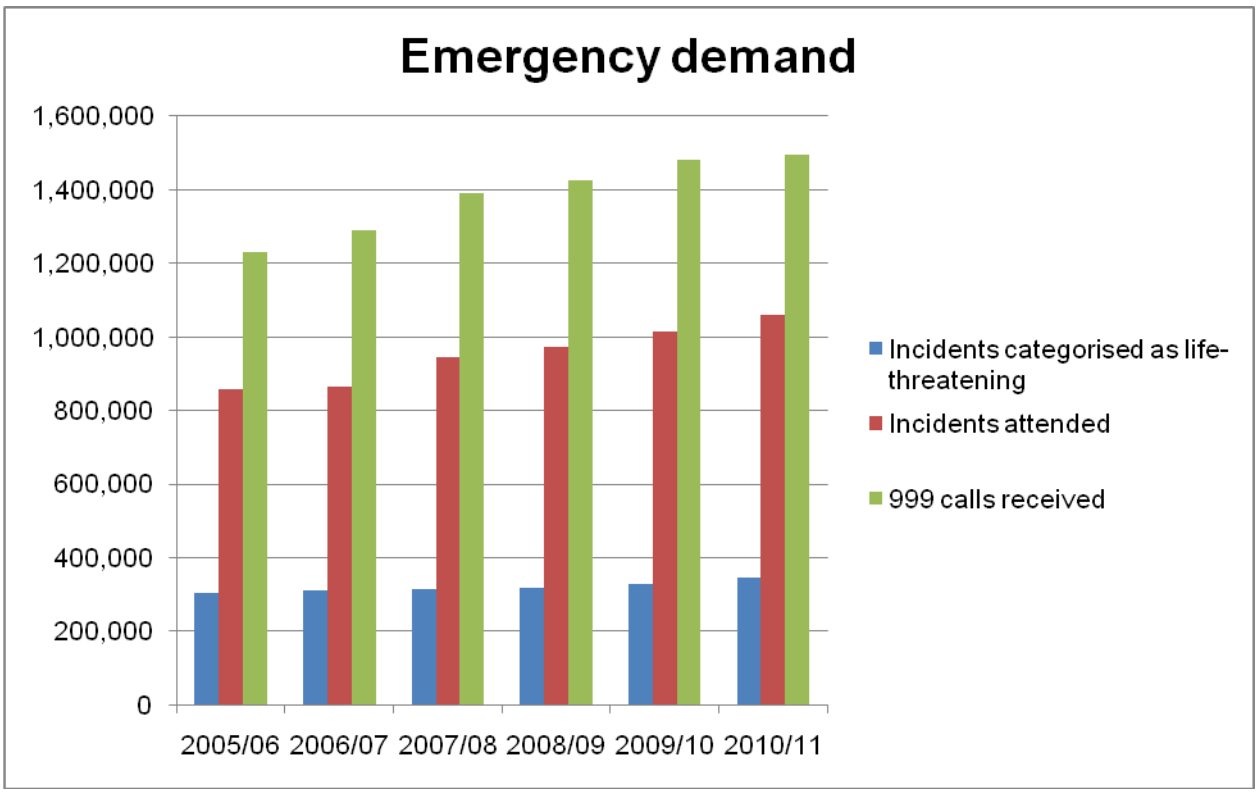
We reached 99 per cent of Category A incidents within 19 minutes, exceeding the target of 95 per cent. This is slightly above our performance in 2009/10, when we reached over 98 per cent of patients within this time.

We saw incidents involving patients with serious but not life-threatening conditions increase by over five per cent during the 12-month period, which was an additional 23,014 incidents compared with the year before. Unfortunately, although our performance against the Category B target improved during the year, we were unable to achieve the 95 per cent target. We responded to 87.2 per cent of these calls within 19 minutes; this compares with 86.4 per cent in 2009/10.

The Category B performance standard is being replaced in 2011/12 with clinical indicators. This set of indicators and measures will be based around the following:

- Cardiac arrest survival rate.
- Cardiac and stroke outcomes.
- Mortality rates from discharge.
- Call handling/clinical telephone advice/NHS Direct.
- Patient experiences.
- Time of treatment (for patients in an immediately life-threatening condition waiting longer than eight minutes).
- Patient's safety while in our care.

Emergency demand						
	2005/06	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
999 calls received	1,231,572	1,288,819	1,389,660	1,423,496	1,480,275	1,494,207
Incidents attended	856,659	865,537	945,776	973,908	1,012,927	1,058,132
Incidents categorised as life-threatening	305,300	312,377	315,744	319,677	328,616	347,675



New call-handling and dispatch system

We are implementing a new system for handling 999 calls and dispatching staff and vehicles.

The new system, CommandPoint, is expected to go live in June 2011 following comprehensive testing and staff training.

The system will improve our ability to handle 999 calls and meet the challenges of population growth in the capital and ever-increasing demand on our service.

Regulation

For two years in a row the Audit Commission has rated the overall management of our finances at level 4 – the highest rating possible. We have also achieved unconditional registration in March 2010 with the Care Quality Commission which we maintained in 2010/11.

The new Director of Health Promotion and Quality is the lead for infection prevention and control and has strengthened our monitoring and audit processes for compliance with the hygiene code regulations.

We were reassessed at level 1 of the NHS Litigation Authority risk management standards for ambulance trusts in October 2010 and achieved this with a much improved score on the 2008 assessment.

An action plan was successfully implemented in March 2010 to address the improvement notice from the Health and Safety Executive concerning refresher training for manual handling and this led to the notice being removed in June 2010.

Governance and risk

Our Trust Board manages risk through the risk management policy and strategy, corporate risk register and board assurance framework, all of which were reviewed during 2010/11. We have revised the board assurance framework and increased the frequency of review by the Quality Committee and the Trust Board. We have added to this the key risk areas that the Trust Board identified for a focus during the year and this has contributed to greater scrutiny of the risks on the corporate register.

The new governance structure was implemented in April 2010 and the Trust Board undertook an interim review of this in December. No significant changes were made and the structure will be fully reviewed in April 2011.

From November 2010 to January 2011 our governance and financial reporting processes were scrutinised by independent accountants as part of the due diligence process in preparation for our foundation trust application. We have implemented an action plan to address the issues arising from this and we are now looking ahead to being authorised as an NHS foundation trust in late 2011.

How we prepare for emergencies

We have to be prepared for anything that may happen in the capital, whether it is a planned event or an unplanned emergency.

Our major incident plan outlines the operational steps we will take in the event of a major or catastrophic incident occurring. This plan has been written in conjunction with all our partner agencies in the capital.

We also have plans in place to ensure we are as prepared as possible for large-scale events such as New Year's Eve, the London Marathon, the Notting Hill Carnival and many other smaller events.

To help us prepare for the unexpected, we regularly take part in major incident exercises with other agencies and successfully managed the medical provision at a number of central London demonstrations and events during 2010/11.

We have a specially-trained team to treat patients in the 'hot zone', or hazardous area, at serious or major incidents. The hazardous area response team (HART) is also equipped to deal with large numbers of casualties at incidents. We also have teams that are trained to work within crowded and often challenging environments such as football matches and demonstrations.

Improving our service through feedback

We believe in taking account of all of the feedback we receive, including complaints. By treating all of this feedback seriously we can gain a better picture of any emerging trends and incidents of particular importance to patient care.

The most important issue from our point of view is that, once feedback from patients has been received and looked into, we are able to address the causes of any poor experience so that we can manage similar situations better in the future.

Every year we receive approximately 500 complaints and around 6,000 enquiries to our patient experiences department, including approximately 200 incident reports from other health and social care agencies. This year we received over 1,500 letters of thanks from our patients; an increase of eight per cent on 2009/10.

We remain committed to safety and public accountability by being open about matters when something goes wrong and using all feedback as a learning opportunity to encourage change and improve practice. We believe feedback can be used to improve the NHS and social care as a whole and we are exploring ways in which we can share lessons learned with all UK ambulance services.

As best practice we now publish case studies on our website at www.londonambulance.nhs.uk under *About us > What we do > Making your experiences count.*

We also continue to use a care plan approach so that we can tailor the needs of patients to an individual care programme matched to their needs. This is especially helpful in not only meeting the needs of patients but in managing demand more effectively. You can find out more about our patient centred action team at www.londonambulance.nhs.uk under *Health professionals > Caring for frequent callers*.

We are also pleased to be increasingly involved in liaising with other agencies to promote safeguarding of both adults and children. More information is available on our website at www.londonambulance.nhs.uk/health_professionals.aspx

Our workforce

We have continued to change the skill mix of our workforce. A two-year major recruitment drive between 2008 and 2010 saw our workforce grow significantly with over 700 people joining us in the new role of student paramedic. This programme has had a very low attrition rate and we currently employ 677 student paramedics. At the end of 2010/11, 63 students had qualified as full paramedics and we expect a further 373 to qualify next year and 265 in 2012/13. Our recruitment activity in 2010/11 has also ensured that staffing levels in control services – where staff answer 999 calls and dispatch ambulances – will meet the additional demands on resources during the implementation of the new call handling system, CommandPoint.

There has been a significant rise in the quantity of training delivered this year and we have rolled out in the region of 6,000 units of clinical training to staff across a range of subject areas.

The rate of sickness among our staff for the 2010 calendar year (January to December 2010) was 5.2 per cent.

How we inform and consult with our staff

Staff communication and consultation: We recognise that an engaged workforce is key to improving services and productivity, and we are committed to communicating and consulting with staff to achieve this. A formal staff engagement strategy has been developed, and approved by the Trust Board, to support and further develop the long-standing partnership agreement with the recognised trade unions.

Partnership working with the unions: We have long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place. This relationship has been strengthened over recent years as we have worked together on major change programmes, including the implementation of Agenda for Change terms and conditions, and new cover arrangements for frontline staff that places them where historical data indicates the next 999 call will come from. The staff side to the Staff Council, the senior consultative group within our Service, has been offered and accepted a governor seat as part of the planning process for foundation trust status. New partnership arrangements for health and safety have also been agreed.

We have continued to consult on the major issues, opportunities and challenges facing the Service. For example, we will continue to hold joint partnership events to foster the agreements and involve more representatives in our planning and preparation for the Olympic and Paralympic Games. This approach will support and supplement the established formal diarised meetings at corporate and local level. We plan to maintain these working relationships when we become a foundation trust.

Staff conferences and consultation meetings: Another effective way in which we engage with staff is through our programme of internal conferences and consultation meetings. Conferences with different staff groups take place throughout the year, and every 18 months our Chief Executive and Medical Director hold consultation meetings at local level, visiting some 30 ambulance stations, as well as fleet workshops, and meeting with patient transport service staff and other staff groups. These meetings have provided a key opportunity for staff to offer their views on what we should be focusing on, and have influenced service strategy.

Health and well-being: We have developed a health and well-being strategy, approved by our Trust Board. Arrangements for occupational health and counselling services have been reviewed, and a new model of counselling, introduced by way of a network of selected counsellors experienced in trauma as well as work-place counselling, has been agreed. A new provider of occupational health and physiotherapy services has been selected and health and safety training for managers and staff has been enhanced. The LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative received national recognition, being awarded second place in the ‘stress’ category of the annual Healthcare People Management Association awards for best practice in human resources.

Following a planned visit and inspection by the Health and Safety Executive, we were served with a formal improvement notice in spring 2010, and the Executive also issued a report which commented upon and made recommendations about arrangements for the management of health and safety in the Service. The improvement notice related to refresher training for operational staff, and gave a three-month period within which to demonstrate compliance. The notice was lifted on time and at the earliest opportunity, and the Executive has declared itself happy with progress against the report and recommendations. This work continues.

New ways of working initiative: We have an initiative to develop clinical leadership at local level which will improve the care we give to patients and improve job satisfaction for staff. Two operational sites have successfully implemented new ways of working, and a further five are currently focussed on achieving these objectives. Staff at all levels locally are being actively engaged and encouraged to contribute to this work which ranges from improving clinical training and leadership skills to introducing team based working with

supporting rotas and increasing community engagement. This initiative will roll out across all local operational areas in over the next two years

Staff survey: We send the annual NHS staff survey to all members of staff, rather than the sample required for the purpose of the national survey. This has enabled us to get a better picture of staff views and concerns across the organisation. The results are fed back to each directorate, and local action plans are developed to address any key issues.

Staff involvement in policy development: There are a number of examples where staff have been directly involved in influencing how we deliver our service, for example how we report concerns about vulnerable adults and children, the introduction of a bicycle ambulance in central London, the launch of the media-dubbed 'booze bus' that deals with alcohol-related calls, and the development of a pan-London programme whereby patients diagnosed with a heart attack are taken directly to one of eight heart attack centres in the capital where they receive specialist treatment. Staff have also been involved in the development of key strategies relating to mental health, long-term conditions, older people and public education.

Representation on the Council of Governors: When we achieve foundation trust status, staff will be able to stand for election to our Council of Governors. We are proposing three seats for staff representatives. This is separate from, and in addition to, the seat for a staff side representative from the Staff Council.

Our approach to equality and inclusion

We welcome our obligations under equalities legislation including the Equality Act 2010. Our aim is to ensure that equality and inclusion is embedded and integral to everything we do.

We welcome people to our organisation from any background, who are committed to providing an excellent service to the diverse communities we serve. We aim to provide innovative and responsive healthcare which meets the needs of all these communities, providing better healthcare for all.

It is our policy to treat everyone fairly and without discrimination. Specifically, we aim to ensure that:

- patients and customers receive fair and equal access to our healthcare service
- everyone is treated with dignity and respect
- staff experience fairness and equality of opportunity and treatment in their workplace.

All of our staff are expected to promote these values at all times and behaviour that does not meet this standard is addressed.

We aim to ensure that:

- our patients and customers are aware of our services and that those services are accessible to all
- our public buildings and information are accessible to all
- our diverse communities in London can be involved in the development and monitoring of our policies and services.

We aim to become an employer of choice for those who want to make London a safer and healthier place for all. We want to attract the best and most talented people from all walks of life to rewarding and challenging career opportunities, where they can develop their potential to the benefit of their fellow staff, patients and customers.

Our aims are to:

- celebrate and encourage the diversity of our workforce and to create a working environment where everyone feels included and appreciated for their work
- promote and provide our training and employment opportunities regardless of age, disability, gender reassignment, marital status, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other aspect of an individual person's background
- foster creativeness and innovation in our working environment, to ensure that each member of staff can give of their best and move our Service forward in our equality and inclusion goals.

As a procurer of goods and services, we are committed to:

- ensuring that contractors from whom we procure goods and services are aligned with our equality and inclusion values
- actively considering supplier diversity as a key aspect in our contract management.

Our policy in relation to disabled employees

We are a member organisation of the Employers' Forum on Disability as well as of Carers UK. We have signed up to the Two Ticks ‘positive about disabled people’ scheme and have established a new staff diversity forum for disabled people and carers, known as Enable. This will provide an active voice on policy and decision-making for our disabled employees and staff who are carers, including their involvement as ‘critical friends’ in our equality analysis. Members of Enable will also lead and participate in relevant engagement events on behalf of the organisation.

Severance payments

No employees left the Service under terms that required Treasury approval.

Sustainability

In March 2010 our Trust Board approved a carbon reduction policy committing us to reducing our 2007 carbon footprint by 10 per cent by 2015. A number of initiatives have now been implemented to help reduce our carbon footprint.

- During 2010/11 we modernised our ambulance fleet with new ambulances that are 100 per cent more fuel efficient than older models. The new vehicles are capable of covering an average of 18 miles per gallon compared to nine miles per gallon for the older ambulances. The new vehicles are also almost 90 per cent recyclable (by weight). We are also investigating the possibility of adding electric or hybrid vehicles to our fleet of non-emergency vehicles.
- Twenty five per cent of our energy is now supplied from green sources. We have also managed to cut energy consumption across our estate through garage lighting

projects, the replacement of 20 life-expired boilers over the last three years and the installation of smart meters for electricity and gas.

- A number of paper-based processes have been moved to web-based systems (such as expenses claims) helping us to reduce the amount of paper we use.
- We have continued to encourage recycling across the organisation.
- A teleconferencing facility is now routinely used across the Service, cutting down on unnecessary journeys between sites.
- We have amended our template for business cases to include an environmental impact assessment that addresses carbon reduction.
- We successfully applied to take part in the Carbon Trust's public sector carbon management programme which starts in 2011/12. This will further support us in meeting the target of reducing our 2007 carbon footprint by 10 per cent by 2015.

Our Trust Board

Our Trust Board is made up of 13 members – a non-executive chairman, six of the Service's executive directors (including the Chief Executive), and six non-executive directors.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. The non-executive directors are appointed by the same method but independently through the Appointments Commission. All executive appointments are permanent and subject to normal terms and conditions of employment.

The Board has five formal sub-committees: the Strategy Review and Planning Group, the Quality Committee, the Audit Committee, the Remuneration Committee and the Charitable Funds Committee. A new Finance & Investment Committee will be introduced from April 2011 and will meet up to three times a year. It will be chaired by the Trust Chair.

The membership of the Strategy Review and Planning Group is made up of all the board members and is chaired by the Trust Chair.

Four non-executive directors and the Chief Executive make up the membership of the Quality Committee, which is chaired by non-executive director Beryl Magrath.

The membership of the Audit Committee comprises three non-executive directors and is chaired by non-executive director Caroline Silver, who also chairs our Charitable Funds Committee.

The Remuneration Committee comprises all non-executive directors and is chaired by the Trust Chair.

Non-executive directors

Richard Hunt CBE joined us as Chairman in July 2009. He was formerly the International President of the Chartered Institute of Logistics and Transport, and has experience extending across the aviation, logistics, international oil and brewing sectors. Richard is a former Chief Executive of Aviance Ltd which handles logistics at UK airports, and he was Chief Executive of EXEL Logistics Europe, the largest UK transport and logistics business. He has also served as a non-executive on the Highways Agency Advisory Board. Richard was appointed CBE for services to logistics and transport in the 2004 New Year Honours.

Brian Huckett is a former director of finance and information technology with Visa International, where he helped to bring card-based banking services to people in the developing worlds of Africa, the Middle East, and Eastern Europe. He has previously worked for TSB Bank, PA Management Consultants, and a variety of international construction companies. Brian is a member of the Audit Committee.

Dr Beryl Magrath MBE took up her post as non-executive director in 2005, and is chair of our Quality Committee. She is a former consultant anaesthetist and previously worked at Bromley Hospitals NHS Trust in Kent. She was a founder of South Bromley HospisCare in

1984 and was medical director of Bromley Hospitals NHS Trust between 1992 and 2000. Beryl is Vice Chairman of Governors for Castlecombe primary school in Bromley.

Sarah Waller CBE stepped down as a non-executive director at the end of November 2010, after serving on our Trust Board since December 2000.

Caroline Silver took up her post as a non-executive director with us in March 2006 and is chair of our Audit Committee and the Charitable Funds Committee. A chartered accountant by background, she is a partner and Managing Director of Moelis and Company, an independent investment banking firm. Prior to that, Caroline spent 20 years in major international investment banks, where her roles included Vice Chairman of Bank of America Merrill Lynch EMEA Investment Banking and Vice Chairman of Morgan Stanley's global Investment Banking Division. She is a specialist in advising clients on international mergers, acquisitions and financings, particularly in the financial services and healthcare sectors. Caroline started her career as a chartered accountant with Price Waterhouse (now PWC).

Roy Griffins CB took up his post as a non-executive director in March 2006. He is chairman of London City Airport and of the Channel Tunnel Intergovernmental Commission. He has had a 30-year career in the British civil and diplomatic service, and was the UK's director of civil aviation between 1999 and 2004, and director-general of Airports Council International Europe from 2004 to 2006. Roy is a member of the Audit and Quality Committees. Roy is also our Deputy Chairman.

Nigel Walmsley took up his post in March 2010. He is currently Chairman of the Broadcast Audience Research Board (BARB) – the research company which measures television viewing – as well as being a member of the Advertising Standards Authority and non-executive director of Passenger Focus, the statutory consumer voice of rail and bus passengers. Nigel was a member of the Quality Committee and stood down as a non-executive director at the end of March 2011. It is expected that this post will be filled during the forthcoming financial year (2011/12).

Jessica Cecil took up her post on 1 December 2010. She has over 20 years of experience working in broadcasting on flagship television programmes such as *Newsnight*, *Panorama* and *Tomorrow's World*. She is now Head of the Director General's Office at the BBC, responsible for strategic projects, senior stakeholder management and running the major boards of the corporation on his behalf.

Executive directors

Chief Executive Peter Bradley CBE joined the London Ambulance Service in May 1996 as Director of Operations and was appointed Chief Executive and Chief Ambulance Officer in 2000. He has worked for 20 years in a variety of posts with ambulance services in New Zealand and was awarded the CBE in the 2005 New Year Honours. In his part-time role for the Department of Health as National Ambulance Advisor, he led the strategic review of NHS ambulance services, the findings of which were published in June 2005.

Deputy Chief Executive Martin Flaherty OBE joined the Service in 1979. His career has included time spent as a paramedic, followed by 20 years as a manager in a variety of positions. He became an executive director in April 2005 and was responsible for coordinating the emergency medical response to the 7 July bombings that year. He was awarded an OBE in the 2006 New Year Honours and became Deputy Chief Executive in May 2009. From July 2010 to January 2011 Martin was on secondment with the HSE

National Ambulance Service in Ireland where he acted as interim Chief Executive. He is currently on secondment with the Great Western Ambulance Service where he has been interim Chief Executive since February 2011.

Director of Finance Michael Dinan joined us in November 2004. He had worked for 13 years for United Parcel Service in a variety of positions including Group Finance Director for the European logistics business. Michael is a fellow of the Chartered Institute of Management Accountants (CIMA).

Director of Health Promotion and Quality Steve Lennox was appointed as an executive director in January 2011, after joining us in September 2010. He was previously a member of the Chief Nurse's healthcare-associated infections and cleanliness team at the Department of Health where he worked at a national level with acute trusts, mental health trusts and ambulance trusts. A Registered General Nurse and a Registered Mental Nurse, Steve has worked in a variety of different clinical fields including HIV, critical care and neurosurgery.

Director of Human Resources and Organisation Development Caron Hitchen was appointed in May 2005. Caron is a qualified nurse, and her career has been predominantly NHS-based. She worked for five years at Mayday Hospital NHS Trust as Director of Human Resources and, prior to that, she spent seven years in human resources management roles at Ealing Hospital NHS Trust.

Medical Director Dr Fionna Moore was appointed in December 1997 and was made an executive director in September 2000. She also chairs our clinical steering group and clinical audit and research group. Fionna has more than 20 years' experience as a consultant in emergency medicine, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She is a BASICS doctor and holds a fellowship in immediate medical care from the Faculty of Pre-Hospital Care of the Royal College of Surgeons Edinburgh. In 2009, Dr Moore was appointed Trauma Director for London.

The Trust Board is supported by four other directors who are non-voting directors.

Directors

Director of Information Management and Technology Peter Suter was appointed in November 2004, after serving as Head of Information Technology at Sussex Police for 10 years. Before that, he had worked for Siemens-Nixdorf, GEC in South Africa, and BT. He is joint chair of the Information Governance Group and currently chair of the National Ambulance Service IM&T Directors Group. Peter holds a BSc in Information Technology from the Open University.

Director of Operations Richard Webber first joined the London Ambulance Service in 1991. His operational career saw him working as a paramedic, training manager and latterly as an operational manager until he left in 2000. He then worked for another ambulance trust, a strategic health authority, and a large acute trust before rejoining us in 2005. After periods heading up the east area and then Control Services, he became Director of Operations in May 2009.

Director of Corporate Services Sandra Adams took up her post in July 2009. Sandra joined us from Moorfields Eye Hospital NHS Foundation Trust, where she held the post of

Director of Corporate Governance and had project managed the application to become one of the first NHS foundation trusts in the country. Sandra had previously worked in commissioning of acute services, and in a number of community and hospital posts, including managing acute service reconfiguration in south west London.

Director of Service Development Kathy Jones left the Service in May 2010, after joining us from the South West Thames Health Authority in September 1993. Kathy became the Director of Service Development in 2005.

Deputy Director of Strategic Development Lizzy Bovill joined the Service as an assistant director of operations in 2008 after leading a change programme at Guy's and St Thomas' NHS Foundation Trust. Her career to date has focused on general management and service improvement roles both in large teaching hospitals, specialist networks and the voluntary sector. Lizzy's current role includes managing and delivering the range of contracts held by the Service with our commissioners, leading on commercial and strategic developments, stakeholder and partner management within and external to the NHS and delivering demand management initiatives.

Meetings

The Board meets in public eight times a year on Tuesdays from 10am in the conference room at our headquarters. Details of the meetings are published on our website at www.londonambulance.nhs.uk

We comply with the code of practice on openness in the NHS and our Trust Board meetings are always open to the public, with time set aside for their questions at the beginning and end of the meetings.

Directors' interests

A register is held of directors' interests. This is available on request from the Director of Corporate Services.

2010/11 financial summary statements

Financial review

We fulfilled four of our statutory financial duties in 2010/2011:

The figures given for periods prior to 2010/11 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

Income and Expenditure £000s

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Surplus/deficit(-) in year	332	1,258	113	398	725	-420	740
Cumulative surplus/deficit(-)	75	1,333	1,446	1,844	2,569	2,149	2,889
Cumulative deficit permitted (0.5%)	-963	-1,080	-1,080	-1,180	-1,308	-1,399	-1,418

The surplus in 2010/2011meant that the cumulative position improved for the tenth year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

1. On income and expenditure we reported a surplus of £740,000 for the year, and therefore did better than the break-even target set by the Department of Health for 2010/2011.

2. We had a £75,000 undershoot against our external financing limit (EFL) for the year, which we are permitted to do.

3. A return on assets (the capital cost absorption duty**)** of 3.5 per cent was achieved. This was within the permitted range of 3.0 per cent to 4.0 per cent.

4. In the capital programme £15.2m was spent on a range of projects, including ambulances, new technology projects and projects to improve the estate. Overall we under spent by £8,918,000 against our capital resource limit, which we are permitted to do.

We were able to pay 84 per cent of our non-NHS and NHS trade invoices respectively within 30 days, which was below the 95 per cent target set by the Department of Health.

Balance sheet

The largest item on the balance sheet is £143 million of fixed assets (£144 million in 2009/10) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. We fund the investment in capital assets through our capital programme. In 2010/11, we invested £15.2 million (£25.6 million in 2009/10). The most significant additions were related to the project to replace the emergency operations centre computer system, Mercedes ambulances and hazardous area response team (HART) vehicles.

We have a net working capital of -£4.7 million (-£6.7 million in 2009/10) and long-term creditors and provisions of £32.9 million (£38.6 million in 2009/10). We had £872,000 cash in the bank as at 31 March 2011 (£5.1 million in 2009/10).

We obtained and fully drew down a £10 million loan from the Department of Health to fund capital expenditures in 2009/10. The loan is spread over eight years with an average fixed interest rate of 2.65 per cent (£265,000) per annum.

In 2010/11, we obtained a loan of £107,000 from SALIX Finance Ltd to support our capital investment in technical measures to improve energy efficiency. The loan was drawn down in August and December 2010 for £60,000 and £47,000 respectively. It is an interest free, unsecured loan with two to five year repayment terms.

Our assets are ultimately owned by the public and the taxpayers' equity section of the balance sheet shows the component elements. Public dividend capital is £62.5 million (£60.9 million in 2009/10) of the equity – this represents the Department of Health's investment in us and annual dividends are payable on this sum. A further £35.7 million (£35.9 million in 2009/10) is held in a revaluation reserve representing the accumulated increase in value of our estate.

Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 11 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial Plan 2011/12

We have formally submitted a plan for 2011/12 that takes into account planned contracted income levels and the expenditure budgets that have been set for the new financial year. The plan is set to deliver a surplus of £2.7m.

Detailed financial planning work is in progress in preparation for our foundation trust application.

Financial risk

We monitor financial risk through the assurance framework and risk management processes as detailed in the statement of internal control included in the financial statements.

International Financial Reporting Standards (IFRS)

The Treasury has announced that public sector bodies are required to prepare their accounts under International Financial Reporting Statements (IFRSs) from 2009/10. It was the first year that we have prepared our accounts under IFRSs, resulting in the rework of 2008/09 results to act as prior year comparators in the 2009/10 accounts.

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2011 for all land and buildings. The net gain and loss on revaluation and impairments was £1,125,000 and £422,000 respectively.

IAS 19 requires us to accrue for remuneration earned but not yet taken. In this instance, we have made an accrual for annual leave of £3,521,000 for the current financial year (£1,321,000 in 2009/10).

Subsequent events after the balance sheet date

There was no important event occurring after the financial year end that has a material effect on the 2010/2011 financial statements.

Other information

The Audit Commission was our external auditor for the year ending 31 March 2011. We paid the Audit Commission £158,000 (£155,000 in 2009/10) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our audit committee.

The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

Independent auditor's report to the Directors of London Ambulance Service NHS Trust

I have examined the summary financial statements for the year ended 31 March 2011 which comprises the 2010/11 financial summary statements, the notes to the financial summary statements and the remuneration report which includes the salaries and pensions of senior managers and exit packages contained in the Annual Report.

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of directors and auditor

The Directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2011.

I have not considered the effects of any events between the date on which I signed my report on the statutory financial statements 9 June 2011 and the date of this statement.

Philip Johnstone, Officer of the Audit Commission
The Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ
9 June 2011

Related party transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with London Ambulance Service NHS Trust.

The Department of Health is regarded as a related party. In 2009/10 London Ambulance Service NHS Trust obtained a £10m capital investment loan from the Department and the current outstanding loan is £8,075k. It also had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	2010/11 Payments to Related Party £000	**2010/11** Receipts from Related Party £000	**2010/11** Amounts owed to Related Party £000	**2010/11** Amounts due from Related Party £000
Department of Health	966	7,396	0	130
London Strategic Health Authority	4	5,193	0	216
Richmond & Twickenham PCT	0	4,628	0	182
Westminster PCT	4	21,477	0	139
Tower Hamlets PCT	0	23,122	0	174
London Primary Care Trusts	49	210,222	24	3,945
Whipps Cross University Hospital NHS Trust	0	1,213	0	231
South London Healthcare NHS Trust	0	2,720	6	0
South West London and St Georges Mental Health NHS Trust	3	1,005	0	0
NHS Litigation Authority	614	0	1	0
NHS Business Service Authority	717	0	25	0

	2009/10 Payments to Related Party £000	2009/10 Receipts from Related Party £000	2009/10 Amounts owed to Related Party £000	2009/10 Amounts due from Related Party £000
Department of Health	230	4,820	202	2
London Strategic Health Authority	11	6,034	0	3,087
Richmond & Twickenham PCT	0	12,628	0	227
London Primary Care Trusts	127	244,124	19	2,094
Whipps Cross University Hospital NHS Trust	0	1,431	0	102
South London Healthcare NHS Trust	0	2,751	1	500
South West London and St Georges Mental Health NHS Trust	2	1,006	3	0
NHS Litigation Authority	689	0	1	0
NHS Business Service Authority	755	0	15	255

For 2010/11 Westminster PCT was the host PCT (2009/10 Richmond & Twickenham PCT).
We received an administration fee of £2,500 (2009/10 £2,500) from the London Ambulance Service Charitable Funds.

The London Ambulance NHS Trust is the corporate trustee of the funds.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of accountable officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- our expenditure and income has been applied to the purposes intended by Parliament and conforms to the authorities which govern them;
- effective and sound financial management systems are in place; and
- our annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Signed

Peter Bradley
Chief Executive
6 June 2011

Statement of Directors' responsibilities in respect of the accounts

The directors are required under the National Health Services Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of our state of affairs and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on the consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent; and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding our assets and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board
Signed

Peter Bradley
Chief Executive
6 June 2011

Mike Dinan
Finance Director
6 June 2011

STATEMENT ON INTERNAL CONTROLS 2010/11

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

As Accountable Officer I have overall accountability for having a robust risk management system in place which is supported by a management structure, processes and monitoring arrangements, and an assurance and risk management framework. These arrangements are documented in the Risk Management Policy and Strategy which defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and subsequent management of the identified risks and the responsibilities of individuals and it describes the Trust Board's corporate responsibility for the system of internal control and robust risk management.

As part of London's local health economy we work with our partners to minimise the risks to patient care. To do so we meet routinely with our lead commissioners and with the performance team at NHS London, and strive to meet and maintain the key performance targets set for ambulance services. We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London. In 2010/11 this has included the development of pathways for stroke, cardiac and major trauma care across London, as well as developing pathways for urgent and emergency care in local areas. In the past year we have consolidated our cardiac referral pathways and developed bypass criteria for patients who have suffered acute stroke and major trauma, so that they can receive the highest standards of care in specialist centres.

2. The Purpose of the System of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the London Ambulance Service NHS Trust for the year ending 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The management of risk is delegated by the Trust Board to the Chief Executive as Accountable Officer and to two board committees: Audit and Quality. An executive

committee, Risk Compliance & Assurance (RCAG), is chaired by the Director of Finance with delegated authority from the Trust Board and the Quality Committee to take an overview of our risk management activities.

Risks are separated into the following groups: strategic, corporate, clinical, governance, financial, human resources, health and safety, business continuity, information management and technology, infection control, logistics, operational, and reputational. Management of risks is delegated to directors:

- Director of Finance – financial risk management.
- Medical Director – clinical quality, safety and effectiveness (and risks associated with infection prevention and control and safeguarding up to September 2010).
- Director of Human Resources & Organisational Development – operational risk management such as health and safety, occupational health, training, and human resources.
- Director of Operations – operational risk management such as frontline ambulance services and control rooms which could impact upon patient care.
- Director of Information Management & Technology – information management and technology, and information risk management.
- Director of Corporate Services – corporate risk management such as regulation and compliance, and overall responsibility for ensuring that corporate risk processes and controls are in place.
- Director of Health Promotion & Quality – risks concerning infection prevention and control and safeguarding (since September 2010).

The Directors of Finance and Corporate Services routinely attend the Audit Committee. Three committees – Risk Compliance and Assurance, Clinical Safety & Effectiveness, and Learning from Experience – report to the Quality Committee which is attended by the chairs. The Director of Health Promotion & Quality is the nominated executive for infection prevention and control and also for safeguarding; the Director of Human Resources and Organisation Development is the nominated director for security management; and the Director of Information Management & Technology is the senior information risk owner reporting to the Trust Board.

A mandatory training plan is in place for our employees. This was assessed by the NHSLA in October 2010 and the standard was achieved at level one. New staff attend a corporate induction which covers the basic risk and safety management responsibilities and includes basic information governance principles such as data protection and confidentiality. Staff are trained to the level and for the areas appropriate to their role. The regular Service-wide bulletin system is used to communicate changes to practice and there are clinical and training updates published for all staff via the intranet. Individual managers are responsible for ensuring their staff receive such information and undertake the training and development required for them to safely undertake their role.

The risk management and governance structure was implemented in April 2010 and an interim review was undertaken in December 2010. The chairman of the Trust Board seeks assurance at each meeting from the chairs of the Audit and Quality committees that the arrangements are working effectively. The structure will be reviewed early in 2011/12 to ensure that it is working effectively for the Trust Board and that it minimises the risks facing us and our ability to meet our strategic goals.

4. The risk and control framework

The Risk Management Policy and Strategy defines the risk management process which specifies the way risk (or change in risk) is identified, assessed and managed through controls. We are compliant with level one of the NHSLA risk management standards for ambulance trusts.

The Risk Management Policy and Strategy describes the process for embedding risk management throughout the Trust and during 2009/10 we introduced the risk register procedure to support this process.

Incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the risk and safety team, using the NPSA risk severity matrix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the RCAG or monitored at a local level.

Following an inspection in 2009/10 against the requirements of the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance' under the Health and Social Care Act 2008, we implemented a number of recommendations and a 12-point action plan which has been managed throughout the year. Improved audit practices are now in place and providing assurance of compliance as well as identifying areas that require more focus.

We received unconditional registration from the CQC in March 2010 to provide the following regulated activities:

- transport services, triage and medical advice provided remotely;
- treatment of disease, disorder or injury; and
- diagnostic and screening procedures.

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The board assurance framework has been further developed during the year to show the linkages between the strategic goals for the next five years and the most significant strategic risks to the achievement of these. This is mapped to the key risks the Trust Board chose to focus on during the year as well as the top risks on the corporate risk register. The board assurance framework is mapped to the care Quality Commission's outcomes and requirements. The Quality Committee reviews the board assurance framework and corporate risk register quarterly as does the Trust Board. The Risk Compliance and Assurance Group review the corporate risk register in detail at each meeting.

Control measures are in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments in to the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

We have undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Actions have been taken in the following areas to strengthen control and minimise risk:

Human resources and organisation development

- We have worked to ensure compliance with the Equality Act 2010.
- Our senior management-led Equality and Diversity Steering Group is functioning well.
- The number of frontline staff delivering patient care increased by 421 to improve achievement of the Category A and B targets.

Clinical care

- We have acquired 390 new model defibrillators to help support the improvement in the cardiac survival rate in London.
- We continue to provide cardio-pulmonary resuscitation training to the public and businesses.
- We have improved the delivery of our clinical care fleet with the acquisition of 72 modern ambulances as part of a rolling programme.
- Clinical care pathways are being developed to support emergency and urgent healthcare across London.
- Training is in place to support the conveyance of major trauma, stroke and cardiac patients to specialist units, bypassing local hospitals, where appropriate
- Management of controlled drugs:
    - Following an audit review undertaken on 2008/09, the auditors undertook a further review in July 2009 and found a number of control weaknesses leading to an audit opinion of 'limited assurance'. We have implemented a robust action plan and progress has been made in the latter part of the year. As a result of the audit opinion, our Trust Board considered there to be insufficient evidence against the core standard for medicines management in the December 2009 declaration. Over the past year we have worked closely with the Metropolitan Police Controlled Drugs Unit to undertake unannounced inspections. We have also introduced a system of peer review which is being rolled out across the organisation. The Trust Board has since received evidence of progress made and has the assurance that there are no significant lapses that could cause a risk to patient safety. The BAF identifies the gaps in controls and assurance specifically as failure to comply with policies and procedures relating to the management of controlled drugs but has assurance that the underpinning policies are sound.
- Medical devices: an audit identified a number of weaknesses in respect of stock holding, reporting of losses and monitoring of losses of these items of equipment. An action plan is being prepared to address and resolve these issues.

Control services

- During the peak in swine flu-related calls we worked closely with NHS Direct to ensure that ambulances were despatched appropriately.

- The expansion of the clinical support function which supports decision making by frontline staff, and the capacity management of specialist units specifically relating to major trauma, stroke and cardiac care.
- Resilience in our control room has been improved with the deployment of increased resources to meet demand.
- Pressure levels within our resourcing escalatory action plan were refined during the year, and contingency plans developed in the event of significantly higher demand as a result of swine flu.

Information management and technology

- We protect data through administrative and technical controls.
- Administrative controls include:
  - data handling policies
  - regulatory compliance, e.g. Caldicott recommendations, NHS Code of Practice, Data Protection Act 1998, Freedom of Information Act 2001and ISO 27001
  - employee background checks.
- Technical controls include:
  - edge security, for example, firewalls and content filtering appliances
  - access control mechanisms
  - laptop encryption
  - removable media encryption.
- Work in implementing the new computer aided dispatch system, which will significantly enhance resilience and capability, remains on track for implementation in June 2011.
- The creation of a dedicated event control room was completed to plan. This facility provides coordination support to annual events such as the London Marathon and the Notting Hill Carnival.

Business continuity

- Our programme of testing departmental plans has continued.
- We held a pandemic flu business continuity workshop during the year and as a result of this a business continuity departmental flu plan document was put in place.
- A business continuity plan for ambulance station complexes has been developed which will include adverse weather considerations.
- Work on developing fuel resilience has taken place.
- Training for both operational and support staff has been under development and for the latter has been delivered as part of a one-day refresher course.

Accounting

- The control weakness listed in 2009/10 has been fully resolved and we have assurance that all journals have been uploaded and posted by different people through out 2010/11.
- The outstanding audit points suggest that during 2010/11 there was a systematic weakness in relation to all budget holders signing off budgets at the earliest opportunity. This control weakness was addressed by November 2010.

Public involvement

- Complaints, incidents, patient experiences and claims are all indicators of risk and are managed and reported in line with our policy. We operate a policy of openness and transparency and seek to engage the public in resolving issues and managing risks. We work in partnership with the LAS Patients' Forum to consider issues of concern about service provision. The Learning from Experience group has been developing the reporting process for integrated review and learning from complaints, patient experiences, incidents, claims and inquests, and the Trust Board receives a monthly summary of complaints activity.

Information governance

- Records management (patient report forms):
    - Internal audit undertook a review of patient record forms and identified that these were not being completed in accordance with our policy in certain cases and that this was not being followed up at a local level. The completeness of patient report forms is monitored at station and complex level and the management of clinical records is a theme throughout the clinical programme training. The risk of unauthorised access has been reduced by repairing and purchasing new red and black patient report form boxes which are used for the collection and transporting of patient identifiable information.

- A serious incident involving the theft of an unencrypted lap top which contained patient information was reported to the Information Commissioners Office in February 2011. A second serious incident report was submitted in March following the theft of patient information from one of our vehicles. We are liaising closely with the Information Commissioner's Office while both incidents are being investigated.

Control issues

The Head of Internal Audit's opinion is as follows:

Based on the work undertaken in 2010/11, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design of controls, and the inconsistent application of controls put the achievement of particular objectives at risk.

The key findings are:-

- Hazardous Area Response Team (HART): Our audit of the HART team identified a number of weaknesses with regards to the establishment of the HART teams within London, specifically around resourcing of the teams and development of suitable accommodation.

  Since the conclusion of our audit, the Trust has made significant progress in addressing the recommendations made, with seven out of the ten now implemented, and action plans in place for two of the remaining three, with the final recommendation outside the control of the Trust to implement.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by bodies such as external auditors, registration under the Care Quality Commission, and the Health and Safety Executive.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit and Quality Committee, and the Risk Compliance and Assurance Group. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board delegates authority for risk management to two committees – the Audit Committee and the Quality Committee. The Chairs of these committees provide a verbal report to the Trust Board following the most recent meeting providing assurance on risk management and the effectiveness of the systems and controls that are in place.

The Audit Committee advises the Board about how well we are operating the risk management system. To carry out this responsibility it receives reports from the Chief Executive and from both internal and external audit when they review risk management systems and processes. The Quality Committee provides assurance to the Trust Board and to the Audit Committee on quality, safety and risk management.

The Risk Compliance and Assurance Group has delegated responsibility for taking a general overview of all our risk management activities and to pick up any specific risk management issues which are not covered by the specific Audit and Quality Committees. This committee also receives a report on the management of all identified high priority risks that have been identified by our systems and processes.

The Trust Board receives regular reports from the Director of Finance and the Medical Director, and my report as Chief Executive provides assurance about the performance of the organisation and any key strategic, regulatory or compliance issues arising during the reporting period. The Trust Board receives a quarterly report on clinical quality and patient safety. In addition, the Trust Board receives an annual report from the Audit Committee and on Equality and Inclusion, and routine reports from patient experiences.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that the London Ambulance Service NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Peter Bradley
Chief Executive Officer
6 June 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2011

	2010/11	2009/10
	£000	£000
Revenue		
Revenue from patient care activities	**280,304**	269,557
Other operating revenue	**3,313**	10,307
Operating expenses	**(279,541)**	(275,633)
Operating surplus (deficit)	**4,076**	4,231
Finance costs:		
Investment revenue	**823**	577
Other gains and (losses)	**1,068**	(128)
Finance costs	**(1,508)**	(1,540)
Surplus/(deficit) for the financial year	**4,459**	3,140
Public dividend capital dividends payable	**(3,772)**	(3,560)
Retained surplus/(deficit) for the year	**687**	(420)
Other comprehensive income		
Impairments and reversals	**(160)**	(10,692)
Gains on revaluations	**1,125**	15,315
Receipt of donated/government granted assets	**0**	0
Net gains/(losses) on available for sale financial assets	**0**	0
Reclassification adjustments:		
- Transfers from donated and government grant reserves	**(2)**	(2)
- On disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year	**1,650**	**4,201**

All income and expenditure is derived from continuing operations.

Reported NHS financial performance position [Adjusted retained surplus/(deficit)]

Retained surplus/(deficit) for the year	**687**
IFRIC 12 adjustment	**0**
Impairments	**303**
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]	**990**

A trust's reported NHS financial performance position is derived from its retained surplus/(deficit), but adjusted for the following:

- Impairments to Fixed Assets. 2009/10 was the final year for organisations to revalue their assets to a Modern Equivalent Asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.
- The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10). NHS trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's operating position.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2011

	31 March 2011 £000	31 March 2010 £000
Non-current assets		
Property, plant and equipment	**128,044**	131,434
Intangible assets	**14,479**	12,639
Investment property	**0**	0
Other financial assets	**0**	0
Trade and other receivables	**6,753**	10,526
Total non-current assets	**149,276**	154,599
Current assets		
Inventories	**2,571**	2,783
Trade and other receivables	**20,342**	16,448
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**872**	5,141
	23,785	24,372
Non-current assets held for sale	**650**	650
Total current assets	**24,435**	25,022
Total assets	**173,711**	179,621
Current liabilities		
Trade and other payables	**(21,952)**	(25,026)
Other liabilities	**0**	0
Borrowings	**(4,847)**	(4,748)
Other financial liabilities	**0**	0
Provisions	**(1,418)**	(1,938)
Net current assets/(liabilities)	**(3,782)**	(6,690)
Total assets less current liabilities	**145,494**	147,909
Non-current liabilities		
Borrowings	**(24,931)**	(29,633)
Trade and other payables	**0**	0
Other financial liabilities	**0**	0
Provisions	**(7,955)**	(8,949)
Other liabilities	**0**	0
Total assets employed	**112,608**	109,327
Financed by taxpayers' equity:		
Public dividend capital	**62,516**	60,885
Retained earnings	**14,796**	12,943
Revaluation reserve	**35,713**	35,914
Donated asset reserve	**2**	4
Government grant reserve	**0**	0
Other reserves	**(419)**	(419)
Total Taxpayers' Equity	**112,608**	109,327

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 31 March 2009							
As previously stated	57,523	12,609	32,045	6	0	(419)	101,764
Prior Period Adjustment	0	0	0	0	0	0	0
Restated balance	57,523	12,609	32,045	6	0	(419)	101,764
Changes in taxpayers' equity for 2009/10							
Total comprehensive income for the year:							
Retained surplus/(deficit) for the year	0	(420)	0	0	0	0	(420)
Transfers between reserves	0	754	(754)	0	0	0	0
Impairments and reversals	0	0	(10,692)	0	0	0	(10,692)
Net gain on revaluation of property, plant, equipment	0	0	15,315	0	0	0	15,315
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	0	0	0	0
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(2)	0	0	(2)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	3,362	0	0	0	0	0	3,362
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2010	60,885	12,943	35,914	4	0	(419)	109,327

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY (Continued)

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010/11							
Balance at 1 April 2010	60,885	12,943	35,914	4	0	(419)	109,327
Total Comprehensive Income for the year							
Retained surplus/(deficit) for the year	0	687	0	0	0	0	687
Transfers between reserves	0	1,166	(1,166)	0	0	0	0
Impairments and reversals	0	0	(160)	0	0	0	(160)
Net gain on revaluation of property, plant, equipment	0	0	1,125	0	0	0	1,125
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Net gain on revaluation of non current assets held for sale	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	0	0	0	0
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(2)	0	0	(2)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	1,631	0	0	0	0	0	1,631
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2011	62,516	14,796	35,713	2	0	(419)	112,608

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2011

	2010/11	2009/10
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit)	**4,076**	4,231
Depreciation and amortisation	**11,713**	12,002
Impairments and reversals	**303**	1,845
Net foreign exchange gains/(losses)	**0**	0
Transfer from donated asset reserve	**(2)**	(2)
Transfer from government grant reserve	**0**	0
Interest paid	**(1,341)**	(1,366)
Dividends paid	**(3,972)**	(3,360)
(Increase)/decrease in inventories	**212**	(183)
(Increase)/decrease in trade and other receivables	**386**	(1,136)
(Increase)/decrease in other current assets	**0**	0
Increase/(decrease) in trade and other payables	**2,622**	1,130
Increase/(decrease) in other current liabilities	**0**	0
Increase/(decrease) in provisions	**(1,680)**	(1,217)
Net cash inflow/(outflow) from operating activities	**12,317**	11,944
Cash flows from investing activities		
Interest received	**61**	53
(Payments) for property, plant and equipment	**(15,006)**	(15,064)
Proceeds from disposal of plant, property and equipment	**7,018**	323
(Payments) for intangible assets	**(5,686)**	(3,867)
Proceeds from disposal of intangible assets	**0**	0
(Payments) for investments with DH	**0**	0
(Payments) for other investments	**0**	0
Proceeds from disposal of investments with DH	**0**	0
Proceeds from disposal of other financial assets	**0**	0
Revenue rental income	**0**	0
Net cash inflow/(outflow) from investing activities	**(13,613)**	**(18,555)**
Net cash inflow/(outflow) before financing	**(1,296)**	(6,611)
Cash flows from financing activities		
Public dividend capital received	**1,631**	3,362
Public dividend capital repaid	**0**	0
Loans received from the DH	**0**	10,000
Other loans received	**107**	0
Loans repaid to the DH	**(1,244)**	(681)
Other loans repaid	**0**	0
Other capital receipts	**0**	0
Capital element of finance leases and PFI	**(3,443)**	(3,522)
Net cash inflow/(outflow) from financing	**(2,949)**	9,159
Net increase/(decrease) in cash and cash equivalents	**(4,245)**	2,548
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**5,081**	2,533
Effect of exchange rate changes on the balance of cash held in foreign currencies	**0**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**836**	5,081

Remuneration report

Our Remuneration Committee consists of the Chairman and the six non-executive directors. The Chief Executive is usually in attendance but is not present when his own remuneration is discussed.

The Remuneration Committee is responsible for advising the Board about appropriate remunerations and terms of service for the Chief Executive and executive directors. It makes recommendations to the Board on all aspects of salary, provisions for other benefits, including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

In formulating their recommendations to the Board, the Committee takes into account a number of factors, including the requirement of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers Pay Framework.

Executive directors are subject to normal terms and conditions of employment. They are employed on permanent contracts which can be terminated by either party with six months' notice.

Their performance is assessed against individually set objectives and monitored through an appraisal process.

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on page 44**.**

The appointment and remuneration of the Chairman and the non-executive directors are set nationally. Non-executive directors are normally appointed for a period of four years and usually serve two terms in office.

The information contained below in the Salary and Pension Entitlement of Senior Managers has been audited by our External Auditors.

Salary and pension entitlements of senior managers

A) Remuneration

Name and Title	2010-11			2009-10		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Richard Hunt, Chairman	£20,001-£25,000	£0		£15,001-£20,000	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Brian Huckett, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Jessica Cecil, Non-Executive Director	£0-£5,000	£0		-	-	
Nigel Walmsley, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	£0	
Roy Griffins, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Sarah Waller, Non-Executive Director	£0-£5,000	£0		£5,001-£10,000	£0	
* Peter Bradley, Chief Executive	£110,001-£115,000	£0	£2,277	£110,001-£115,000	£0	£3,448
Michael Dinan, Director of Finance	£115,001-£120,000	£0		£115,001-£120,000	£0	
**Martin Flaherty, Deputy Chief Executive	£50,001-£55,000	£0	£1,326	£115,001-£120,000	£0	£1,300
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£100,001-£105,000	£0	
Stephen Lennox, Director of Health Promotion & Quality	£5,001-£10,000	£0		-	-	
*** Fionna Moore, Medical Director	£70,001-£75,000	£0		£70,001-£75,000	£0	

The figures shown under the heading 'benefit in kind' refer to the provision of lease cars.
* Excludes remuneration recharged to the Department of Health for role as National Ambulance Advisor.
** Martin Flaherty was on a secondment to the Irish Ambulance Service from July 2010 to January 2011 and to Great Western Ambulance Service NHS Trust since February 2011.
*** Fiona Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.
Sarah Waller and Nigel Walmsley resigned as non-executive director in November 2010 and March 2011 respectively. Jessica Cecil was appointed as a non-executive director on 1 December 2010. Stephen Lennox was appointed as Executive Director of Health Promotion & Quality in January 2011.

Salary and pension entitlements of senior managers (continued)

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Richard Hunt, Chairman	**	**	**	**	**	**	**	
Caroline Silver, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Brian Huckett, Non-Executive Director	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Nigel Walmsley, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Non-Executive Director	**	**	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£2,501-£5,000	£10,001-£15,000	£35,001-£40,000	£297,431	£288,254	£6,424	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£5,001-£10,000	£25,001-£30,000	£146,122	£139,828	£4,406	
Martin Flaherty, Deputy Chief Executive	£0-£2,500	£5,001-£7,500	£15,001-£20,000	£55,001-£60,000	£374,101	£366,768	£5,133	
Caron Hitchen, Director of Human Resources	£0-£2,500	£2,501-£5,000	£25,001-£30,000	£80,001-£85,000	£441,267	£471,771	-£21,353	
Stephen Lennox, Director of Healthcare Promotion	£0-£2,500	£2,501-£5,000	£25,001-£30,000	£80,001-£85,000	£415,155	£358,126	£6,453	
Fionna Moore, Medical Director	£0-£2,500	£2,501-£5,000	£45,001-£50,000	£140,001-£145,000	£1,137,365	£1,137,365	£0	

** As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

C) Expenses 2010/11

Name and Title	Travel - UK	Travel - Overseas	Provision of Lease Cars	Mobile Phones	Subscription	Hospitality	Total
	£	£	£	£	£	£	£
Richard Hunt, Chairman	3,405	-	-	-	-	16	**3,421**
Beryl Magrath, Non-Executive Director	113	-	-	-	-	-	**113**
Sarah Waller, Non-Executive Director	-	-	-	-	-	-	**-**
Roy Griffins, Non-Executive Director	-	-	-	-	-	-	**-**
Brian Huckett, Non-Executive Director	-	-	-	-	-	-	**-**
Caroline Silver, Non-Executive Director	-	-	-	-	-	-	**-**
Nigel Walmsley, Non-Executive Director	-	-	-	-	-	-	**-**
Jessica Cecil, Non-Executive Director	-	-	-	-	-	-	**-**
Peter Bradley, Chief Executive	3,084	-	6,272	729	-	139	**10,224**
Michael Dinan, Director of Finance	604	-	-	486	-	349	**1,439**
Martin Flaherty, Deputy Chief Executive	34	-	7,344	-	-	-	**7,378**
Caron Hitchen, Director of Human Resources	616	511	-	457	143	-	**1,727**
Fionna Moore, Medical Director	-	-	1,996	799	-	-	**2,795**
Stephen Lennox, Director of Health Promotion & Quality	-	-	-	-	-	-	**-**
Total	**7,856**	**511**	**15,612**	**2,471**	**143**	**504**	**27,097**

Sarah Waller resigned as a non-executive director on 30 November 2010 and Jessica Cecil was appointed as a non-executive director on 1 December 2010.
Stephen Lennox was appointed as Director of Health Promotion & Quality in January 2011.
The Trust Board approves all travel outside of the European Community.

The above expense figures have not been audited.

Reporting of other compensation schemes – exit packages 2010/11

NHS Body		**London Ambulance Service NHS Trust**			
	a	b	c	d	e
1	**Exit package cost band (including any special payment element)**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band (total cost)**	**Number of departures included in (b) and (c) where special payment element (totalled))**
2	**<£20,001**	0	0	0	0
3	**£20,001 - £40,000**	0	1	1 (£40,000)	0
4	**£40,001 - £100,000**	1	0	1 (£87,000)	0
5	**£100,001 - £150,000**	1	0	1 (£136,000)	0
6	**£150,001 - £200,000**	0	0	0	0
7	**Total number of exit packages by type (total cost)**	3 (£223,000)	1 (£40,000)		
8				**Total number (and cost) of exit packages**	**Total number of special payments (and total cost of special payment element)**
				3 (£263,000)	0

Management costs

	2010/11 £000	2009/10 £000
Management costs	18,921	19,300
Income	281,197	271,143

Better payment practice code – measure of compliance

	2010/11		2009/10	
	Number	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	**62,654**	**83,829**	64,530	87,130
Total non NHS trade invoices paid within target	**52,816**	**75,015**	55,518	80,160
Percentage of non-NHS trade invoices paid within target	**84%**	**89%**	86%	92%
Total NHS trade invoices paid in the year	**421**	**4,379**	525	3,038
Total NHS trade invoices paid within target	**352**	**3,392**	459	2,606
Percentage of NHS trade invoices paid within target	**84%**	**77%**	87%	86%

The Better Payment Practice Code requires us to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

EXTERNAL FINANCING

We are given an external financing limit which it is permitted to undershoot.

	£000	2010/11 **£000**	2009/10 £000
External financing limit		**1,371**	18,423
Cash flow financing	1,296		6,611
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**1,296**	6,611
Undershoot/(overshoot)		**75**	11,812

This summary financial statement does not contain sufficient information to allow as full an understanding of our results and state of affairs nor of our policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. Where more detailed information is required a copy of our full accounts and reports are obtainable free of charge.

A copy of our full accounts is available from the Financial Controller at the following address:

Financial Controller
Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Explanation of statutory financial duties

Break-even duty

We are required to break-even on our income and expenditure account taking one year with another.

External financing limit (EFL)

The external financing limit (EFL) is the means by which the Treasury via the NHSE controls public expenditure in NHS trusts. This is an absolute financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. There is no tolerance above the EFL target without prior notification and agreement.

Most of the money spent by us is generated from our service agreements for patient care and income generation (income from operations). The EFL determines how much more (or less) cash than is generated from its operations we can spend in a year.

Each year, each individual NHS trust is allocated an EFL as part of the national public expenditure planning process. We have a statutory duty to maintain net external financing within its approved EFL.

Capital resourcing limit (CRL)

The CRL is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that resources allocated by the government for capital spending are used for capital, rather than to support revenue budgets. All NHS bodies have a capital resource limit. The CRL is accruals based as opposed to the cash-based EFL in NHS trusts.

Underspends against the CRL are permitted and overspends against the CRL are not permitted.

A capital resource limit controls the amounts of capital expenditure that a NHS body may incur in the financial year.

Capital Cost Absorption Duty

The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. We are required to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, bears to the average relevant net assets of the trust. To meet this duty we must achieve a rate between 3.0 per cent and 4.0 per cent.