London Ambulance Service
NHS Trust

Annual Report
2012/13

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.

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 planning for, and responding to, large-scale events or major incidents in the capital.

We have over 4,500 staff who work across a wide range of roles. We serve more than eight 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 2012/13 we handled over 1.7 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 Richard Hunt's views

What was your impression of how the Service coped with two of the biggest events – the Queen's Diamond Jubilee celebrations and the Olympics?

They were the standout events in a busy year, and it was very pleasing that all the planning and preparation that went into them paid off. Both will live long in the memory, and I was very proud of what we contributed and were able to achieve.

The Olympics and Paralympics in particular were the culmination of many years of hard work. As important as the fact that we were able to play our part in caring for those who needed treatment at Games venues, we also maintained our service to patients across the rest of London, and met our commitments in that regard as well.

How do you think the Service performed overall during 2012/13?

As well as Olympics and the Jubilee, it was a year of change – not least in seeing both our Chief Executive and two other senior directors leave us for new opportunities elsewhere.

In light of that, and the ever increasing workload, we did well to once again achieve our main performance target and in doing so reach more of the most seriously ill and injured patients more quickly.

Having said that, we know that there are things that we need to change to move on and deal with ever increasing demand and continue to improve what we are doing. I would like to send my thanks to all colleagues in the Service for the part they played in delivering both event and day-to-day performance during a remarkable and challenging year.

What has been the impact of the ongoing financial savings plan?

It was a very difficult year for us financially and delivering on our planned budget proved even more challenging than we had expected it to be.

Our priority was to do all we could to protect patient care despite our financial challenges, and this led to greater levels of spending in some areas than we had budgeted for.

We have received additional funding from 2013/14 from the clinical commissioning groups to help increase our frontline staffing levels, but are fully aware that we need to continue to make savings in other parts of the Service and have to spend every penny carefully.

When do you now hope to become a foundation trust?

We are continuing with our plans to be licensed to operate as an NHS foundation trust and are working with the newly-formed NHS Trust Development Authority on building a new timeline towards a new application in 2014/15. However, our governance processes and ways of working will increasingly be brought in line with those required of a foundation trust over the coming months.

Chief Executive Ann Radmore's views

What have been your first impressions of the Service since taking up your post in January?

I have been very impressed with the compassion and commitment I've seen in staff across the organisation. I have spent time in our control rooms, with frontline crews and a number of support departments, and it is clear that people are very proud to work for us and want to do all they can for the benefit of our patients.

What do you see as the main challenges over the next 12 months?

We have reached the point where we have to make changes to the way we work in order to be able to provide all our patients with a safe and high-quality service in the future. At the same time, we also have to improve the working lives of our staff.

We are providing a good level of service to people with life-threatening illnesses and injuries, but some who have less serious conditions have been having to wait longer for our help than they should.

With the support of funding to help increase our frontline staffing levels, we are going to have to start to work differently and more efficiently to be able to respond to everyone who calls us.

In terms of plans to modernise the organisation, what will be the benefits for patients?

The changes we will be making will include ensuring rosters for frontline staff are more closely aligned with our patterns of demand and changing our annual leave arrangements – meaning patients will receive more appropriate and timely treatment from us, leading to better outcomes for them.

We are also being very mindful of the findings of the Francis Report into Mid Staffordshire NHS Foundation Trust, and what learning we can take from its recommendations.

How do see you see changes to the wider NHS, such as those to A&E departments, impacting on the Service?

One of the big changes is that we are now commissioned directly by GPs who want a more local service which reflects how they see the priorities for their patients in a particular area.

In terms of reconfiguration programmes, we continue to support proposals that will lead to better clinical care and the changing face of the NHS in London. Our commissioners also recognise that we will need additional investment to help manage increasing demand created as a result of local NHS changes.

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.

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.

These are supported by a number of corporate objectives, details of which can be found in the following pages of this report.

In the longer term, we believe that we will be better placed to achieve our goals by becoming an NHS foundation trust.

This will bring benefits in terms of making us more accountable to our patients and the communities we serve, giving us greater financial freedom and providing more opportunities for longer term planning.

We are now working with the newly-formed NHS Trust Development Authority on a timeline for this process.

Our achievements during 2012/13

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

Our staff are often the first point of contact for people in the capital who want medical help, and so we have an important role to play in improving the health outcomes of patients in London.

Our objectives are:

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

During the year we continued to provide very good care to our most seriously ill and injured patients, but at the same time recognise that we need to improve our response to some of our patients with less serious conditions.

2012/13 was the second year when we and other ambulance services across the country were measured against a range of clinical indicators, which as well as covering traditional time-based targets also look in more detail at the quality of care provided to patients. The indicators include outcomes for stroke and cardiac patients, as well as the number of patients cared for without needing to be taken to hospital.

Our Quality Account reports in detail on the progress we made in improving the quality of care we provide to our patients.

The year also saw the publication of the Francis Report into the failings at the Mid Staffordshire NHS Foundation Trust. It was published following a public inquiry into much higher than expected death rates at the hospital and raised issues around patient care which require serious consideration by all NHS organisations. We are considering all the Report's recommendations, identifying those that are relevant to us, and using these to improve and develop our service.

At the end of April 2013, we also announced plans for a programme of modernisation to help improve quality of care, patient experience and waiting times. At the time of writing, staff had been asked for their views on the details of these plans.

Below are detailed some of the key achievements from the 2012/13 year, including examples of how patients have benefited from our care.

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

  Trauma care: Our staff continued to take patients with life-threatening injuries, such as those sustained in serious road traffic incidents or stab or gunshot wounds, to one of four specialist centres in the capital. These are open round the clock, with expert clinicians available to provide the best possible care.

Priscila's story

One example of a patient who has benefited from receiving specialist care is Priscila Currie, who suffered serious leg and arm injuries following a road traffic collision in 2010.

Our staff who attended her assessed that she should be taken to the nearest trauma centre at the Royal London Hospital, rather than the local A&E department.

She underwent surgery but made a full recovery and, following the experience of the care she received, has since joined the Service as a student paramedic.

Cardiac care – heart attack: There are eight specialist centres in London where patients who are diagnosed as suffering a common type of heart attack, known as an ST-elevation myocardial infarction, can be taken directly by ambulance staff. They can then undergo primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

One of the national clinical indicators looks at the percentage of those who receive this treatment within two and a half hours of the 999 call being received. The Service's latest available figure, from April to December 2012, was 91.7 per cent[1].

Full year figures for 2011/12 – published in our heart attack annual report at the end of 2012 – showed that the quickest of these so called 'call to balloon' times was just 42 minutes.

Bhupen's story

In December, Bhupen Mistry met up with Emergency Medical Technician James Dixon, who treated him after he suffered a heart attack in January 2012. James and his crewmate bypassed local A&E departments to take Bhupen to the heart attack centre at Hammersmith Hospital.
After undergoing primary angioplasty, he was discharged just two days later.

Cardiac care – cardiac arrest: Thanks to the quality of care provided by our staff, the survival rates of patients who suffer an out-of-hospital cardiac arrest continue to rate as some of the highest in the country, and our published figures are also among the best in the world.

[1] This figure is provisional, base d on data available on 3 May 2013

Statistics for the period from April to December 2012 show that 27.3 per cent[2] of patients whose hearts stopped beating, at home or in public, were resuscitated and discharged from hospital.
The last whole year figures were for 2011/12, when the figure was 31.7 per cent – double that of just three years before.

Ian's story

Among patients whose lives were saved was 50-year-old Ian Brown, who suffered a cardiac arrest while on a construction site in May 2012.
Colleagues immediately called 999 and began to give rescue breaths and chest compressions before our staff arrived within five minutes and gave three shocks with a defibrillator – a machine used to restart the heart. Paramedic Adrian Thatcher said: "His workmates helped to save his life by starting CPR so quickly, and we then diagnosed that he'd had a heart attack that led to the cardiac arrest and took him straight to the specialist centre at King's College Hospital."

Through working with the British Heart Foundation, we are now responsible for nearly 1,000 defibrillators available in public places across the capital.

These include tourist attractions, airports and train stations and, in December, 16 of the machines were installed in the Houses of Parliament.

During the year, we also trained more than 17,000 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 55 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 968 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 just under 9,500 stroke patients to a hyper acute stroke unit during the year, equating to around 95 per cent of all stroke patients who we attended.[3]

[2] This figure is provisional, based on data available on 3 May 2013
[3] This figure is provisonal, based on data available on 21 May 2013

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 67.8 per cent of cases. Although this represents an improvement on last year (from 65.1 per cent), we will continue to work to improve this figure.

Peter's story

Teacher Peter Banks was able to return to work during the year after suffering a stroke in January 2012. After carrying out an assessment, staff took him to the hyper-acute stroke unit at Charing Cross Hospital where he received thrombolysis – a clot busting drug to restore the flow of blood to the brain. He was allowed home five days later.

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

  During 2012/13, we treated a wide range of patients presenting with less serious conditions.

  Taking patients to the right place of care: As part of a wider NHS response to managing patients with less serious conditions, we 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 68,479 patients over the phone, slightly down from 70,842 in the previous year but up from 50,058 in 2010/11.

  This way of responding to those with less serious illnesses and injuries was supported by the development of a new clinical hub in our main control room, supporting both call takers and frontline staff.

  Care for elderly fallers: 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. Since the introduction of a system to refer patients who did not need hospital treatment to their GP, we have referred an average of around 1,200 patients each month, and are continuing to encourage staff to use the system so that the GP can take steps to help prevent the patients falling again in the future.

Care of mental health patients: We have been working with the nine mental health trusts across London to develop arrangements so that any mental health patients who we attend can be taken to the right place for treatment, rather than unnecessarily transporting them to an emergency department.

The last of these came into operation in March and should help ensure patients receive continuity of care.

We also continued 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.

End-of-life care: We continued to work with both NHS and hospice-based end-of-life care providers to provide appropriate care and support. We 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: As well as a response to emergency calls, we offer pre-arranged transport for patients to and from their hospital appointments.

During last year, we carried out 177,379 of these journeys last year, compared to 180,004 in 2011/12.

We delivered patients to hospital on time for 92 per cent of the journeys – compared with 92 per cent the year before, and 90 per cent in 2010/11. And we departed hospital on time in 94 per cent of cases. This compares with 93 per cent in 2011/12, and 95 per cent in the year before that.

Ninety seven per cent of our patients had a journey time of less than an hour, an increase from 95 per cent delivered in the previous three years.

Our total number of contracts at the end of the year stood at 17, down from 20 last year. The reduction is the result of the continuing realignment of the NHS operating structure, with smaller contracts being merged into geographical groups with a lead commissioning body. We expect to see this trend continue throughout 2013/14.

- ***Meeting response times routinely***

  Demand on our service continues to increase, and 2012/13 was busier than ever.

  We received a total of 1,708,597 emergency calls during the year, an increase of 6.4 per cent on the 1,605,956 in 2011/12.

  Of all the calls we handled last year, we responded to 1,068,338 emergency incidents, up from 1,041,739 the year before.

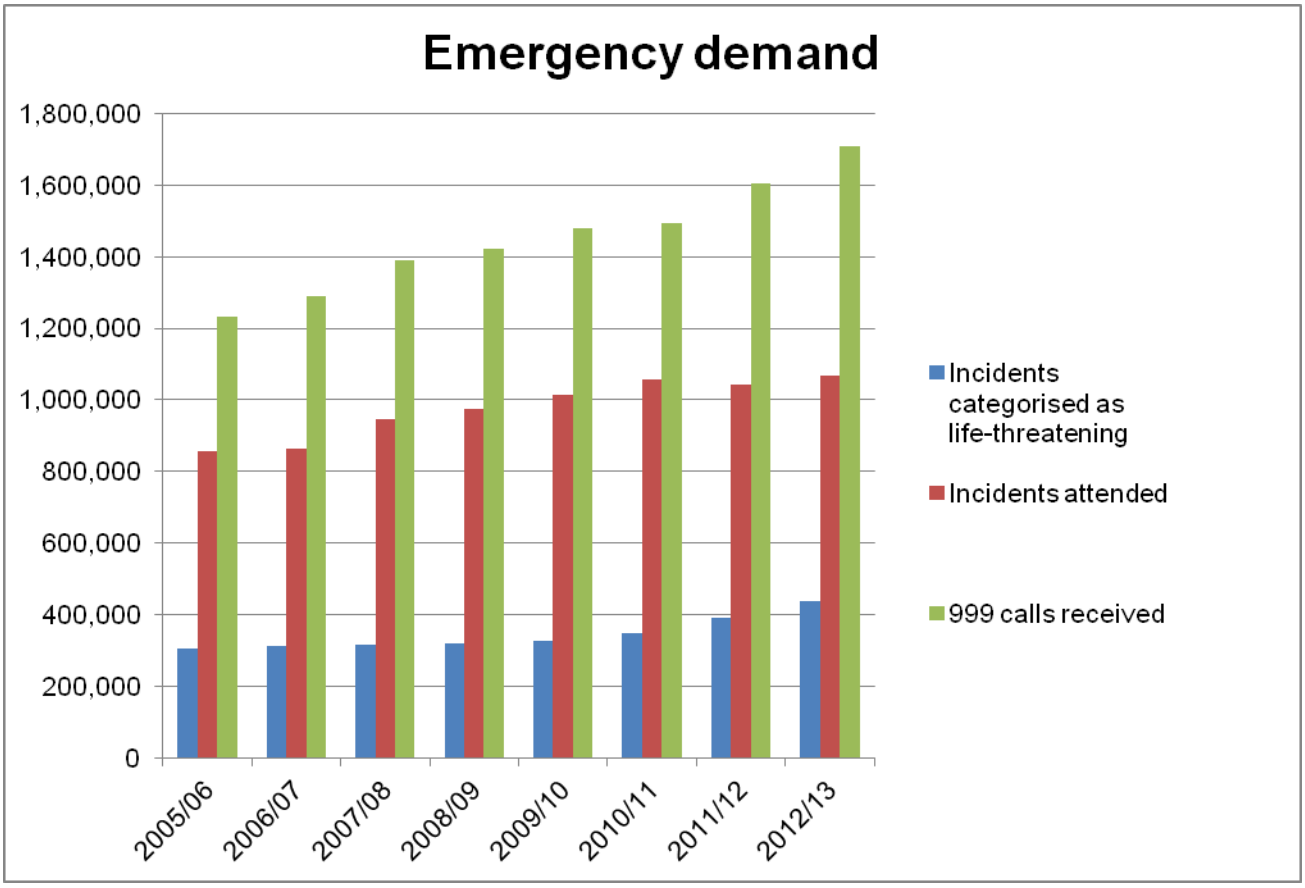
  We took marginally more patients to a hospital accident and emergency department – 747,630 compared to 735,270 the year before. However, we also conveyed more

people to an appropriate care centre such as a minor injuries unit – 89,996 compared to 74,127 in 2011/12 and 27,578 the year before that. In 250,185 cases, our staff attended a patient but did not take them anywhere for further medical treatment.

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 2012/13 increased by 12.8 per cent (465,197 calls were received compared to 412,426 in 2011/12).
We attended 438,067 of these incidents, compared to 390,229 in 2011/12, and we reached 75.41 per cent (330,366) of these patients within eight minutes – the tenth year in a row that we have achieved this national response time target.
We reached 98.16 per cent (430,010) of Category A patients within 19 minutes, against the target of 95 per cent.



All other calls fall into one of four C categories. We received 1,242,284 calls to Category C (lower priority) patients last year, up from 1,155,909 in 2011/12. Of these, 642,438 received an ambulance response, compared to 628,687 the previous year, and we reached 86.48 per cent of these patients within our target time of 60 minutes. This was down from 91.04 per cent in 2011/12, and was reflective of the difficulties we faced in providing a good level of service to all of our less seriously ill and injured patients.

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

  We achieved unconditional registration in March 2010 with the Care Quality Commission (CQC) which we maintained in 2010/11.

  Further to a routine visit to the Service at the end of March 2012, detailed in last year's report, the CQC also carried out to further inspections, in June and November.

  The latter of these identified two areas of concern. The first was against regulation 16 (safety, availability and suitably of equipment), finding that 'ambulances were not all suitably equipped to meet the care needs of the people using the service. The other was around staffing, and that 'we had failed to ensure that there were a sufficient number of suitably qualified, skilled and experienced persons employed to meet demands on the service'. This has led to delays in responding to calls for an ambulance and a reduction in staff achieving mandatory updates.
  Action plans on both were submitted to the CQC in January 2013.

  We achieved full compliance when we were reassessed at level 1 of the NHS Litigation Authority risk management standards for ambulance trusts 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.

<u>Strategic goal: Deliver care with a highly skilled and representative workforce</u>

We want all staff on the frontline to 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 2013, we had a workforce of 4,614 staff.

  As part of our savings plan, we reduced our workforce by a total of 194 posts during the year, of which 90 were from the frontline with the remainder from support departments. And over the course of the year, a total of 447 people left the Service – a turnover rate of 9.6 per cent, compared to 7.1 per cent last year.

More student paramedics qualified during the year after completing their three-year training programme, while almost 100 apprentice paramedics started working for us as part of a five-year course run in partnership with the Open University.

After working with our commissioners to identify what capacity we need to meet future increases in demand, we are now finalising our plans to recruit additional staff in the coming year.

The rate of sickness among our staff for 2012/13 was 5.84 per cent, against a target of 5.5 per cent. This compares with a sickness rate of 5.32 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: We welcome our obligations under equalities legislation, including the Equality Act 2010. 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. We aim to provide innovative and responsive healthcare which meets the needs of all these communities, providing better healthcare for all.

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 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 the year, we took 22nd place in the charity Stonewall's Top 100 Employers list – up from 94th place in the previous year. We were also recognised in the top 10 of their Healthcare Equality Index. Both were significant achievements and recognition of our inclusive policies and support networks for staff. As well as a Lesbian, Gay, Bisexual and Transgender Forum, we also have a very active Deaf Awareness Forum.

In terms of disabled employees, we are members of the Employers' Forum on Disability as well as Carers UK. We have signed up to the Two Ticks ‘positive about disabled people scheme’ and 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 engaging with staff to achieve this.

Our staff engagement score last year, informed by the NHS staff survey, was 3.21 (based on a score range from 1 to 5). This was 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.

Although this was up from 3.15 in 2011, it compared with a national ambulance trust average of 3.27 (up from 3.23 last year).

Staff survey findings: The 2012 survey highlighted some improvements on the previous year, such as reductions in the number of staff reporting they cannot meet conflicting demands on their time at work and those who felt they were not able to do their work to a standard they were pleased with.

However, the results also showed a number of areas of concern. These included increases in the percentage of staff who felt unwell due to work-related stress, and the number saying they had received health and safety training in the previous year was significantly lower compared to other ambulance trusts.

Following publication of the results in February, departments and station complexes have developed plans to try to address some of the main issues identified by their respective groups of staff.

Listening into Action: In March this year, we signed up to be part of Listening into Action, which is already being used by a number of other trusts across the country to change the way they listen to and involve staff.

Led by the Chief Executive, it is an approach designed to bring about positive change through collaboration with staff and will be taking place through 2013/14.

Staff conferences: There was a programme of internal conferences throughout the year which provided staff with an opportunity to hear about our future plans, and to raise issues that matter to them.
In total, 11 events were held for managers, support staff and team leaders.

Unlike in previous years, however, there were no local consultation meetings as the timing for these coincided with the departure of the former Chief Executive. It is though planned to hold these meetings again in late summer and early autumn 2013.

Opportunities for giving feedback and sharing ideas: We continued to use 'temperature check' surveys for staff to give feedback and suggestions on how to make improvements for the benefit of patients and their own working lives.
Our first mobile app, developed through the course of the year with funding from the strategic health authority, has been built based on suggestions of content from staff and should be launched in summer 2013.
Total Reward Statements - providing health service staff with personalised information on the value of their employment package, pension and other benefits available to them - will be rolled out across the NHS after feedback from our staff helped in the development of the statements.

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 now has 110 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 continued to use our long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place.

We consulted 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.

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.

Strategic goal: Provide value for money

It continues to be very important that we provide Londoners with a service that represents value for money.

To achieve this goal we will:

- use our resources efficiently and effectively, and

- maintain service performance during major events, both planned and unplanned – which last year included the 2012 Games.

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

  Our aim has been to maintain safe levels of patient care despite having to make savings over this period.

  We achieved our target of making savings of £12.5 million during the year, after also achieving our target of £15m in 2011/12. Both were achieved through reducing pay costs through reduced head count and making savings in areas of non-pay.

  To help cope with very high levels of demand during the winter months – when calls to the most seriously ill and injured patients rose by around 14 per cent on the same period in 2011/12 – we received £6.2 million of additional funding as part of £57 million allocated to the NHS in London.

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

  As well as the day-to-day demand, we have to be ready to deal with both planned events and larger emergency incidents.

  In a normal year, these include New Year's Eve celebrations, the London Marathon and the Notting Hill Carnival. 2012 was even more significant for the capital, with the Queen's Diamond Jubilee followed by the Olympic and Paralympic Games.

  Jubilee celebrations: More than 200 staff covered the central London area as over 1.5 million people attended events connected with the Queen's Diamond Jubilee celebrations over four days in June last year.

  Working with volunteers from St John Ambulance and the Red Cross, we treated 1,151 patients for a range of injuries and illnesses. The Sunday, which saw the Thames River Pageant taking place, proved to be the busiest day for us, with those treated including a number of people from the flotilla suffering from the effects of the cold and wet weather.

  London 2012: The Games were the culmination of more than five years of planning and preparation for us, and we played an important role in their success.

  Our focus was to maintain our service to Londoners while providing medical care to patients at Games venues and associated events.

  To help achieve this, around 400 frontline staff were dedicated to the Games, with half of these coming from other NHS ambulance services.

  All of those involved received additional specialist training - including in disability awareness - while those from outside London also spent an extra two days familiarising themselves with our vehicles, equipment, policies and protocols.

In addition to people treated by volunteers working for the London Organising Committee of the Olympic and Paralympic Games (LOCOG), staff at the Games venues treated approximately 1,250 patients – 850 from the Olympics and 400 during the Paralympics. Around 670 of these were either taken to one of the pre-selected hospitals used for patients or a polyclinic set up at the Olympic Park.

As well as being able to meet the demands of the Games, we were able to offer a high level of service and patient care across the rest of the capital. During the competitions, crews reached an average of nearly 83 per cent of the most seriously ill and injured patients within eight minutes.

Major incident planning: During the year, we published our revised major incident plan which outlines the operational steps we will take in the event of a major or catastrophic incident occurring. It incorporated learning from a number of issues that were highlighted during the inquests into the 2005 London bombings.

Governance of our organisation

Our Trust Board manages risk through our risk management policy and strategy, corporate risk register and board assurance framework.

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.

Full details can be found in our governance statement on page 26 of this document.

Our use of feedback to make improvements

Feedback from patients, their families and the public is an important way of helping to improve our services.

One of the most valuable forms of feedback we receive is through complaints, of which we received 976 during the year, up from 673 in 2011/12.

This significant increase reflected some of the difficulties we faced in terms of an above expected rise in demand, with the most frequent cause for complaint being a delay in staff attending patients.

During the year, we reviewed the way in which our Learning from Experience Group and processes work, to take greater account of what patients have to tell us and also issues arising from complaints.

This includes inviting a patient or a relative to speak at each public meeting of our trust board about their own experiences of using our service.

Our Patient Experiences Department also received more than 5,700 general enquiries.

A significant number of these concerned lost property, and we have made changes to the way this system is managed to help make it easier for patients to track down missing items.

We continue to liaise more and more with other agencies to promote safeguarding of both adults and children.

Principles for Remedy

We manage our complaints handling process as promoted by in the good practice guidance of the Principles of Remedy. This includes:

- All complaint responses include reference to, and contact details for, the Parliamentary and Health Service Ombudsman.
- Our website and operational vehicles carry details of how to make a complaint about the service or experience received.
- Numbers and themes of complaints are provided in a monthly clinical quality and safety report to the Trust Board, which is discussed in the Part One of the meeting.
- The Learning from Experience Group reviews the themes and issues emerging from complaints and the action then taken to improve service and the experience of patients

Our plans to reduce our carbon footprint

We remain committed to making improvements in all aspects of our environmental performance.

Environmental monitoring and reporting enables us to quantify the environmental and social effects of delivering our service; to improve both our management of any associated adverse environmental and social impact, and our overall environmental performance; and to work towards achieving the targets in the NHS Carbon Reduction Strategy.

In 2012, the Carbon Trust reviewed and 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. A carbon footprint is measured in tonnes of carbon dioxide equivalent (tCO2e). This is based on a baseline for the Service of 62,776 tonnes CO2e 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. As the data we are using becomes more reliable, we are able to better assess our carbon footprint and to identify areas where additional efforts are required.

The overall trajectory is downwards from the baseline figure of 62,776 tCO2e – a reduction of 26 per cent achieved primarily from a reduction in procurement spend and fuel.

Fuel consumption: Our core business means that we have high levels of fuel consumption. In 2012/13 we used over 4.2 million litres of fuel, compared to 4.3 million

litres in 2011/12 – meaning that despite an increase of more than 2.5 per cent in incidents attended, we used approximately five per cent less fuel.

In September, we met Transport for London's deadline for ensuring that our fleet is compliant with Low Emissions Zone (LEZ). In addition, after switching to a new supplier, 95 per cent of our engine parts are now recycled, with an average of 20 engines replaced each year.

Energy use: Although over half of our 70 ambulance stations are more than 50 years old, when measured against other ambulance services we score well in our energy consumption per metre. The 'long' winter experienced in 2012/13 saw our energy consumption rise by approximately 30 per cent. We sought to offset the increase in consumption via various initiatives such as replacing boilers and garage lighting. During the year we recycled 93 per cent of our waste.

Procurement: The overall trend is downwards from the baseline of circa 43,969tCO2e to 24,730tCO2e. Comparing expenditure in 2012/13 against that in the baseline year reveals a significant decrease in the amount spent on consultancy, mobile calls and rental, rent and service charges and computer hardware.

Environmental impact performance indicators

Area		Non financial data 2010/11 (baseline)	Non financial data 2011/12 Year 0	Non financial data 2012/13 Year 1		Financial data 2010/11 '000	Financial data 2011/12 '000	Financial data 2012/13 '000
Finite resources	Water	**57**	**53**	**50**	**Water cost**	**97,189**	**91345**	**86,029**
	Electricity	**3,913**	**4,289**	**4,407**	**Electricity cost**	**1,055,486**	**1054406**	**779,423**
	Gas	**1,515**	**518**	**1,807**	**Gas cost**			**357,169**
	Fuel	**12,387**	**12,082**	**11,519**	**Fuel cost**	**5,846,323**	**5383166**	**4,316,464**
Procurement	Procurement	**44,904**[1]	**31,237**	**28,473**		**74,524,230**	**56,084,612**	**68,651,920**
TOTAL		**62,776**	**48,179**	**46,256**		**81,523,228**	**62,613,529**	**74,191,005**

1. Total expenditure on water for 2012/13 – figure given is the known expenditure to date.
2. Total expenditure on energy consumption not available as yet, carbon footprint estimated from data available from 33 per cent of metered estate tracked over the year.
3. The carbon footprint for procurement in 2011/12 and 2012/13 has been estimated by assigning DEFRA emission factors per pound of spend against individual cost centres. This is an improvement on the method used in 2011 to estimate the baseline figure for 2010/11.

Looking ahead to this and future years, our environmental priorities will include:

- Further investment in energy conservation works to reduce carbon emissions from energy use across our estate
- Continuing to raise staff environmental awareness
- Reviewing procurement arrangements to identify opportunities for carbon reduction and cost savings
- Working with suppliers to minimise waste and identify opportunities for associated carbon reduction.

Changes to the London healthcare system

The Health and Social Care Act 2012 came into effect on 1 April 2013 and signalled significant changes to the management of NHS services in London. We are now commissioned by 32 clinical commissioning groups and this is co-ordinated through the North West London Commissioning Support Unit.

London's strategic health authority was disestablished on 31 March 2013 and we are now performance managed through the NHS Trust Development Authority, who will also support us through the foundation trust application process.

NHS England (London) co-ordinates the commissioning arrangements across London and holds the 32 clinical commissioning groups accountable.

Monitor has now extended its role to regulating all providers of NHS services and we will be applying for a provider licence during 2013/14, to come into effect from 1 April 2014.

Our Trust Board

In 2012/13 our Trust Board was 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, previously through the Appointments Commission and as from October 2012 through the NHS Trust Development Authority. All executive appointments are permanent and subject to normal terms and conditions of employment.

There were a number of changes to the Trust Board during the year. Peter Bradley left as Chief Executive Officer in September 2012 to take up the post of Chief Executive Officer with St John Ambulance Service, New Zealand. Martin Flaherty, Chief Operating Officer, acted up as Chief Executive Officer until 6 January 2013 when he retired from the Service. Ann Radmore was appointed as Chief Executive Officer in October 2012 and took up the post on 7 January 2013.

Michael Dinan, Director of Finance, left the Service on 18 January 2013 and Andrew Grimshaw was appointed as Interim Director of Finance from January 2013 and subsequently as substantive Director of Finance with effect from July 2013.

Murziline Parchment left the position of non-executive director in September 2012 and Nicholas Martin was appointed as non-executive director from 1 October 2012.

Brian Huckett left the position of non-executive director in December 2012 and John Jones took up the role on 1 January 2013.

We appointed a clinical associate non-executive director, Robert McFarland, who will take up the position on 1 May 2013. Dr Beryl Magrath completed her second term of office as non-executive director on 31 March 2013.

The Board has six formal sub-committees: the Strategy Review and Planning Committee, 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 Committee 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 was chaired during the year 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 was chaired by the Chairman (to 31 March 2013) and has three non-executive directors, three executive directors and three directors as its members. 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.

Dr Beryl Magrath MBE took up her post as non-executive director in 2005, and was 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. She completed her second term of office as a non-executive director in March.

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 an independent member 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. Jessica is the senior independent non-executive director.

John Jones started as an associate non-executive director in October 2012, and took up his substantive role on 1 January 2013. He has 17 years' experience at board level in the NHS and has held a number of executive finance director positions. As a Director of Finance with Hertfordshire Partnership NHS Foundation Trust, John helped them to attain foundation trust status. John is a member of the Chartered Institute of Management Accountants and the Chartered Institute of Public Finance and Accountancy. He is a member of the Audit Committee, and Finance and Investment Committee.

Brian Huckett left his position as a non-executive director in December 2012 having reached the end of his second term of office.

Nicholas Martin took up his post in October 2012, and is a member of the quality and finance and investment committees. He has 30 years' experience of corporate finance advising a wide range of companies from different sectors. He has served on a number of boards and governing bodies in executive and non-executive roles, including Cambridge University, Hammersmith Hospitals NHS Trust, NHS City & Hackney Primary Care Trust and NHS Haringey Primary Care Trust. He is a barrister, a Chartered Fellow of the Chartered Institute of Securities & Investment, and a former Cabinet Special Adviser.

Nicholas replaced **Murziline Parchment,** who stepped down from her position in September 2012 after joining the Board in September 2011.

Executive directors

Chief Executive Ann Radmore joined the Service in January 2013 after working as Chief Executive of NHS South West London where she led the establishment of the South West London Cluster in early 2010. Ann was previously Chief Executive of NHS Wandsworth and led the trust out of financial difficulties into a high performing primary care trust. After graduating from Cambridge University, Ann joined the NHS in 1983 as a national management trainee. She has worked in both specialist teaching and acute hospital and community settings as well as commissioning and a strategic health authority and has managed a wide range of clinical and support services. She has led two major hospital redevelopments, one in Greenwich and one at Queen Mary's Roehampton. Ann also led the Londonwide implementation of the ground-breaking stroke and cardiovascular models – which significantly improved outcomes for patients through specialist units.

She replaced **Peter Bradley CBE,** who left the Service in September 2012 to become Chief Executive of St John in New Zealand.

Director of Finance Andrew Grimshaw initially joined the Service on an interim basis in January 2013 and was appointed to the permanent post in March. Having joined the NHS as a trainee accountant in 1989, he has worked at district general hospitals, specialist and teaching hospitals throughout his career. He has worked as a Director of Finance since 2004 both for NHS trusts and foundation trusts.
He took over from **Michael Dinan** after he left the Service in January.

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 Workforce 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 21 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 other non-voting directors and one senior manager who attends 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 Committee. 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.

Director of Strategy and Planning 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.

As part of an interim six month executive management structure that was put in place by the new Chief Executive, from January 2013, three further directors also attend board meetings:

Director of Service Delivery (North Thames) Jason Killens has 16 years' experience working in both clinical and senior management posts. His current responsibilities include the strategic planning and command of major public events, and he was the Service's Strategic Commander for the Queen's Diamond Jubilee celebrations and the 2012 Olympic and Paralympic Games.

Director of Service Delivery (South Thames) Paul Woodrow joined the Service in 1991. His career has included time spent working as a paramedic – including a secondment on London's Air Ambulance – and clinical team leader. He has since held a number of managerial positions with responsibility for the operational delivery and performance. Before taking up his current post, Paul completed secondments with NHS London and Great Western Ambulance Service.

Director of Modernisation Jane Chalmers joined the Service in January 2013. Her first career was in the Royal Air Force, where she trained as an air traffic controller and then completed a number of senior appointments. These included roles in national and multi-national strategic communication, strategic planning and commanding the training school which trained all the air traffic controllers and operations officers for the RAF and the Royal Navy. Since leaving the RAF, Jane has worked in the public sector and took up her first role in the NHS in 2009. She has been a programme manager for a reconfiguration programme and for the re-organisation programme which planned and delivered the transition of five primary care trusts into one cluster. Latterly she was the Director of the Chief Executive's office in NHS South West London.

Meetings

The Board meets in public eight times a year on Tuesdays from 9am 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.

Governance Statement

Scope of responsibility

The Board is accountable for internal control and, 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 governance structure (please figures one and two), processes and monitoring arrangements, and an assurance and risk management framework. These arrangements are documented in the Risk Management Policy and Strategy which defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and subsequent management of the identified risks and the responsibilities of individuals and it describes the Trust Board's corporate responsibility for the system of internal control and robust risk management.

As part of London's local health economy we work with our partners to minimise the risks to patient care. To do so we meet routinely with our lead commissioners and with the performance team at NHS London in order to progress and maintain the key performance targets set for ambulance services.

We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London. In 2012/2013 this included service developments in the care provided to diabetic patients and the weekend opening of the Soho Alcohol Recovery Centre. We increased the number of calls we handled and resolve through hear and treat and we worked with emergency departments and NHS London to improve the handover of patients from our service into an acute healthcare setting. We continued to consolidate our cardiac referral pathways and developed bypass criteria for patients who have suffered acute stroke and major trauma, so that they can receive the highest standards of care in specialist centres.

We provided care and treatment to patients at various events during the Queen's Diamond Jubilee Celebrations in June 2012. We successfully implemented the Olympic delivery plan, providing increased resources to the Olympics and Paralympics whilst maintaining a safe service to London residents and visitors. We actively engaged with a wide range of stakeholders across London which has been particularly important during the transition phase of the implementation of the Health and Social Care Act in the NHS. We undertook approximately 1,086 patient and public involvement events including local community and foundation trust membership events, all of which were well received by those attending.

Our governance framework

I can confirm that arrangements in place for the discharge of statutory functions have been checked for any irregularities and that they are legally compliant. The governance structure underpinning these arrangements is described below. These include the arrangements in place for the Trust Board to govern and manage the organisation through a committee structure that covers a range of functions.

Each board committee is chaired by a non-executive director. Membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and required. The Quality Committee is chaired by a non-executive director. The governance structure was fully reviewed in July 2012 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 & Effectiveness, and Learning from Experience.

No further changes were made to the governance structure and the Trust Board continued to take assurance from this throughout 2012/13. Our Chair and Director of Corporate Services undertake 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 was 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.

The annual Board effectiveness review comprises the Corporate Governance Code and other recommended good practice on Board governance, such as Monitor's Code of Governance. The Trust Board reviewed its effectiveness in July 2012, based on the 2010 Code and there were no areas of non-compliance to report. The review identified an overall rating of 'good' and areas where further development was required: strategic planning and review, annual appraisal and time commitment for non-executive directors. These reflected the independent board governance assurance framework review for which an action plan is in place and has been progressed. Aspects of the review were refreshed in February 2013 with positive assurance that progress was being made. The Board development programme also addresses some of the areas.

Attendance by Board members at Trust Board meetings is recorded in the minutes and included in the annual effectiveness review. Attendance at key board committees is also monitored and recorded by the Committee Secretariat (see figures two to seven).

The Trust Board understands its responsibilities for discharging the statutory functions and takes assurance from the Audit Committee that systems are in place and that these are legally compliant.

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 the Trust Board meeting on 4 June 2013 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. Throughout the year, the committee assesses the appropriateness and effectiveness of the corporate processes around risk identification and management, as reflected in the corporate risk register. 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 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 the Trust Board meeting on 26 March 2013 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 five 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. At the Trust Board meeting the chair of the committee reported on the cash position, cash management, liquidity, CIP progress, and capital expenditure. The committee meets five times during the year.

The 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 2012/13. We have prepared our constitution, governance rationale and standing orders in readiness for foundation trust status and will update these prior to application. The constitution will be updated in 2013/14 to reflect Monitor's Model Core Constitution and therefore the requirements of the Health and Social Care Act 2012. The governance rationale meets the requirements of Monitor's Code of Governance and will be updated in 2013/14.

We were subject to a number of external independent reviews during 2012/13. KPMG undertook the Board Governance Assurance Framework review; RSM Tenon undertook a review against Monitor's Quality Governance Framework. The incoming Director of Finance commissioned an independent baseline financial review by Grant Thornton, incorporating cash planning, cash forecasting, income and expenditure, and capital expenditure.

Once a review is completed we implement an action plan to address areas requiring development and these are then monitored by the Executive Management Team, the Trust Board and the relevant Board committee. The potential scope and impact of the recommendations of the Francis Report and Winterbourne review have been presented to the Trust Board.

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 undertook an unannounced compliance inspection in November 2012. Two areas for improvement were identified and action plans have been implemented to address the following: Outcome 11:- Safety, availability and suitability of equipment - moderate impact on patient safety and care; and Outcome 13:- Staffing – minor impact on patient safety and care.

We can confirm that all premises which we own, occupy or manage had fire risk assessments that complied with the Regulatory Reform (Fire Safety) Order 2005. We also achieved compliance with the Department of Health Fire Safety Policy.

Risk assessment

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

The Risk Management Policy and Strategy describes the process for embedding risk management throughout the Trust and during 2012/13 we made further progress with developing and managing local risk register processes. Risks can be escalated to the Risk Compliance Assurance Group (RCAG) for discussion and addition to the corporate risk register if required. We have also aligned project management risks with the corporate risk register. The policy and strategy have been updated and re-formatted in line with NHSLA requirements. A risk maturity audit was undertaken by the internal auditors who report compliance and recommend strategies for embedding the framework within the Trust. The audit showed that our risk maturity was increasing with more emphasis on risk management approaches being built into normal business processes.

Patient and staff safety and other incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the risk and safety team, using the NPSA risk severity matrix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the RCAG or monitored at a local level. A Serious Incident Group meets weekly to review any serious incidents that need investigating and may need to be formally declared as Serious Incidents.

New risks with a net severity rating of High >15 are added to the corporate risk register and the board assurance framework which are reviewed by the Trust Board on a quarterly basis. The following risks were added in 2012/13:

- ID 355 – Mandatory training

There is a risk of staff not receiving clinical and non-clinical mandatory training.

- ID 368 – CommandPoint and mobile data terminal messaging

There is a risk that messages between mobile data terminals in vehicles and the CommandPoint CAD system become out of sequence, cross one another while one is being processed or a job is being ‘cycled’ through to closure in error.

- ID 378 – Locality Alert Register

There is a risk that insufficient information is contained within Metropolitan Police Service referrals for inclusion in our locality alert register.

- ID 379 – Category C calls – delayed or inappropriate responses

There is a risk that calls received and triaged as Category C, subdivided into C1, C2, C3 and C4, could receive a delayed or inappropriate response because of increased levels of Category A demand.

- ID 371 – Level 2 information governance toolkit – risk due to lack of training

There is a risk that we will not continue to maintain Level 2 for IG Toolkit Requirement 112 because operational staff will not have completed their online IG refresher training.

There were two risks assessed below the threshold for the board assurance framework but being kept visible to the Trust Board and these concerned the changes to Board membership during 2012/13 and into 2013/14 and the potential impact of these on a) our governance, and b) signing off the strategy.

There were 11 lapses of data security in 2012/13 but none reached the threshold for reporting to the Information Commissioner.

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

To provide increased resilience and reduce the risk of service failure a second control room has been opened at Bow. This will allow for some transition of call taking should the Emergency Control room at Waterloo become inoperable. We now have two control rooms in operation.

We continued to make significant progress against the Information Governance toolkit in-year achieving 82 per cent at the required Level 2 standards.

The risk and control framework

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The board assurance framework shows the linkages between the strategic goals for the next five years and the most significant strategic risks to the achievement of these. This is mapped to the key risks the Trust Board chose to focus on during the year as well as the top risks on the corporate risk register. The board assurance framework is mapped to the Care Quality Commission's outcomes and requirements. The Quality Committee reviews the board assurance framework and corporate risk register quarterly as does the Trust Board. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Risk Compliance and Assurance Group reviews the corporate risk register in detail at each meeting, adding 17 risks and archiving 24 risks during 2012/13. The Audit Committee assess the effectiveness of the corporate risk register annually. The Trust Board, Quality Committee and Executive Management Team 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. During 2012/13 we undertook a procurement exercise for local counter fraud services and the contract was awarded to KPMG from 1 April 2013.

The Internal Auditors attend four meetings of the Audit Committee per year and work closely with the Governance and Compliance team to execute the annual audit workplan. Internal audit also attend meetings of the Quality Committee and the committee has input to the development of the annual audit workplan. This work is also informed by the executive team.

During 2012/13 we undertook a procurement exercise for internal audit services and the contract was awarded to KPMG from 1 April 2013.

KPMG will manage the transition from RSM Tenon to the new contract in the first quarter of 2013/14.

The Audit Commission ceased to provide external audit services during 2012/13. The Department of Health awarded the contract to Price Waterhouse Cooper and this took effect during 2012/13.

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 is informed by the work of the internal auditors, clinical audit and our executive management team who have responsibility for the development and maintenance of the internal control framework.

I have drawn on 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 Board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant issues

We declared 16 serious incidents to NHS London and the Commissioners in 2012/13. Thematically, four were related to maternity calls and nine were delays in responding to patients, while there was one each relating to equipment, a road traffic incident and the response to an incident also involving the police.

With our lead commissioners, we recognised the increasing gap between demand and the available resources and jointly commissioned ORH Limited, a company specialising in planning and modelling, to undertake a capacity review. This was reported in January 2013 and has informed the contract for 2013/14 including identifying risk sharing arrangements and mitigating actions. This is incorporated in our modernisation programme that commences in May 2013.

As a result of the mitigating actions we took to ensure resources were available to meet the increasing demand on services during 2012/13, we sought and gained approval from NHS London to reduce the control total from £3.2m to £262k. We therefore failed to meet the 2012/13 financial plan. We also undershot on our Capital Resourcing Limit and failed to deliver CQUINs to an approximate value of £3m. The Grant Thornton review was commissioned to undertake a baseline financial review incorporating cash planning and forecasting, income and expenditure and capital expenditure, the outcome of which will inform future financial planning and management.

Our organisation underwent several Board changes during 2012/13. Peter Bradley left the post of Chief Executive on 10 September 2012 and Martin Flaherty was acting Chief Executive until 6 January 2013. I took over the position of Chief Executive on 7 January 2013. Michael Dinan left the post of Director of Finance on 20 January 2013 and Andrew Grimshaw was appointed as interim Director of Finance for a period of six months. Mr Grimshaw was subsequently appointed to the substantive post and will assume the role permanently from July 2013.

Letters of representation were obtained from Martin Flaherty and Michael Dinan confirming that, to the best of their knowledge, there were no significant issues arising during their period of office in 2012/13. My statement therefore as Accountable Officer pertains to the period 7 January – 31 March 2013. This was discussed by the Audit Committee and assurance given that the Trust Board is accountable for internal control with responsibility delegated to Peter Bradley as Chief Executive during the period 1 April – 10 September 2012. The Board is unaware of any significant issues other than those stated in the narrative above.

Head of Internal Audit opinion
Based on the work undertaken in 2012/13, 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.

Accountable Officer: Ann Radmore, Chief Executive

Organisation: London Ambulance Service NHS Trust

Date: 4 June 2013

Figure 1

Governance Structure – February 2013

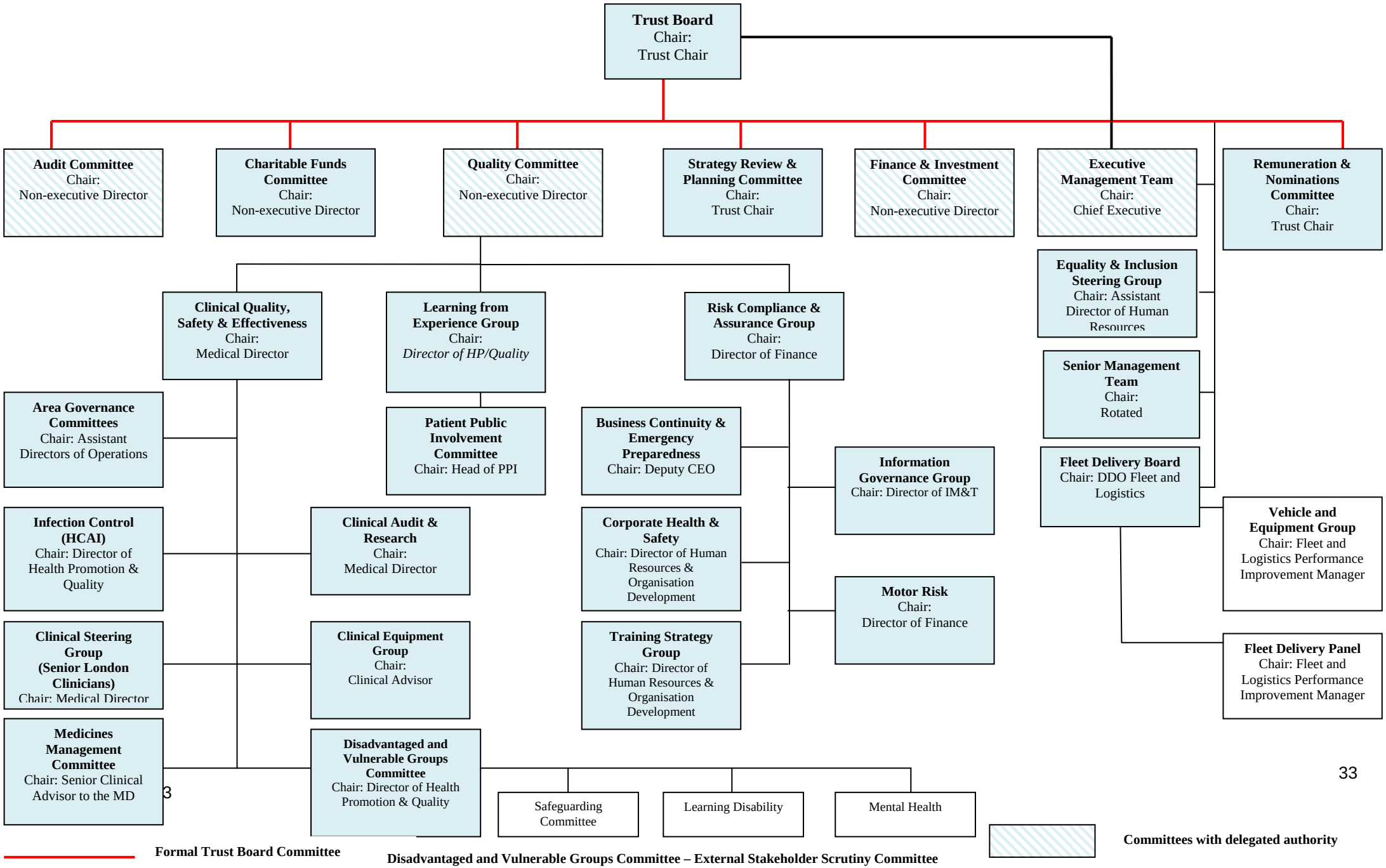


Figure 2 - Committee membership

Formal Trust Board committee	Chair	Current members
Audit committee	Non-executive director, Caroline Silver	Brian Huckett (non-executive director) – to 31/12/12 Roy Griffins (non-executive director) John Jones (non-executive director) – from 1/1/13
Charitable funds committee	Non-executive director, Caroline Silver	Caron Hitchen (executive director)
Quality committee	Non-executive director, Dr Beryl Magrath MBE	Roy Griffins (non-executive director) Peter Bradley (Chief Executive) Jessica Cecil (non-executive director) Murziline Parchment (non-executive director) – to 30/9/12 Nick Martin (non-executive director) – from 1/10/12
Finance & investment committee	Trust Chair, Richard Hunt, CBE	Non-executive director member of the audit committee Non-executive director member of the quality committee Executive directors – Finance, Workforce, Corporate Services *, Health Promotion & Quality, Strategy & Planning * *Non-voting directors
Strategy review and planning committee	Trust Chair, Richard Hunt CBE	All board directors, voting and non-voting.
Remuneration and Nomination committee	Trust Chair, Richard Hunt CBE	All non-executive members of the Trust Board

Figure 3 – Attendance at Trust Board meetings

	29 May 2012	26 June 2012	21 August 2012	25 September 2012	27 November 2012	29 January 2013	26 March 2013	Comments
Trust Board members (voting)								
Richard Hunt (Non-Executive Chair)	x	✓	✓	✓	✓	✓	✓	
Peter Bradley (Chief Executive)	✓	✓	✓					Left in September 2012
Jessica Cecil (Non-Executive Director)	✓	x	✓	✓	x	✓	✓	
Mike Dinan (Director of Finance)	✓	✓	✓	✓	✓			Left in January 2013
Martin Flaherty (Chief Operating Officer)	✓	✓	✓	✓	✓			Left in January 2013
Roy Griffins (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	
Andrew Grimshaw (Director of Finance)						✓	✓	Joined in January 2013
Caron Hitchen (Director of Workforce)	✓	✓	✓	✓	✓	✓	x	
Brian Huckett (Non-Executive Director)	✓	✓	x	✓	✓			Left in December 2012
John Jones (Non-Executive Director)					✓	x	✓	Joined in January 2013
Steve Lennox (Director of Health Promotion and Quality)	✓	x	✓	✓	✓	✓	x	
Ann Radmore (Chief Executive)					✓	✓	✓	Joined in January 2013
Beryl Magrath (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)					✓	✓	✓	Joined in October 2012
Fionna Moore (Medical Director)	✓	✓	✓	✓	✓	✓	x	
Murziline Parchment (Non-Executive Director)	✓	✓	x	✓				Left in September 2012
Caroline Silver (Non-Executive Director)	x	✓	x	✓	✓	x	x	
Non-voting								
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓	✓					Maternity leave from September 2012
Jane Chalmers (Director of Modernisation)						✓	x	Joined in January 2013
Bob McFarland (Associate Non-Executive Director)							✓	Joined in March 2013
Jason Killens (Director of Service Delivery, North Thames)					✓	✓	✓	Commenced role of Director of Service Delivery in September 2012
Angie Patton (Head of Communications)	x	x	✓	✓	✓	✓	✓	
Peter Suter (Director of Information Management and Technology)	✓	✓	x	✓	✓	✓	✓	
Paul Woodrow (Director of Service Delivery, South Thames)					✓	✓	✓	Commenced role of Director of Service Delivery in September 2012

Figure 4 – Attendance at Quality Committee meetings

	25 April 2012	20 June 2012	15 August 2012	24 October 2012	13 December 2012	20 February 2013	Comments
Quality Committee members							
Beryl Magrath	✓	✓	✓	✓	✓	✓	
Jessica Cecil	✓	✓	✓	x	x	✓	
Roy Griffins	✓	✓	x	✓	✓	✓	
Nick Martin				✓	✓	✓	
Murziline Parchment	✓	x	x				Left in September 2012
Peter Bradley	x	x	✓				Left in September 2012
Attending							
Sandra Adams (Director of Corporate Services)	✓	✓	x	✓	✓	✓	
Mike Dinan (Director of Finance)	✓	✓	x	✓	x		Left in January 2013
Martin Flaherty (Chief Operating Officer)	x	x	x	x	x		Left in January 2013
Caron Hitchen (Director of Human Resources and Organisation Development)	✓	✓	✓	✓	✓	✓	
Steve Lennox (Director of Health Promotion and Quality)	✓	x	✓	✓	✓	✓	
Fionna Moore (Medical Director)	✓	x	✓	✓	✓	x	
Paul Woodrow (Director of Service Delivery)	x	✓	✓	✓	✓	x	

Figure 5 – Attendance at Audit Committee meetings

	14 May 2012	1 June 2012	3 September 2012	5 November 2012	Comments
Audit Committee members					
Caroline Silver (Non-Executive Director)	✓	✓	✓	✓	
Roy Griffins (Non- Executive Director)	✓	✓	✓	✓	
Brian Huckett (Non-Executive Director)	✓	x	✓	x	Left in December 2012
Attending					
Peter Bradley (Chief Executive)	x	✓	x		Left in September 2012
Mike Dinan (Director of Finance)	✓	✓	✓	✓	
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	

Figure 6 – Attendance at Strategy Review and Planning Committee meetings

	24 April 2012	24 July 2012	23 October 2012	11 December 2012	Comments
Trust Board members (voting)					
Richard Hunt (Non-Executive Chair)	✓	✓	✓	✓	
Peter Bradley (Chief Executive)	✓	✓			Left in September 2012
Jessica Cecil (Non-Executive Director)	✓	x	x	✓	
Mike Dinan (Director of Finance)	✓	✓	✓	✓	
Martin Flaherty (Chief Operating Officer)	✓	✓	✓	✓	
Roy Griffins (Non-Executive Director)	✓	x	✓	x	
Caron Hitchen (Director of Workforce)	✓	✓	✓	✓	
Brian Huckett (Non-Executive Director)	✓	x	✓	✓	
John Jones (Non-Executive Director)			✓	✓	Joined as Associate Non-Executive Director in October 2012
Steve Lennox (Director of Health Promotion and Quality)	✓	✓	x	✓	
Ann Radmore (Chief Executive)				✓	Joined in January 2013
Beryl Magrath (Non-Executive Director)	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)			x	✓	Joined in October 2012
Fionna Moore (Medical Director)	✓	✓	✓	✓	
Murziline Parchment (Non-Executive Director)	✓	✓			Left in September 2012
Caroline Silver (Non-Executive Director)	x	x	✓	✓	
Non-voting					
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓			Maternity leave from September 2012
Jason Killens (Director of Service Delivery, North Thames)			✓	x	Commenced role of Director of Service Delivery in September 2012
Angie Patton (Head of Communications)	✓	✓	✓	✓	
Peter Suter (Director of Information Management and Technology)	✓	✓	x	✓	
Paul Woodrow (Director of Service Delivery, South Thames)			✓	x	Commenced role of Director of Service Delivery in September 2012

Figure 7 – Attendance at Finance and Investment Committee meetings

	15 May 2012	10 July 2012	18 September 2012	13 November 2012	12 March 2013	Comments
Quality Committee members						
Richard Hunt (Non-Executive Director)	✓	✓	✓	✓	✓	
Jessica Cecil (Non-Executive Director)	✓	✓	x	x		
Brian Huckett (Non-Executive Director)	✓	✓	✓	✓		Left in December 2012
John Jones (Non-Executive Director)				✓	✓	Joined as Associate Non-Executive Director in October 2012
Beryl Magrath (Non-Executive Director)	✓	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)				✓	✓	
Attending						
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓				Maternity leave from September 2012
Mike Dinan (Director of Finance)	✓	x	✓	✓		Left in January 2013
Andrew Grimshaw (Director of Finance)					✓	Joined in January 2013
Caron Hitchen (Director of Human Resources and Organisation Development)	x	✓	x	✓	✓	
Steve Lennox (Director of Health Promotion and Quality)	x	✓	✓	✓	x	
Ann Radmore (Chief Executive)					✓	Joined in January 2013

2012/13 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	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Retained surplus/(deficit) for the year	113	398	725	-420	740	2,527	-417
Adjustments for impairments	0	0	0	1,845	262	247	723
Adjustments for impact of policy change re donated grants asset	0	0	0	0	0	-23	-44
Break-even in-year position	113	398	725	1,425	1,002	2,751	262
Break-even cumulative position	1,446	1,844	2,569	3,994	4,996	7,747	8,009
Break-even cumulative position as a percentage of turnover	0.67	0.78	0.98	1.43	1.76	2.75	2.64

The surplus in 2012/13 meant that the cumulative position improved for the 12th 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 £262,000 for the year, and therefore did better than the break-even target set by the Department of Health for 2012/13.

We achieved our external financial limit (EFL) (£1,998) for the year.

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, £9.7million was spent on a range of projects, including ambulances, new technology projects and projects to improve the estate. Overall, we under spent by £5,084,000 against our capital resource limit, which we are permitted to do.

We were able to pay 81 per cent and 55 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 £133 million of fixed assets (£138 million in 2011/12) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. We fund the investment in capital assets through our capital programme. In 2012/13, we invested £9.7 million (£16.2 million in 2011/12). 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 have a net working capital of -£3.3 million (-£5.2 million in 2011/12) and long-term creditors and provisions of £13.7 million (£19.4 million in 2011/12). We had £5,500,000 cash in the bank as at 31 March 2013 (£5,250,000 in 2011/12).

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. The interest paid in 2012/13 was £174,000 per annum.

In 2010/11, we obtained a loan of £107,275 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 £47,275 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 2011/12) of the equity – this represents the Department of Health's investment in us and annual dividends are payable on this sum. A further £33.4 million (£33.7 million in 2011/12) 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 9.5 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial plan 2013/14

We have formally submitted a plan for 2013/14 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 £262,000.

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 2013 for all land and buildings. The net gain and loss on revaluation was £1,741,000 and the total impairments were £1,584,000.

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 £3,527,000 for the current financial year (£3,460,000 in 2011/12).

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 2012/13 financial statements.

Other information

Price Waterhouse Coopers was our external auditor for the year ending 31 March 2013. We paid £91,000 (Audit Commission £139,000 in 2011/2012) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our audit committee.

Historically we were audited by the Audit Commission; the last audit performed by them was for the year ending 31 March 2012.

The directors confirm that as far as they are aware there is no relevant audit information of which the NHS body's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

We conform to the Treasury's guidance on setting charges for information supplied to the public or commercial organisations.

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 auditors' statement to the Directors of the Board of London Ambulance Service NHS Trust

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Summary Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the related notes, and the information in the Directors' Remuneration Report that is described as having been audited.

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Secretary of State for Health.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the full annual statutory financial statements and the Directors' Remuneration Report and its compliance with the relevant requirements of the directions issued by the Secretary of State.

We also read the other information contained in the Annual Report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the summary financial statement.

This statement, including the opinion, has been prepared for, and only for, the Board of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the Trusts full annual statutory financial statements describes the basis of our audit opinion on those financial statements, and the Directors' Remuneration Report.

Opinion

In our opinion the summary financial statement is consistent with the full annual statutory financial statements and the Directors' Remuneration Report of London Ambulance Service NHS Trust for the year ended 31 March 2013 and complies with the relevant requirements of the directions issued by the Secretary of State.

Janet Dawson, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP
Appointed Auditors
London
21 August 2013

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- 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.

Ann Radmore
Chief Executive
4 June 2013

STATEMENT OF THE 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

Ann Radmore
Chief Executive
4 June 2013

Andrew Grimshaw
Finance Director
4 June 2013

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2013

	2012-13 £000	2011-12 £000
Gross employee benefits	**(211,242)**	(205,248)
Other costs	**(87,779)**	(68,774)
Revenue from patient care activities	**301,285**	278,267
Other operating revenue	**1,824**	3,464
Operating surplus	**4,088**	7,709
Investment revenue	**77**	281
Other losses	**(233)**	(715)
Finance costs	**(498)**	(864)
Surplus for the financial year	**3,434**	6,411
Public dividend capital dividends payable	**(3,851)**	(3,884)
Retained (deficit)/surplus for the year	**(417)**	2,527

Other comprehensive income	2012-13 £000	2011-12 £000
Impairments and reversals	**(861)**	(956)
Net gain on revaluation of property, plant and equipment	**1,741**	922
Total comprehensive income for the year*	**463**	2,493

*This sums the rows above and the surplus for the year before adjustments for PDC dividend and absorption accounting

Financial performance for the year		
Retained surplus/(deficit) for the year	**(417)**	2,527
Impairments	**723**	247
Adjustments to donated asset	**(44)**	(23)
Adjusted retained surplus)	**262**	2,751

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

a) Impairments to fixed assets: 2009/10 was the final year for organisations to revalue their assets to a modern equivalent asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.
b) The 2011/12 Treasury FReM changed the treatment of donated assets. Donated assets are now shown as income and are not considered part of the organisation's operating position.

Note that prior year performance is not re-assessed following accounting restatements

PDC dividend: balance (payable) at 31 March 2013	**(6)**
PDC dividend: balance (payable) at 31 March 2012	**(52)**

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2013

	31 March 2013	31 March 2012
	£000s	£000s
Non-current assets:		
Property, plant and equipment	**119,021**	123,055
Intangible assets	**13,628**	15,033
Trade and other receivables	**0**	1,770
Total non-current assets	**132,649**	139,858
Current assets:		
Inventories	**3,264**	2,812
Trade and other receivables	**16,075**	11,940
Cash and cash equivalents	**5,500**	5,250
Total current assets	**24,839**	20,002
Total assets	**157,488**	159,860
Current liabilities		
Trade and other payables	**(24,546)**	(21,364)
Provisions	**(2,098)**	(1,411)
Borrowings	**(309)**	(1,268)
Capital loan from Department	**(1,244)**	(1,244)
Total current liabilities	**(28,197)**	(25,287)
Non-current assets plus/less net current assets/liabilities	**129,291**	134,573
Non-current liabilities		
Provisions	**(8,731)**	(7,743)
Borrowings	**(641)**	(6,130)
Capital loan from Department	**(4,343)**	(5,587)
Total non-current liabilities	**(13,715)**	(19,460)
Total Assets Employed:	**115,576**	115,113
FINANCED BY:		
TAXPAYERS' EQUITY		
Public dividend capital	**62,516**	62,516
Retained earnings	**20,053**	19,304
Revaluation reserve	**33,426**	33,712
Other reserves	**(419)**	(419)
Total taxpayers' equity:	**115,576**	115,113

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	**62,516**	**19,304**	**33,712**	**(419)**	**115,113**
Changes in taxpayers' equity for 2012-13					
Retained surplus/(deficit) for the year	0	(417)	0	0	**(417)**
Net gain/(loss) on revaluation of property, plant, equipment	0	0	1,741	0	**1,741**
Impairments and reversals	0	0	(861)	0	**(861)**
Transfers between reserves	0	1,166	(1,166)	0	**0**
Net recognised revenue/(expense) for the year	**0**	**749**	**(286)**	**0**	**463**
Balance at 31 March 2013	**62,516**	**20,053**	**33,426**	**(419)**	**115,576**

Balance at 1 April 2011	**62,516**	**14,851**	**35,672**	**(419)**	**112,620**
Changes in taxpayers' equity for the year ended 31 March 2012					
Retained surplus/(deficit) for the year	0	2,527	0	0	2,527
Net gain / (loss) on revaluation of property, plant, equipment	0	0	922	0	922
Impairments and reversals	0	0	(956)	0	(956)
Transfers between reserves	0	1,926	(1,926)	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 CASH FLOWS FOR THE YEAR ENDED 31 March 2013

	2012-13 £000s	2011-12 £000s
Cash flows from operating activities		
Operating surplus	**4,088**	7,709
Depreciation and amortisation	**12,956**	11,430
Impairments and reversals	**723**	248
Donated assets received credited to revenue but non-cash	**0**	(23)
Interest paid	**(300)**	(670)
Dividend paid	**(3,897)**	(3,832)
Increase in Inventories	**(452)**	(241)
(Increase)/decrease in trade and other receivables	**(6,163)**	13,495
Increase/(decrease) in trade and other payables	**5,908**	(13,976)
Provisions utilised	**(1,160)**	(1,047)
Increase in provisions	**2,305**	636
Net cash inflow from operating activities	**14,008**	13,729
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	**77**	59
Payments for property, plant and equipment	**(11,468)**	(13,987)
Payments for intangible assets	**(655)**	(1,600)
Proceeds of disposal of assets held for sale (PPE)	**36**	8,868
Net Cash outflow from investing activities	**(12,010)**	(6,660)
NET CASH INFLOW BEFORE FINANCING	**1,998**	7,069
CASH FLOWS FROM FINANCING ACTIVITIES		
Loans repaid to DH - capital investment loans repayment of principal	**(1,244)**	(1,244)
Capital element of payments in respect of finance leases and On-SoFP PFI and LIFT	**(504)**	(1,411)
Net cash outflow from financing activities	**(1,748)**	(2,655)
NET INCREASE IN CASH AND CASH EQUIVALENTS	**250**	4,414
Cash and cash equivalents (and bank overdraft) at beginning of the period	**5,250**	836
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	**5,500**	5,250

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 50 to 53**.**

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2012/13 was in the range of £180,001 to £185,000. This was 4.73 times the median remuneration of the workforce, which was £38,603.88. In 2011/12, 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 £31,259.64.

In 2012/13, 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 a decrease in pay received in 2012/13
- a change in the workforce composition in 2012/13 leading to a increase 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	2012/13			2011/12		
	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	£0-£5,000	£0		£5,001-£10,000	£0	
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
* 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	
** Nicholas Martin, Non-Executive Director	£0-£5,000	£0		£0-£5,000	£0	
** John Jones, Non-Executive Director	£0-£5,000	£0		£0-£5,000	£0	
** Ann Radmore, Chief Executive	£40,001-£45,000	£0		£0-£5,000	£0	
** Andrew Grimshaw, Interim Finance Director	£75,001-£80,000	£0		£0-£5,000	£0	
* Peter Bradley, Chief Executive	£105,001-£110,000	£0	£1,961	£180,001-£185,000	£0	£4,091
*/**** Michael Dinan, Director of Finance	£100,001-£105,000	£0		£115,001-£120,000	£0	
* Martin Flaherty, Deputy Chief Executive	£105,001-£110,000	£0	£3,810	£60,001-£65,000	£0	£3,134
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£100,001-£105,000	£0	
Stephen Lennox, Director of Health Promotion & Quality	£90,001-£95,000	£0		£95,001-£100,000	£0-	
*** Fionna Moore, Medical Director	£65,001-£70,000	£0		£75,001-£80,000	£0	

The figures shown under the heading 'benefit in kind' refer to the provision of lease cars.

* The following directors left the Trust: Peter Bradley on 9 September 2012, Murziline Parchment on 30 September 2012, Brian Huckett on 31 December 2012, Martin Flaherty on 6 January 2013, Michael Dinan on 20 January 2013 and Beryl Magrath on 31 March 2013.
** The following directors joined the Trust: Nicholas Martin on 1 October 2012, John Jones on 1 January 2013, Ann Radmore on 7 January 2013 and Andrew Grimshaw on 21 January 2013.
*** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.
****Michael Dinan In addition to the note above, the Trust made a compensation payment to director of finance in the banding of £75,000 to £80,000 for loss of office in 2012/13.

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 2013 (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 2013	Cash equivalent transfer value at 31 March 2012	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	**	**	**	**	**	**	**	
Nicholas Martin, Non-Executive Director	**	**	**	**	**	**	**	
John Jones, Non-Executive Director	**	**	**	**	**	**	**	
Ann Radmore, Non-Executive Director	£0-£2,500	£2,501-£5,000	£55,001-£60,000	£160,001-£165,000	£1,122,210	1,005,164	£18,631	
* Andrew Grimshaw, Non-Executive Director	*	*	*	*	*	*	*	
Peter Bradley, Chief Executive	£0-£2,500	£2,501-£5,000	£25,001-£30,000	£75,001-£80,000	£0	£453,599	£0	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£10,001-£15,000	£35,001-£40,000	£0	£187,834	£0	
Martin Flaherty, Deputy Chief Executive	£2,501-£5,000	£10,001-£12,500	£55,001-£60,000	£170,001-£175,000	£0	£483,979	£0	
Caron Hitchen, Director of Human Resources	£0-£2,500	£2,501-£5,000	£25,001-£30,000	£85,001-£90,000	£545,494	£508,540	£25,868	
Stephen Lennox, Director of Healthcare Promotion	£0-£2,500	£2,501-£5,000	£35,001-£40,000	£105,001-£110,000	£605,842	£567,149	£27,085	
Fionna Moore, Medical Director	£0-£2,500	£0-£2,500	£45,001-£50,000	£145,001-£150,000	£1,137,365	£1,137,365	£0	

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

* Andrew Grimshaw is an interim finance director employed through an employment agency, there will be no entries in respect of pensions for him.

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.”

Reporting of other compensation schemes – exit packages agreed in 2012/13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
£25,001-£50,000	1	0	1	0	0	0
£50,001-£100,000	1	0	1	0	0	0
Total number of exit packages by type (total cost	**2**	**0**	**2**	0	0	0
Total resource cost (£000s)	**103**	**0**	**103**	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Better payment practice code – measure of compliance

Better Payment Practice Code

Measure of compliance	**2012-13 Number**	**2012-13 £000s**	2011-12 Number	2011-12 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**49,368**	**64,627**	51,604	69,019
Total Non-NHS Trade Invoices Paid Within Target	**39,893**	**49,073**	46,136	60,795
Percentage of NHS Trade Invoices Paid Within Target	**80.81%**	**75.93%**	89.40%	88.08%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**311**	**3,357**	339	**4,133**
Total NHS Trade Invoices Paid Within Target	**171**	**1,866**	289	**2,331**
Percentage of NHS Trade Invoices Paid Within Target	**54.98%**	**55.59%**	85.25%	56.40%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust has signed up to the government prompt payments code.

EXTERNAL FINANCING

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

	£000s	2012-13 £000s	2011-12 £000s
External financing limit		**(1,998)**	(9,225)
Cash flow financing	**(1,998)**		(7,069)
External financing requirement		**(1,998)**	(7,069)
Undershoot/(overshoot)		**0**	(2,156)

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.

Under spends 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.