London Ambulance Service NHS
NHS Trust

Annual Report

2011/12

Contents

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 provide 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 over 4,500 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 2011/12 we handled over 1.6 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, and visit London.

Chairman's views

What were the key achievements last year?

Last year was one of our best ever in terms of the number of calls handled, patients attended to within eight minutes, and lives saved.

It was also a year in which we hit our financial targets. We were near the top of the new clinical quality indicators, and our chief executive has been instrumental in pushing for a new clock start time initiative, which will help triage our calls more efficiently and ensure we send the appropriate response.

What were the biggest challenges and how were these met?

Our events planning experience was put to the test as London hosted a number of high-profile events during the year including the Royal Wedding and President Obama's state visit.

The 7 July bombings inquests, which concluded May 2011, were a hugely challenging experience for colleagues who had to relive those terrible events as they gave evidence. And I recall watching the London riots unfold in August and thinking about the daunting task faced by our staff attending patients in those difficult circumstances.

On top of that, as the financial year drew to a close, we brought in our new 999 call-taking and dispatch system. This has been a difficult and demanding project, as all such complex system upgrades tend to be. However, the dedication and commitment of staff from all areas of the organisation has paid off, and the system is working well.

What improvements have patients seen?

We attended more critically ill and injured patients than ever before last year, and we have continued to improve the care we provide to them.

We play a vital role in the London trauma system, taking patients with life-threatening injuries such as amputations and stab wounds to specialist centres for treatment; latest figures show that, as a result, an additional 58 of these patients survived in London compared to the national average.

More people who suffer a cardiac arrest, when their heart stops beating, are surviving because of the care we provide. And our staff now take over 90 per cent of our patients who have heart attacks to specialist treatment centres.

It is not only our most seriously injured and ill patients who are getting better care; we are referring more elderly people who fall in their home to their GP so that solutions can be found to prevent this. And we are working with more mental health trusts to improve the care we provide to their patients.

When do you expect to become a foundation trust?

We were disappointed not be granted foundation trust status this year. We were rated on a framework and when everything was added up, we were told we were not quite ready. We aim to achieve it next year instead.

The Government expects us to become a foundation trust, so we need to respond to that. But, this status will bring advantages, including the opportunity to retain any surplus budget to reinvest in our business, and this provides us with greater freedom to shape our Service for the future.

Chief Executive's views

What kind of year has it been for the Service?

It has been one of our most successful years ever. We have continued to answer 999 calls to world-class standards and can point to improvements in the quality of care we provide across a range of patient groups, from stroke, cardiac care and trauma patients to those who need end-of-life care.

Alongside our successes, we've faced some challenges. We received a record number of 999 calls last year, making it our busiest year ever. We came under pressure when half of our staff withdrew their labour during industrial action over the Government's proposed pension reforms last November, and we have been the focus of reviews by the London Assembly and the National Audit Office.

There is no doubt that the issues and scrutiny we face in London are different to elsewhere in the country, and I feel really privileged and proud to have led the London Ambulance Service over the last 12 years. It is, in my view, the best capital city ambulance service in the world.

How has the Service performed against the new national clinical quality indicators?

The new national indicators show us how the quality of care we provide compares with other ambulance services across the country, and the first year's results are encouraging.

We have some of the fastest 999 call answering rates in the country, and we are doing particularly well in terms of our re-contact rates, which show that the number of patients who call us back after we have given them advice over the phone or treated and discharged them at scene is very low.

The care we provide to patients in cardiac arrest is of a very high standard, and we provide more clinical advice over the telephone than many ambulance services. Of course, there is always more we can do and we will focus on those areas where we are doing less well over the next year.

You announced a five-year savings plan of £53m. How will you achieve this without compromising patient care?

All NHS trusts need to achieve their share of savings and we are no different.

In the first year of our savings plan we made £15m of savings without affecting patient care. This year, we need to find further savings of £12.5m and we will continue to keep a close eye on whether budget reductions are having any impact on the quality of care we provide.

We know that we can work more efficiently, and we continue to look at more appropriate ways of responding to our patients to ensure they get the right care, first time.

This includes providing more clinical advice over the phone, reducing the number of resources we send to calls when it is not necessary, and working with hospitals to reduce the amount of time it takes our crews to hand over patients at A&E departments. We also

want to identify more alternative places of care to hospital where our staff can take patients for treatment.

Are you ready for the Olympic and Paralympic Games?

Yes, we are. We have spent a number of years preparing and planning for what will be the biggest event we have ever dealt with.

We have around 440 frontline staff dedicated to working at Games venues – half of these are coming from other NHS ambulance services around the country.

We expect demand on our Service to be around five per cent higher than normal, with it increasing by nine per cent during peak periods. Our priority will be to maintain our day-to-day emergency service across the capital whilst providing medical care to Olympic-related patients.

We have tested our plans and held our first ever national exercise to test all aspects of our response. The Games promise to be a great opportunity to show how the NHS ambulance services in England can work together to deliver high quality patient care.

What are the other priorities for this year?

The Trust Board has agreed to have fewer priorities this year given that we have the 2012 Games and a range of other large events to manage.

However, it is important that we continue develop our Service so we will open a second call-taking room this year to provide more resilience; we will continue to work towards becoming a foundation trust; and we will further improve our fleet. We will address issues that were raised by our staff at last year's consultation meetings and through the staff survey, and we want to continue to develop our relationships with key stakeholders including the new clinical commissioning groups who will buy our services.

Directors' Report

Our vision and strategic goals

Our vision is to be a world-class service, meeting the needs of the public and our patients, with staff who are well-trained, caring, enthusiastic and proud of the job they do.

We want to deliver the highest standards of healthcare and contribute towards Londoners having health outcomes that are among the best in the world.

We have a vital role to play in delivering healthcare in London, and have achieved much to improve the quality of our service, and ensure that our patients receive the right care, delivered in the right place at the right time.

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.

In December last year, NHS London gave approval for our foundation trust application to be submitted to the Department of Health. Having reviewed our application, the Department of Health has asked for additional assurance to be provided on some areas. We have revisited the timescales for our submission, taking account of our focus over the summer to provide a safe Olympic and Paralympic games, and we anticipate that we will resubmit our application to the Department of Health in March 2013.

Our achievements during 2011/12

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

We attended more patients than ever before in 2011/12, responding to more than one million incidents.

Over the last 12 months, we have continued to improve the care we provide to our patients, whether they have life-threatening conditions or less serious illnesses or injuries. And since April last year, the quality of care we provide has been measured against a range of clinical indicators, which extend beyond time-based targets.

Our Quality Account reports in detail on the progress we have made in improving the quality of care we provide to our patients. Below are some of the key achievements.

- ***Improving the experience and outcomes for patients who are critically ill or injured***

  Trauma care: Our staff continue to play a vital role in the new London trauma system which saw 58 additional patients with life-threatening injuries, such as amputations and gunshot wounds, survive during 2010/11, compared with the national average.

  Following a clinical assessment and vital treatment at scene, ambulance crews take trauma patients direct to one of four specialist centres in the capital where consultants are on hand 24/7 to provide expert clinical care, giving patients the best possible chance of survival. The average ambulance journey time from the scene of an incident to a major trauma centre is 16 minutes.

  Cardiac care – heart attack patients: In 2011/12, we took over 2,600[1] patients who were diagnosed as suffering a common type of heart attack, known as an ST-elevation myocardial infarction, directly to a heart attack centre. There are eight specialist heart centres in London where patients undergo primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

  The new national clinical indicators measure how many heart attack patients receive primary angioplasty within two and a half hours of having a heart attack; in London the latest available figure (for the period April to December 2011) is 91.9 per cent.

  Cardiac care – cardiac arrest patients: The chances of surviving a cardiac arrest in London are better than ever, and are higher than elsewhere in the country.

  Our most recent figures (for the period April to December 2011) show that 30.3 per cent of patients whose hearts stopped beating, at home or in public, were resuscitated and discharged from hospital. Back in 1998/99, only 2.5 per cent of these patients survived.

[1] This figure is provisional based on data available on 18 May 2012

The current figures are also a significant increase on the cardiac arrest survival rate for 2010/11 which was recorded as 22.8 per cent, when 259 patients survived after their hearts stopped.

The improvement in cardiac arrest survival rates reflects a wide range of developments in the care and treatment of cardiac patients in the capital.

The public has an important part to play as well, and we have done a great deal of work to enable others to start giving life-saving treatment to cardiac arrest patients before we arrive.

Working with the British Heart Foundation, we placed a further 185 defibrillators – machines that are used to re-start a patient's heart with an electric shock – in public places last year. This means there are now over 750 defibrillators across London including at tourist attractions, and in airports and train stations. And we trained almost 1,400 people working in these areas in their use in 2011/12, bringing the total to 8,058 across the capital.

During the last 12 months, our staff also trained 8,234 members of the public in cardio-pulmonary resuscitation – a simple life-saving technique which involves giving chest compressions and rescue breaths to someone whose heart has stopped beating.

We currently manage 30 community responder and co-responder schemes in London whereby volunteers are trained to attend emergency calls in their local area and provide first aid to patients until an ambulance arrives. We now have 750 trained volunteers within these schemes.

Stroke care: We take patients who we diagnose with stroke symptoms directly to one of eight specialist stroke centres in London. Here they have rapid access to life-saving treatment which can increase their chances of survival and cut the risk of long-term disability caused by a stroke – which occurs when the blood supply to part of the brain is cut off.

We took 8,200 stroke patients to a hyper acute stroke unit in 2011/12; this was 95 per cent of all stroke patients who we attended[2].

One of the national indicators measures the percentage of stroke patients who arrive at a specialist centre within 60 minutes of us receiving the 999 call. Figures available for the first nine months of last year show that we achieved this in 65.1 per cent of cases. We are concerned with our performance against this measure, bearing in mind the relatively short journey time to the stroke units – on average this is 17 minutes. We will be looking at how we can reduce the time our crews are spending with stroke patients before they take them to hospital.

- ***Improving the experience and providing more appropriate care for patients with less serious illnesses and injuries***

  During 2011/12, we treated a wide range of patients presenting with less serious conditions.

[2] Figures given here are provisional based on data available 18 May 2012

Taking patients to the right place of care: As part of a wider NHS response to managing patients with less serious conditions, we have continued our work to identify suitable alternative destinations where appropriate 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. Frontline staff have received training and guidance to enable them to better assess minor injuries, illnesses and conditions, and from this decide on the appropriate destination for patients.

Clinical telephone advice: Our clinical telephone advisors helped 70,842 patients over the phone, an increase from 50,058 last year and 47,180 in 2009/10.

Care for elderly fallers: We have introduced a new system to improve the care given to older people who fall in their homes. Every month we respond to around 6,500 people aged 65 and above who have had a non-traumatic fall – usually a slip or stumble – at home. Last April we started to refer those patients who did not need hospital treatment to their GP. The referral means GPs can spot if their patients are falling regularly, and help prevent this. We are now referring almost 1,200 patients each month to their GP, with a total of just under 9,000 being referred since the start of this initiative.

Care to mental health patients: We now have arrangements in place with four of London's nine mental health trusts so that any mental health patients we attend receive the right care in the right place. We plan to agree similar arrangements with the other trusts.

We have also started work to examine complaints with a mental health component, and where possible are meeting with mental health trusts to agree personalised care plans for their patients, and the options available to them apart from calling for an ambulance.

The process for other agencies to request support from us to transfer any mental health patients who are assessed in the community was revised during the year. The policy for booking ambulances for mental health sections now enables us to provide a service that ensures privacy and dignity for the patient, improves reliability, allows us to send staff with the right skills for an individual's needs, and ensures the safety of the patient and our staff.

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

We have been working with both NHS and hospice-based end-of-life care providers to provide end-of-life care support that is appropriate. We have also continued 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.

Patients with pre-arranged hospital appointments: We offer pre-arranged transport for patients to and from their hospital appointments, and we carried out 180,004 of these journeys last year, compared to 204,454 in 2010/11.

We delivered patients to hospital on time for 92 per cent of the journeys, compared with 90 per cent the year before, and 92 per cent in 2009/10. And we departed hospital on time in 93 per cent of cases. This compares with 95 per cent in 2010/11, and 93 per cent in the year before that.

Ninety five per cent of our patients had a journey time of less than an hour; this was the same as the previous three years.

Our total number of contracts at the end of the year stood at 20. One of these is a new contract that started in July 2011 at Queen Mary's Hospital Roehampton.

- ***Meeting response times routinely***

In 2011/12, we received 7.5 per cent more 999 calls than in the previous year. A total of 1,605,956 emergency calls were handled in our control room, compared to 1,494,207 in 2010/11 and 1,480,275 in the year before.

We have introduced a new system for handling 999 calls and sending staff and vehicles to patients. The system, CommandPoint, was initially implemented in June 2011, but there were technical problems and we had to switch it off. The faults which caused the system to fail were fixed, and following further developments and staff training, live tests were carried out before it was re-introduced fully at the end of March this year.

The system, which has been running well since it was brought in, 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.

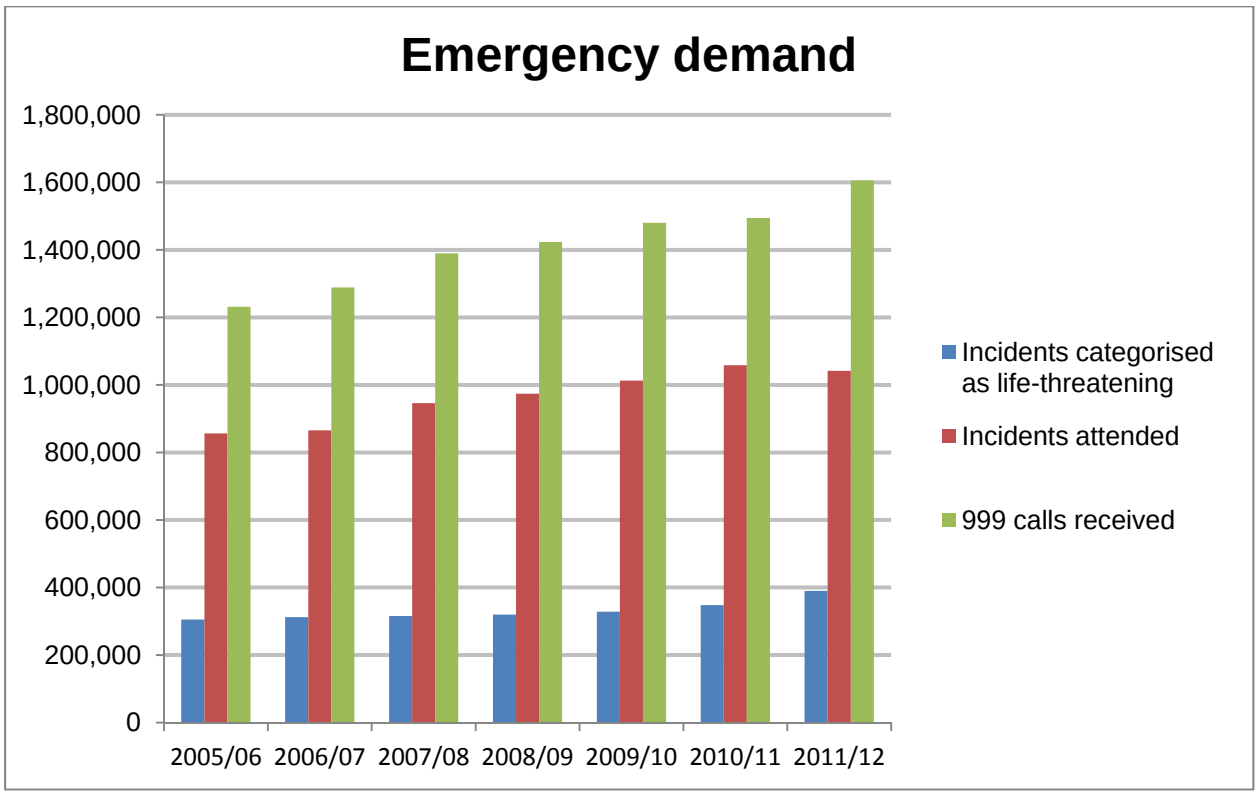
Of all the calls we received last year, we responded to 1,041,739 emergency incidents, down from 1,058,132 the year before.

We took fewer patients to a hospital accident and emergency department – 735,270 compared to 785,014 the year before. And we conveyed more people to an appropriate care centre such as a minor injuries unit; in 2011/12 this was 74,127 compared to 27,578 and 21,896 in 2010/11 and 2009/10 respectively. In 232,342 cases, our staff attended a patient but did not take them anywhere for further medical treatment. We also gave clinical advice over the phone to 70,842 patients with minor illnesses or injuries, up from 50,058 the year before.

Despite a busy year, we achieved the national response time targets to reach:

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

The number of life-threatening (Category A) calls received during 2011/12 increased by over 12.5 per cent (412,426 calls were received compared to 366,296 in 2010/11). We attended 390,229 of these incidents, compared to 347,675 the year before, and we reached 75.74 per cent (295,551) of these patients within eight minutes. This is the ninth year in a row that we have achieved this national response time target.
We reached 99.14 per cent (374,970) of Category A patients within 19 minutes, exceeding the target of 95 per cent.



All other calls fall into one of four C categories. We received 1,048,894 calls to category C (lower priority) patients last year. Of these, 628,526 received an ambulance response, and we reached 91.04 per cent of these patients within our target time of 60 minutes.

- ***Meeting all other quality, regulatory and performance requirements***

We achieved unconditional registration in March 2010 with the Care Quality Commission which we maintained in 2010/11. The Commission carried out a routine visit to the Service at the end of March 2012. The review identified one minor concern against outcome 9. This has already been addressed and action taken, and a new compliant system has been implemented. Areas of strength observed by inspectors included the care we provide to mental health patients and those with learning disabilities, and the work of our public education team. In terms of improvement, inspectors stated that there was scope for us to tighten our recording of mandatory training.

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. We are due to have another assessment in October 2012.

The 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. A scorecard is presented each month showing performance against key infection prevention and control indicators.

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 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 also want to improve the diversity of our workforce, and 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 deliver high quality care to a diverse population, and
- engage with our staff to improve patient care and productivity.

- ***Developing our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population***

  Our workforce: At the end of March 2012, we had a workforce of 4,526 staff; this was against a total of 4,708 funded posts.

  As part of our savings plan, we reduced our workforce by 151 posts at the start of the year; 132 were frontline posts, and the remainder were support posts. We had 166 people join the organisation, down from 325 in 2010/11. And over the year, 342 people left the Service – a turnover rate of 7.1 per cent, which is the same as the previous year.

  Our numbers of paramedics continued to increase, as more of our student paramedics qualified during the year. Approximately 700 people were recruited into the new role of student paramedic between 2008 and 2010, and those who successfully complete a three-year training programme become fully qualified paramedics. In 2011/12, 281 student paramedics qualified. In addition, 70 emergency medical technicians completed training to become paramedics, 25 students qualified on higher education foundation degree programmes, and 18 qualified on BSc degree programmes.

  In the coming year, we expect a further 379 student paramedics to qualify as paramedics, as well as 48 emergency medical technicians and 71 students through higher education. This will bring the total number of paramedics to around 1,950, taking us closer to our ambition to ensure all patients who receive an emergency ambulance response are treated by a paramedic.

  In terms of training, we provided 7,447 units of training, against a plan of 10,374 covering 42 subject areas. This compares with approximately 6,000 units last year. The rate of sickness among our staff for 2011/12 was 5.32 per cent, against a target of five per cent. This compares with a sickness rate of 5.2 per cent in the previous year.

In relation to severance payments, no employees left the Service under terms that required Treasury approval last year.

Our approach to equality and inclusion: Our aim is to ensure that equality and inclusion is integral to everything we do.

We welcome people to our organisation from any background, who are committed to providing high-quality care that meets the needs of the diverse communities we serve.

Our policy is to treat everyone fairly and without discrimination, and we want 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.

We also 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 want to be an employer of choice, and to attract the best and most talented people from all walks of life to a career where they can develop to their full potential.

As an employer, we are focusing on:

- celebrating and encouraging the diversity of our workforce and creating a working environment where everyone feels included and appreciated for their work
- promoting and providing 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
- fostering creativeness and innovation in our working environment, so that all staff can deliver to the best of their ability and help us take forward our equality and inclusion goals.

During 2011, we were named amongst the country's most gay-friendly workplaces. We took 94th place in Stonewall's Top 100 Employers list, being the only ambulance service to be recognised. Stonewall's workplace equality index recognises organisations that have inclusive policies, engage with staff on sexual orientation issues, demonstrate visible leadership for lesbian, gay and bisexual (LGB) equality, and have well-supported LGB network groups that play a constructive role in the organisation.

We are members of the Employers' Forum on Disability as well as Carers UK. Our diversity forum for disabled people and carers, known as Enable, provides staff with a 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.

We are also members of Opportunity Now, a membership organisation representing employers who want to transform the workplace by ensuring inclusiveness for women; and we are members of Race for Opportunity which is a race diversity campaign committed to improving employment opportunities for ethnic minorities across the UK.

- ***Engaging with our staff to improve patient care and productivity***

We recognise that an engaged workforce is key to improving our services and productivity, and we are committed to communicating and consulting with staff to achieve this.

Our staff engagement score last year, informed by the NHS staff survey, was 3.15 (based on a score range from 1 to 5). This is calculated from findings related to staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Service as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

This score is down from 3.28 in 2010 which is disappointing, although nationally there has been a decline across ambulance service scores from 3.30 in 2010 to 3.23 last year.

Staff survey findings: Last year's survey highlighted improvements in areas such as the number of staff who received e-learning and those who were trained to handle confidential information. At a local level, 60 per cent of respondents at our Greenwich complex felt managers encouraged team working and helped them with difficult tasks; at Isleworth over 65 per cent felt they had clear objectives; and 87 per cent of staff at Hanwell said they are trusted to do their job.

In terms of overall results, however, job satisfaction was below average compared to other ambulance services. And the survey highlighted some staff involvement issues that we need to improve. For example, fewer staff said that they felt able to contribute to improvements at work and there was a drop in the number of staff who said that communication between senior management and staff was effective.

Staff conferences and consultation meetings: We ran programme of internal conferences and consultation meetings throughout the year which provided staff with an opportunity to hear about our future plans, and to raise issues that matter to them.

There were a total of 13 conferences held for managers, support staff and team leaders, and our Chief Executive and Medical Director spoke with over 1,200 frontline staff at local consultation meetings. Meetings also took place with call handling staff, student paramedics and university students.

The main issues that came up at consultation meetings for frontline staff - and which the Chief Executive has made a commitment to address this year - are the lack of rest breaks given to staff, late finishes on shifts, the frequency that staff have to go out of their local area to attend patients, the arrangements for shift rotas, and the lack of vehicles and equipment. A&E support staff also feel that they have limited opportunities for career progression and training.

Opportunities for giving feedback and sharing ideas: Last year we introduced a 'temperature check' survey which is carried out three times a year to enable staff to give running feedback on their views about working for the Service and how they think working life can be improved.

When we announced our five-year cost saving plans, we also encouraged staff to suggest ideas about where they felt savings could be made. Staff shared ideas directly with the Chief Executive and members of his management team through face-to-face meetings, and over 400 cost saving suggestions were submitted through a dedicated email address.

Over fifty ideas have been received through another recently-launched initiative, Change one thing, which gives staff the opportunity to make suggestions that will improve the working lives of staff or the experiences of patients.

As a result of staff feedback, for example, a clinician has been working with the procurement department to review contracts with suppliers in a bid to purchase better products for less. It is expected that the renegotiation of prices for ECG electrodes and other equipment such as defibrillator pads could achieve annual savings of £100,000.

Health and well-being: Our LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative marked its tenth year this year. The informal, voluntary network has 100 trained staff who can listen to and support Service colleagues on issues from work-related stress to family and social problems.

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.

We have continued to consult on the major issues, opportunities and challenges facing the Service, and we plan to maintain these working relationships when we become a foundation trust.

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.

We worked with the unions during the year to successfully bid for funding for the development of apps for staff as part of the strategic health authority's Engaging for Quality initiative. We have been granted £52,000 to produce the apps, and plan to engage with staff to decide on the topics that should be covered, as well as the content and look and feel of the products.

Representation on our 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.

<u>Strategic goal: Provide value for money</u>

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 maintain levels of 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.

- ***Using our resources efficiently and effectively***

  In April last year, we announced a five-year plan to make savings of £53m.

  Our aim is to maintain high levels of patient care despite having to make cuts over this period. This will involve us working differently and more efficiently.

  With 80 per cent of our budget going on staff costs, however, staffing numbers will be affected. We are therefore planning to reduce the number of posts across the organisation by 890 over the five-year period.

  We have achieved our first-year savings target of £15m in 2011/12.

  The reductions, which equated to five per cent of our £282m budget, were delivered through reducing pay costs and making savings in areas of non-pay.

  In all, 151 posts were removed from the workforce establishment as part of the savings plan, and agency costs were reduced by £2m.

  Savings in non pay costs have been made by renegotiating contracts with suppliers, and acting on ideas suggested by staff, particularly about the equipment they use in their jobs.

- ***Maintain service performance during major events, both planned and unplanned including the 2012 Games***

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

  Managing events in 2011/12: We successfully managed a range of large-scale planned events during the year, notably the Royal Wedding, as well as New Year's Eve, the London Marathon, and the Notting Hill Carnival.
  During early August, we assessed and treated around 250 people who were injured during the violent disturbances that hit the capital. Specially trained response teams attended calls to help patients in the main areas of disorder, working closely with Metropolitan Police public order officers. Crews also had to be escorted by the police to attend some patients not involved in the violence but who lived nearby and needed medical help.

We have recently revised our major incident plan which outlines the operational steps we will take in the event of a major or catastrophic incident occurring. The amended plan, which will be published early in the 2012/13 financial year, has incorporated a number of issues from the London bombings inquests.

London bombings: At the end of the inquests, coroner Lady Justice Hallett stated that there was more that could and should be done to learn lessons from the bombings, and she published nine recommendations intended to prevent loss of life in the future.

One recommendation was specific to the Service – "that the LAS, together with Barts and the London NHS Trust (on behalf of London's Air Ambulance) review existing training in relation to multi-casualty triage (ie the process of triage sieve) in particular with respect to the role of basic medical intervention".

The coroner expressed concern that the speed of the triage (assessment and treatment) process did not "encourage treatment", and although it allowed for putting an unconscious patient into the recovery position and providing basic airway management and applying a dressing to serious bleeding, this had not happened at each of the incident sites on 7 July 2005. As a result, we have committed to delivering major incident training to all frontline staff over the next two years which will address these issues.

In addition, our updated major incident plan advises staff who are carrying out the initial triage to work in pairs, take key equipment with them – and if necessary leave it nearby for other staff to use, look for signs of life when they assess patients and record patient observations and treatment details more fully. The plan also explains the protocol for covering deceased patients, another issue raised by the coroner.

Planning for London 2012: Planning has continued throughout the year to ensure that the Service is prepared so that it can play its part in delivering a safe and secure Olympic and Paralympic Games.

Our focus during the Games will be to maintain our service to Londoners while providing medical care to Olympic-related patients. We expect demand to increase on average by 5.6 per cent; this may rise to nine per cent at peak times – an increase of around 360 calls a day.

The Department of Health has agreed funding of £7.6m to help us deliver our service during Games time. In addition, we have absorbed a further £2.5m of costs within our current budget.

We plan to meet the increased demand in a number of ways. We will have over 400 staff working at the Games venues, and half of these will be from other NHS ambulance services. All clinical staff will complete a six-day tailored training package before the Games begin.
There are a large number of cultural events in the run-up to and during the Games period, and we will work with voluntary and private ambulance providers to cover these.

Other measures to help us maintain our service include deferring planned training and postponing non essential activities, so that we can maximise the number of ambulance staff working on the frontline during Games time.

And we have worked with Transport for London to get access to the Olympic and Paralympic route networks to attend emergencies and take patients to hospital, as well as to transport staff to and from venues.

Throughout the last year, we have taken part in joint agency exercises to test our plans for the summer. We have also supported the London 2012 Organising Committee (LOCOG) at sporting test events, including the road races and those within venues.

- ***Improving engagement with key stakeholders***

  We have a challenging change programme ahead, and we recognise the need to engage with a range of stakeholders to enable us play our part in improving emergency and urgent care in the capital.

  NHS reform means that our stakeholders within the health economy are changing. As well as engaging with our strategic health authority and our primary care commissioners, we have started to develop relations with GPs leads in the local clinical commissioning groups that will buy our services in the future.

  We have improved our relations with the Mayor's Office during the year, particularly with the Mayor's advisor for health and families. And the review carried out by the London Assembly of our Service gave us a valuable opportunity to engage with members of the Health and Public Services committee. We formally responded to the committee's review recommendations in March 2012.

  In addition, we have met a number of London MPs throughout the year from all parties.

Governance of our organisation

Our Trust Board manages risk through our risk management policy and strategy, corporate risk register and board assurance framework, all of which were reviewed during 2011/12.

The board assurance framework and corporate risk register are presented to the Trust Board each quarter, and further scrutiny is applied through the Quality and Audit Committees. The risk register is reviewed in detail by the Risk Compliance and Assurance group on a quarterly basis. Our Trust Board has been able to take assurance that the work carried out to mitigate and manage the key risk areas has effectively reduced the level of risk and removed all but two of the risks from the corporate register by the end of 2011/12.

The Board reviewed the effectiveness of each of its committees and the overall governance structure in July 2011 and no further changes were made. Our Chair seeks assurance from committee chairs at each Board meeting as to the effectiveness of the committee and the relationship with others. The structure benefits from cross-representation of non-executive directors on the key board committees. The Finance and Investment Committee was established in early 2011 and will be included in the committee effectiveness review in June 2012.

We went through a refresh of our external due diligence assessment in April and November 2011 in support of our foundation trust application. The Trust Board and the strategic health authority have been able to take assurance from the progress made within the year to manage and remove areas of concern.

A new process – the Board Governance Assurance Framework – was introduced by the Department of Health in December 2011 and our Trust Board undertook its self assessment and signed off the Board Governance Memorandum on 27 March 2012. This is being independently assessed by accountants and the final report will be presented to the Trust Board on 29 May 2012. An action plan has been prepared to address areas for improvement.

We also had an external assessment of our quality governance arrangements in December last year as part of the foundation trust application process. The outcome of this contributed to the delay to our application and an action plan is in place to address areas for improvement. This will be reassessed in July 2012.

Our use of feedback to make improvements

We continue to use the feedback we receive, including complaints, to improve our services and the quality of care we provide.

This year, for example, we have made changes to the advice we give to callers when we are not sending them an ambulance straight away; this helps to manage their expectations as not all calls need an ambulance response despite people thinking this will happen automatically.

We have also redesigned our maternity packs so that they have more appropriate equipment in them; a hat has been added to keep the baby warm, and the addition of an extra towel means ambulance crews no longer use two packs when helping with the delivery of a baby.

We work very closely with other organisations regarding the feedback we receive, and this helps to drive change across health and social care in London. This has led, for example, to one acute hospital introducing better directional signage for patients and visitors, and another has reviewed its maternity care practice.

We also have governance mechanisms in place so that we can gain a better picture of any emerging trends and incidents of particular importance to patient care.

During 2011/12, we received 673 complaints, which equates to 0.04 per cent of the total calls we received. This compares with approximately 450 complaints in each of the two previous years. There are a number of reasons for the increase. Firstly, the impact of a change introduced in 2009 to how complaints are recorded is now becoming evident; secondly, the Service is handling more 999 calls which brings with it a corresponding increase in complaints; and thirdly, as we have changed the way we deliver our service, including providing more clinical advice over the phone, the public's expectations of automatically receiving an ambulance are no longer being met.

Our Patient Experiences Department also received 6,200 enquiries, including approximately 100 incident reports from other health and social care agencies.

We remain committed to safety and public accountability by being open about matters when something goes wrong, and we publish case studies on our website at www.londonambulance.nhs.uk under *About us > What we do > Making your experiences count.*

Our use of a care plan approach, where we tailor the needs of patients to an individual care programme, has been widely adopted by UK ambulance services. As well as helping us to meet the needs of patients, this approach enables us to manage demand more effectively. Details about our Patient Centred Action Team are available on our website under *Health professionals > Caring for frequent callers.*

We continue to liaise more and more with other agencies to promote safeguarding of both adults and children. More information is available on our website under the *Health professionals* section.

Our plans to reduce our carbon footprint

The Carbon Trust has recently approved our five-year carbon management plan which sets out how we will reduce our carbon footprint as part of our contribution to tackling climate change.

Our aim is to reduce our carbon emissions by 8,959 tonnes CO^2 by March 2016. This is based on a baseline for the Service of 62,776 tonnes CO^2 that was calculated in 2010/11.

There are three areas in which we will focus our activity – fuel consumption, energy use and procurement. We aim to reduce our energy and fuel consumption by 25 per cent over the five year period, and by focusing on procurement we will cut indirect emissions from products and services by 10 per cent.

It is envisaged that this will achieve total costs savings of over £5.5m.

In 2011/12, we reduced our total carbon emissions by four per cent to 60,084 tonnes CO^2.

Fuel consumption: Our core business means that we have high levels of fuel consumption. In 2011/12, we responded to more than one million incidents, using over 4.2 million litres of diesel.

Over the last two years we have replaced our old LDV ambulances. Our new ambulances can cover an average of 18 miles per gallon, compared to nine miles covered by the old ambulances. The new vehicles are almost 90 per cent recyclable by weight.

We will be developing a business case in 2012/13 to purchase electric vehicles for use by our post room and our patient transport service, following a trial during the last 12 months.

Energy use: We have over 70 ambulance stations across London, half of which are over 50 years old. Our average daily consumption of gas and electricity for all our properties is 42,355 kWh.

Last year, we carried out a number of initiatives to reduce energy consumption. These included garage lighting projects at three of our ambulance stations, the replacement of boilers at two properties including our headquarters, and the installation of LED lighting at other stations.

Procurement: Each day we spend on average £204,175 on supplies and equipment; 17 per cent of this is on medical equipment and 13 per cent on computer related items. Over the last year, clinical staff have worked with our procurement team to reduce unnecessary purchases and stock levels, to help reduce our carbon footprint.

Other initiatives: A range of other initiatives have helped reduce our carbon footprint, including recycling over 55 per cent of our waste – equivalent to 178 tonnes CO^2, and the rollout of a web based expenses system to eliminate the need for paper-based claims which has saved at least three tonnes CO^2.

Looking ahead, we will consider other measures including:

- installing meters on all of our property to reduce energy consumption
- ensuring new properties meet sustainability standards
- reducing the number of patients who we transport to hospital or other treatment centres, as part of our strategy to ensure patients receive the right treatment in the right place at the right time.

Our internal auditors recently carried out a review of our response to sustainability legislation and requirements, and we will be incorporating their findings and recommendations into our five-year plan.

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 six formal sub-committees: the Strategy Review and Planning Group, the Quality Committee, the Audit Committee, the Finance and Investment Committee, the Remuneration and Nominations Committee and the Charitable Funds Committee.

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

Four non-executive directors and the Chief Executive make up the membership of the Quality Committee, which is chaired by non-executive director Dr 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 Finance and Investment Committee is chaired by the Chairman and has three non-executive directors, three executive directors and three directors as its members, and the Remuneration and Nominations Committee, also chaired by the Chairman, comprises all non-executive directors.

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.

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 Vice Chairman of Camden's Standards Committee. He is also a non-executive director of NHS Blood and Transplant. Roy 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, and is also our Deputy Chairman.

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.

Murziline Parchment took up her post in September 2011. She is currently the Head of the Mayor's Office in Tower Hamlets. Murziline has had a 15-year career in law as a barrister specialising in public law. She was Director of Major Projects and Service Delivery at the Greater London Authority between 2003 and 2008, and has been a member on the boards of Transport for London, London Bombings Relief Fund and London Organising Committee for the Olympics and Paralympics Games.

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, mostly as a paramedic and latterly as Chief Ambulance Officer of the Auckland Ambulance Service. In his additional role for the Department of Health as National Ambulance Director, he led the strategic review of NHS ambulance services, *Taking Healthcare to the Patient*, which was the catalyst for the transformation in ambulance services over the last seven years. Peter was awarded the CBE in the 2005 New Year Honours.

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. Between July 2010 to November 2011 Martin was on secondment with the Irish Ambulance Service and Great Western Ambulance Service where he held interim Chief Executive positions. He returned to the Service in November 2011 as Chief Operating Officer and Deputy Chief Executive.

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 chairs our clinical, quality safety and effectiveness committee, 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 two directors who are non-voting directors, and two senior managers who attend the Board meetings.

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. Peter holds a BSc in Information Technology from the Open University.

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.

Deputy Director of Strategic Development Lizzy Bovill joined the Service as an assistant director of operations in 2008, moving from 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.

Head of Communications Angie Patton joined the Service in 2002, having previously worked for seven years with Hertfordshire Constabulary, latterly as Head of Communication. Prior to starting her career in public relations, Angie worked for National Power plc and Vickers Shipbuilding and Engineering.

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.

2011/12 financial summary statements

Financial review

The figures given for periods prior to 2009/10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

Break-even performance	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Retained surplus/(deficit) for the year	1,258	113	398	725	-420	740	2,527
Adjustments for impairments	0	0	0	0	1,845	262	247
Adjustments for impact of policy change re donated grants asset	0	0	0	0	0	0	-23
Break-even in-year position	1,258	113	398	725	1,425	1,002	2,751
Break-even cumulative position	1,333	1,446	1,844	2,569	3,994	4,996	7,747
Break-even cumulative position as a percentage of turnover	0.62	0.67	0.78	0.98	1.43	1.76	2.75

The surplus in 2011/12 meant that the cumulative position improved for the 11th year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

On income and expenditure we reported a surplus of £2,751,000 for the year, and therefore did better than the break-even target set by the Department of Health for 2011/12.

We had an unanticipated overshoot of £2,156,000 against our external financing limit (EFL) for the year. NHS London has been notified and the circumstances of the overshoot have been explained to the Audit Committee.

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

In the capital programme, £16.2million was spent on a range of projects, including ambulances, new technology projects and projects to improve the estate. Overall, we underspent by £2,508,000 against our capital resource limit, which we are permitted to do.

We were able to pay 89 per cent and 85 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 £138 million of fixed assets (£143 million in 2010/11) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. We fund the investment in capital assets through our capital programme. In 2011/12, we invested £16.2 million (£15.2 million in 2010/11). The most significant additions were related to the project to replace the emergency operations centre computer system, ambulances, vehicles, defibrillators and mobile data terminals.

We sold Park Royal ambulance station during the year for £900,150.

We have a net working capital of -£5.6 million (-£4.7 million in 2010/11) and long-term creditors and provisions of £19.1 million (£32.9 million in 2010/11). We had £5,250,000 cash in the bank as at 31 March 2012 (£872,000 in 2010/11).

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 (£62.5 million in 2010/11) of the equity – this represents the Department of Health's investment in us and annual dividends are payable on this sum. A further £33.7 million (£35.7 million in 2010/11) 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 2012/13

We have formally submitted a plan for 2012/13 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 £3 million.

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 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 2012 for all land and buildings. The net gain and loss on revaluation and impairments was £930,000 and £1,204,000 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 £3,460,000 for the current financial year (£3,521,000 in 2010/11).

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 2011/12 financial statements.

Other information

The Audit Commission was our external auditor for the year ending 31 March 2012. We paid the Audit Commission £139,000 (£158,000 in 2010/11) 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 audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2012 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. I have also audited the information in the Remuneration Report that is described as having been audited.

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

As explained more fully in the Statement of Directors' Responsibilities, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements give a true and fair view of the financial position of London Ambulance Service NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my opinion, the part of the Remuneration Report to be audited has been prepared properly in accordance with the requirements directed by the Secretary of State with the

consent of the Treasury as relevant to the National Health Service in England; and the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I report to you if:

- in my opinion the governance statement does not reflect compliance with the Department of Health's Guidance
- I refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because I have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken unlawful action likely to cause a loss or deficiency, or
- I issue a report in the public interest under section 8 of the Audit Commission Act 1998.

I have nothing to report in these respects.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements. I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2011, as to whether the Trust has proper arrangements for:

- securing financial resilience, and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2012.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2011, I am satisfied that, in all significant respects, London Ambulance Service NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2012.

Certificate

I certify that I have completed the audit of the accounts of London Ambulance Service NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Philip Johnstone, Officer of the Audit Commission
The Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ
1 June 2012

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 the Accountable Officer 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
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place, and
- 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

1 June 2012

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service 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 the state of affairs of the Trust 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 a 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
- 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 the assets of the Trust 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
1 June 2012

Mike Dinan
Finance Director
1 June 2012

Governance statement

Scope of responsibility

Our Trust 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, an assurance and risk management framework, and a programme of staff training and development. We publish bulletins on the intranet and use our weekly information bulletin to communicate clinical and risk management issues. These arrangements are documented in our 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 and clinical indicators set for ambulance services. In 2011/12, we were ranked as the top performing ambulance trust for seven performance indicators and were placed in the upper quartile for 21 of the 23 indicators.

We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London. In 2011/2012, this has included the development of pathways for elderly people that fall and end-of-life care for patients across London, as well as developing pathways for urgent and emergency care in local areas. We have increased the number of calls we handle and resolve through hear and treat, and we have worked with emergency departments and NHS London to improve the handover of patients from our service into an acute healthcare setting. We continue to achieve good outcomes for some of our sickest patients through conveyance to cardiac centres, hyper acute stroke units and major trauma centres.

We successfully implemented a new call-taking and dispatch system in March 2012. We have been working with the London Olympic Games Organising Committee and associated partners to prepare for the 2012 London Olympic and Paralympic Games when we will be providing the emergency healthcare response as well as maintaining a safe and high-quality service to the rest of London. We engage with a wide range of stakeholders across London and have carried out approximately 900 patient and public involvement and education events during the year.

Our governance framework

We implemented a new governance structure in April 2010 and added the Finance and Investment Committee to this in early 2011. All board committees are chaired by a non-executive director and membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and

required. The structure was fully reviewed in July 2011 along with the annual effectiveness review of the Trust Board, its reporting committees and the quality, safety and risk-related committees: Risk Compliance and Assurance, Clinical Quality Safety and Effectiveness, and Learning from Experience. No further changes were made to the governance structure and our Trust Board has continued to take assurance from this throughout 2011/12.

Our Chairman and Director of Corporate Services carry out a post-Board review each month to ensure the agenda has been covered, sufficient time allotted to agenda items and effective contribution and scrutiny given. The Board has been formally observed on at least one occasion during the year and feedback has been built into subsequent board meetings and taken up with individual board members where appropriate.

Attendance by Board members at Trust Board meetings is recorded in the minutes and included in the annual effectiveness review. From 2011/12, attendance at key board committees will also be monitored.

The Chair of the Audit Committee provides a report to the next meeting of the Trust Board. This report includes a summary of the business discussed and the assurances received from the executive, the internal and external auditors and from counter fraud. The role of the Audit Committee is to focus on the controls and related assurance that underpin the achievement of our objectives and the processes by which the risks to achieving these objectives are managed. At our Trust Board meeting on 27 March 2012, the Audit Committee chair provided assurance to the Board of the effectiveness of our systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework. The committee undertakes a detailed review of the corporate risk register annually. The committee meets five times during the year with one meeting held without the internal or external auditors present.

The Chair of the Quality Committee provides a report to the next meeting of the Trust Board. This report includes a summary of the committee's assessment of quality and risk as taken from the reports and evidence presented to the committee, and from quarterly review of the board assurance framework and corporate risk register. The committee also reviews the cost improvement programme to seek assurance that there is no detrimental impact on patient and staff safety and the quality of services provided as a result of the programme. At our Trust Board meeting on 27 March 2012, the Quality Committee Chair provided assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee meets six times during the year.

The Chair of the Finance and Investment Committee provides a report to the next meeting of the Trust Board. The committee provides assurance on the scrutiny of current finance and investment issues based on the reports and evidence presented to it throughout the year. The committee meets five times during the year.

Our Trust Board works within the remit of the standing orders and standing financial Instructions and scheme of delegation, and each of these has been reviewed and updated during 2011/12. We have prepared our constitution, governance rationale and standing orders in readiness for foundation trust status and will update these prior to application. The governance rationale meets the requirements of Monitor's code of governance.

Risk assessment

We are compliant with level one of the NHSLA risk management standards for ambulance trusts.

Our 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. It describes the process for embedding risk management throughout our Trust, and during 2011/12 we have made further progress with developing and managing local risk register processes. Risks can be escalated to the Risk Compliance and Assurance Group for discussion and addition to the corporate risk register if required. Further progress has been made to align project management risks with the corporate risk register.

Incidents are reported in accordance with the incident reporting procedure and are 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 Risk Compliance and Assurance Group or monitored at a local level. An integrated risk report is produced quarterly for review by Learning from Experience, the Senior Management Group, and the Quality Committee.

We received unconditional registration from the Care Quality Commission (CQC) in March 2010 to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.

The CQC carried out a routine compliance visit on 29 March 2012 and identified one minor concern for Outcome 9 – management of medicines. We have implemented new processes that will ensure compliance with this outcome.

Our risk and control framework

We have systems in place to monitor compliance throughout the year and to address any emerging gaps or risks. Our board assurance framework shows the linkages between our 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 that the Trust Board chose to focus on during the year as well as the top risks on the corporate risk register. A review in the fourth quarter of 2011/12 showed that through this focus we have been able to mitigate and reduce the level of risk for all but two of the risk focus areas.

The board assurance framework is mapped to the CQC 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. The Audit Committee reviews the corporate risk register annually. Risks with a net severity rating of High >15 are added to the corporate risk register and the board assurance framework.

The Trust Board, Quality Committee and Senior Management Group receive a quality dashboard showing monthly performance and any identified risks, from which they seek improvements and mitigations.

The local counter fraud specialist (LCFS) attends four meetings of the Audit Committee per year and monthly executive counter fraud meetings. In 2011/12, the LCFS undertook 93 days of proactive work including designing and publishing fraud literature; developing an e-learning package; and reviews into agency staff usage and purchasing cards. The LCFS undertook 191.35 days of reactive counter fraud work. We were awarded level 3 in its Qualitative Assessment which is an indication that we performed well in relation to counter fraud.

The three risks that were identified and added to the corporate risk register (with a gross and net rating of >15) in 2011/12 were:

- the risk that problems arising during the development and testing of CommandPoint result in the system not being ready to go live as planned by the end of March 2012. This risk is due for formal review at the end of Quarter 1 2012/13; however, this risk was not realised and the system has been fully implemented.

- the risk that staff do not receive clinical and non-clinical mandatory training. This risk is due for review at the end of Quarter 1 2012/13.

- the risk that the clinical coordination desk will not be able to operate effectively due to a lack of suitable trained staff. Action has been taken to train additional staff and this risk will be reviewed in Quarter 1 2012/13.

Control measures are in place to ensure that all the organisation's 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, employer’s 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 carried out 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.

The system of internal control has been in place for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts. 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
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and our senior management team who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the content of the quality report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

We have made significant progress against the information governance toolkit in-year achieving the required Level 2 standards. There has also been a focus on the management and reporting of serious incidents during 2011/12.

We declared 24 serious incidents to NHS London during 2011/12. These included the unsuccessful implementation of our new call-handling and dispatch system, CommandPoint, on 8 June 2011 which led to delays in responding to patients, and the impact on our capacity to maintain normal service provision due to industrial action related to the national public sector pensions dispute on 30 November 2011. These two incidents are described more fully below.

The remaining serious incidents are broadly categorised as loss of information (five), delayed response (13), equipment and software (two), and staff and patient behaviour (two). Of the five information governance/security serious incidents, one met the threshold for notification to the Information Commissioner. Actions have been taken to address the root causes. The investigation reports for serious incidents include recommendations and actions to be implemented to reduce the likelihood of recurrence. The successful introduction of CommandPoint in March 2012 is evidence of robust investigation techniques, organisational learning and actions implemented. There is no evidence to suggest that the declared serious incidents prevented the successful achievement of the Business Plan in 2011/12.

CommandPoint: On Wednesday 8 June 201, we began to implement the new electronic call-taking and dispatch software system, CommandPoint. Following the technical cut-over, the system initially operated for several hours before slowing and ultimately failing. Our control room reverted to operating on paper until transferring to the old computer aided system some hours later. This failure delayed responses to patients representing a serious risk. A serious incident was declared and a full investigation was undertaken. The Trust Board was kept fully aware of the risks and issues during the subsequent months. The root causes were identified and resolved and a new phased approach to

implementation was agreed by the Trust Board. CommandPoint was successfully implemented and the new system brought live on Wednesday 28 March 2012.

National public sector pensions dispute: On Wednesday 30 November 2011, we experienced one of our most difficult days in many years. A combination of higher staff shortages associated with industrial action as part of a national public sector pensions dispute, and an unexpected increase in demand, meant that we were unable to respond to hundreds of patients either at all or in line with agreed response times standards.

National planning assumptions were that between 10 and 30 per cent of staff would opt to take full industrial action during the national day of action. On the day, half of our frontline staff decided to withdraw their labour entirely. Of the remaining frontline staff, 15 per cent chose to work normally and 35 per cent provided emergency cover. Assurances were given by the trade unions at national, regional and local level that patient care was at the top of the agenda during the industrial action and that staff would commit to the provision of emergency cover within the arrangements agreed. Therefore, we planned that 75 per cent of staff would be available for normal working or as part of the agreed emergency cover arrangements. This was not the case.

We declared a serious incident and I, as Chief Executive, carried out a full investigation. The outcome report was presented to our Trust Board with 19 recommendations which have all been accepted and are now being developed and implemented. A separate investigation and report by NHS North West London on behalf of NHS London was completed and published on 27 March 2012.

Head of Internal Audit Opinion
Based on the work undertaken in 2011/12 to date, 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.

Conclusion
As Accountable Officer and based on the review process outline above, we have identified and taken action to address control issues arising in the year which have been disclosed in the body of this report.

Accountable Officer: Peter Bradley CBE
Chief Executive

Organisation: London Ambulance Service NHS Trust

Signature: 

Date: 16 May 2012

Statement of comprehensive income for the year ended 31 March 2012

	2011-12 £000	2010-11 £000 (restated)
Employee benefits	**(205,248)**	(210,895)
Other costs	**(68,774)**	(69,208)
Revenue from patient care activities	**278,267**	280,284
Other operating revenue	**3,464**	3,946
Operating surplus/(deficit)	**7,709**	4,127
Investment revenue	**281**	823
Other gains and (losses)	**(715)**	1,068
Finance costs	**(864)**	(1,508)
Surplus/(deficit) for the financial year	**6,411**	4,510
Public dividend capital dividends payable	**(3,884)**	(3,772)
Retained surplus/(deficit) for the year	**2,527**	738
Other comprehensive Income		
Impairments and reversals	**(956)**	414
Net gain/(loss) on revaluation of property, plant & equipment	**922**	510
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Net gain/(loss) on other reserves	**0**	0
Net gain/(loss) on available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year	**2,493**	1,662

All income and expenditure is derived from continuing operations.

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

Retained surplus/(deficit) for the year	**2,527**
Prior period adjustment to correct errors	**0**
IFRIC 12 adjustment	**0**
Impairments	**247**
Adjustments to/from donated asset	**(23)**
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]	**2,751**

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 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, 089 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 2012

	31 March 2012 £000	31 March 2011 £000
Non-current assets:		
Property, plant and equipment	**123,055**	128,044
Intangible assets	**15,033**	14,479
Investment property	**0**	0
Other financial assets	**0**	0
Trade and other receivables	**1,770**	7,736
Total non-current assets	**139,858**	150,259
Current assets:		
Inventories	**2,812**	2,571
Trade and other receivables	**11,940**	19,246
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**5,250**	872
Total current assets	**20,002**	22,689
Non-current assets held for sale	**0**	650
Total current assets	**20,002**	23,339
Total assets	**159,860**	173,598
Current liabilities		
Trade and other payables	**(21,364)**	(21,827)
Other liabilities	**0**	0
Provisions	**(1,411)**	(1,418)
Borrowings	**(1,268)**	(3,603)
Other financial liabilities	**0**	0
Working capital loan from Department	**0**	0
Capital loan from Department	**(1,244)**	(1,244)
Total current liabilities	**(25,287)**	(28,092)
Non-current assets plus/less net current assets/liabilities	**134,573**	145,506
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(7,743)	(7,955)
Borrowings	(6,130)	(18,100)
Other financial liabilities	0	0
Working capital loan from Department	0	0
Capital loan from Department	(5,587)	(6,831)
Total non-current liabilities	**(19,460)**	(32,886)
Total assets employed:	**115,113**	112,620
Financed by taxpayers' equity:		
Public dividend capital	62,516	62,516
Retained earnings	19,304	14,851
Revaluation reserve	33,712	35,672
Other reserves	(419)	(419)
Total taxpayers' equity:	**115,113**	112,620

Statement of changes in taxpayers' equity

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2011	62,516	14,851	35,672	(419)	**112,620**
Opening balance adjustments		0	0	0	**0**
Adjustments for transforming community services transactions		0	0	0	**0**
Restated balance at 1 April 2011	62,516	14,851	35,672	(419)	**112,620**
Changes in taxpayers' equity for 2011-12					
Retained surplus/(deficit) for the year		2,527			**2,527**
Net gain/(loss) on revaluation of property, plant, equipment			922		**922**
Net gain/(loss) on revaluation of intangible assets			0		**0**
Net gain/(loss) on revaluation of financial assets			0		**0**
Net gain/(loss) on revaluation of assets held for sale			0		**0**
Impairments and reversals			(956)		**(956)**
Movements in other reserves				0	**0**
Transfers between reserves		1,926	(1,926)	0	**0**
Release of reserves to SOCI			0		**0**
Transfers to/(from) other bodies within the resource account boundary	0	0	0	0	**0**
Reclassification adjustment on disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0				**0**
New PDC received	0				**0**
PDC repaid in year	0				**0**
PDC written off	0				**0**
Transferred to NHS foundation trust	0	0	0	0	**0**
Other movements in PDC in year	0				**0**
Net actuarial gain/(loss) on pension	0			0	**0**
Net recognised revenue/(expense) for the year	0	4,453	(1,960)	0	2,493
Balance at 31 March 2012	**62,516**	**19,304**	**33,712**	**(419)**	**115,113**

Statement of changes in taxpayers' equity (continued)

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010-11					
Balance at 1 April 2010	60,885	12,947	35,914	(419)	109,327
Retained surplus/(deficit) for the year		738			738
Net gain/(loss) on revaluation of property, plant, equipment			510		510
Net gain/(loss) on revaluation of intangible assets			0		0
Net gain/(loss) on revaluation of financial assets			0		0
Net gain/(loss) on revaluation of assets held for sale					0
Impairments and reversals			414		414
Movements in other reserves				0	0
Transfers between reserves		1,166	(1,166)	0	0
Reclassification adjustment on disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution		0	0	0	0
Originating capital for Trust established in year	0				0
New PDC received	1,631				1,631
PDC repaid in year	0				0
PDC Written Off	0				0
Transferred to NHS foundation trust	0	0	0	0	0
Other movements in PDC in year	0				0
Net actuarial gain/(loss) on pension		0		0	0
Net recognised revenue/(expense) for the year	1,631	1,904	(242)	0	3,293
Balance at 31 March 2011	**62,516**	**14,851**	**35,672**	**(419)**	**112,620**

Statement of cash flows for the year ended 31 March 2012

	2011/12 £000	2010/11 £000
Cash flows from operating activities		
Operating surplus/deficit	**7,709**	**4,127**
Depreciation and amortisation	**11,430**	**11,713**
Impairments and reversals	**248**	**262**
Other gains/(losses) on foreign exchange	**0**	**0**
Donated assets received credited to revenue but non-cash	**(23)**	**0**
Government granted assets received credited to revenue but non-cash	**0**	**0**
Interest paid	**(670)**	**(1,341)**
Dividend paid	**(3,832)**	**(3,972)**
Release of PFI/deferred credit	**0**	**0**
(Increase)/decrease in inventories	**(241)**	**212**
(Increase)/decrease in trade and other receivables	**13,495**	**499**
(Increase)/decrease in other current assets	**0**	**0**
Increase/(decrease) in trade and other payables	**(13,976)**	**2,497**
(Increase)/decrease in other current liabilities	**0**	**0**
Provisions utilised	**(1,047)**	**(727)**
Increase/(decrease) in provisions	**636**	**(953)**
Net cash inflow/(outflow) from operating activities	**13,729**	**12,317**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	**59**	61
(Payments) for property, plant and equipment	**(13,987)**	(15,006)
(Payments) for intangible assets	**(1,600)**	(5,686)
Proceeds from disposal of plant, property and equipment	**8,868**	7,018
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	**(6,660)**	**(13,613)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**7,069**	(1,296)
CASH FLOWS FROM FINANCING ACTIVITIES		
Public dividend capital received	0	1,631
Public dividend capital repaid	0	0
Loans received from DH - new capital investment loans	0	0
Loans received from DH - new working capital loans	0	0
Other loans received	0	107
Loans repaid to DH - capital investment loans repayment of principal	(1,244)	(1,244)
Loans repaid to DH - working capital loans repayment of principal	0	0
Other loans repaid	0	0
Cash transferred to NHS foundation trusts	0	0
Capital element of payments in respect of finance leases and On-SoFP PFI and LIFT	(1,411)	(3,443)
Capital grants and other capital receipts	0	0
Net cash inflow/(outflow) from financing activities	**(2,655)**	**(2,949)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**4,414**	**(4,245)**
Cash and cash equivalents (and bank overdraft) at beginning of the period	836	5,081
Opening balance adjustment - TCS transactions	0	

Restated cash and cash equivalents (and bank overdraft) at beginning of the period	836	5,081
Effect of exchange rate changes in the balance of cash held in foreign currencies	0	0
Cash and cash equivalents (and bank overdraft) at year end	5,250	836

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 pages 49 and 50**.**

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2011/12 was in the range of £190,001 to £195,000. This was 6.2 times the median remuneration of the workforce, which was £31,259.64. In 2010/11, the banded remuneration of the highest paid director £190,001 to £195,000. This was 6.1 times the median remuneration of the workforce, which was £31,489.56.

In 2011/12, as in the previous year, none of the employees received remuneration in excess of the highest paid director.

Total remuneration includes salary, non consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The change in ratio was due to:

- a change to the remuneration of the most highly-paid individual through an increase in benefits-in-kind received in 2011/12
- a change in the workforce composition in 2011/12 leading to a slight decrease in median pay.

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	2011/12			2010/11		
	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		£20,001-£25,000	£0	
Caroline Silver, 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	£5,001-£10,000	£0		£0-£5,000	-	
Beryl McGrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Roy Griffins, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
**Murziline Parchment, Non-Executive Director	£0-£5,000	£0		£0-£5,000	£0	
* Peter Bradley, Chief Executive	£180,001-£185,000	£0	£4,091	£110,001-£115,000	£0	£2,277
Michael Dinan, Director of Finance	£115,001-£120,000	£0		£115,001-£120,000	£0	
**Martin Flaherty, Deputy Chief Executive	£60,001-£65,000	£0	£3,134	£50,001-£55,000	£0	£1,326
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£100,001-£105,000	£0	
Stephen Lennox, Director of Health Promotion & Quality	£95,001-£100,000	£0		£5,001-£10,000	-	
*** Fionna Moore, Medical Director	£75,001-£80,000	£0		£70,001-£75,000	£0	

The figures shown under the heading 'benefit in kind' refer to the provision of lease cars.
* The Chief Executive's total pay has not changed since last year. The apparent increase shown above is due to a reduction in the portion of his time being recharged to the Department of Health for his role as National Ambulance Director.
** Martin Flaherty was on a secondment to the Great Western Ambulance Service NHS Trust until 15 October 2011. Murziline Parchment joined the Service as a non-executive director in September 2011.
*** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.

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 2012 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	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	**	**	**	**	**	**	**	
Roy Griffins, Non-Executive Director	**	**	**	**	**	**	**	
Murziline Parchment, Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£5,001-£7,500	£20,001-£25,000	£65,001-£70,000	£450,224	£389,077	£34,360	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£10,001-£15,000	£30,001-£35,000	£187,834	£146,122	£26,027	
Martin Flaherty, Deputy Chief Executive	£0-£2,500	£0-£2,500	£20,001-£25,000	£70,001-£75,000	£483,979	£428,656	£29,424	
Caron Hitchen, Director of Human Resources	£0-£2,500	£0-£2,500	£25,001-£30,000	£80,001-£85,000	£508,540	£441,267	£37,516	
Stephen Lennox, Director of Healthcare Promotion	£5,001-£7,500	£2,501-£5,000	£30,001-£35,000	£100,001-£105,000	£567,149	£415,155	£97,387	
Fionna Moore, Medical Director	£0-£2,500	£2,501-£5,000	£45,001-£50,000	£145,001-£150,000	£1,137,365	£1,137,365	-£24,681	

** 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.

“A change in the Government Actuarial Department’s (GAD) actuarial factors has occurred during the year, following revised guidance from HM Treasury. NHS Pensions are using the most recent set of actuarial factors produced.”

C) Expenses 2011/12

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**
Roy Griffins, Non-Executive Director	-	-	-	-	-	-	**-**
Brian Huckett, Non-Executive Director	-	-	-	-	-	-	**-**
Caroline Silver, Non-Executive Director	-	-	-	-	-	-	**-**
Jessica Cecil, Non-Executive Director	-	-	-	-	-	-	**-**
Murziline Parchment, 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**

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 2011/12

The Trust did not make any compensation payments in 2011/12.

Better payment practice code – measure of compliance

	2011/12		2010/11	
	Number	**£000**	Number	£000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**51,604**	**69,019**	62,654	83,829
Total non-NHS trade invoices paid within target	**46,136**	**60,795**	52,816	75,015
Percentage of NHS trade invoices paid within target	89%	88%	84%	89%
NHS Payables				
Total NHS trade invoices paid in the year	**339**	**4,133**	421	4,379
Total NHS trade invoices paid within target	**289**	**2,331**	352	3,392
Percentage of NHS trade invoices paid within target	85%	56%	84%	77%

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.

		2011/12	2010/11
	£000	**£000**	£000
External financing limit		**(9,225)**	1,371
Cash flow financing	(7,069)		1,296
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**(7,069)**	1,296
Undershoot/(overshoot)		**(2,156)**	75

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 Department of Health and NHS London, controls public expenditure in NHS trusts. This is a statutory financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. Exceeding these limits requires prior approval.

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 we can spend in a year than is generated from our operations.

Each year, we are allocated an EFL as part of the national public expenditure planning process.

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 three per cent and four per cent.