London Ambulance Service NHS
NHS Trust

Annual Report

2009/10

Contents

Who we are

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

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

However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. Often these patients will receive more appropriate care somewhere other than at hospital and so we offer a range of care to these patients, 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 five executive directors, including the Chief Executive.

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

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

In 2009/10 we handled almost 1.5 million emergency calls from across London and attended more than one million incidents.

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

Our Trust Board

Our Trust Board is made up of 12 members – a non-executive chairman, five of the Service's executive directors (including the Chief Executive), and six non-executive directors.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. The non-executive directors are appointed by the same method but independently through the Appointments Commission.

All executive appointments are permanent and subject to normal terms and conditions of employment.

The Board has five formal sub-committees: the Strategy Review and Planning Group, the Quality Committee, the Audit Committee, the Remuneration Committee and the Charitable Funds Committee.

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

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

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

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

Non-executive directors

Richard Hunt CBE joined us as Chairman on 1 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.

Sigurd Reinton CBE stepped down as our Chairman at the end of June 2009 having served three terms, the maximum allowed. Sigurd was first appointed in October 1999 and was made an honorary CBE in the 2008 New Year Honours list.

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

Dr Beryl Magrath MBE took up her post as non-executive director in 2005, and is chair of our Quality Committee. She is a former consultant anaesthetist and previously worked at Bromley Hospitals NHS Trust in Kent. She was a founder of South Bromley HospisCare in 1984 and was medical director of Bromley Hospitals NHS Trust between 1992 and 2000. Beryl is Vice Chairman of Governors for Castlecombe primary school in Bromley

Sarah Waller CBE is the programme director for the King's Fund's 'Enhancing the Healing Environment' programme. She joined the King's Fund in 2000 to develop the programme following a career in nursing and human resources management in the NHS and civil service and has been both a local councillor and health authority member. She was appointed CBE for services to nursing and the NHS in the 2008 New Year Honours list. Sarah was a member of the Audit Committee in 2009/10 and is a member of the Quality Committee.

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

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

Nigel Walmsley took up his post in March 2010. He spent the first 16 years of his career in the public service sector and following that was Chief Executive of Capital Radio Group and then of Carlton Television. He was a governor of the South Bank Centre, a non-executive director of the Ambassadors Theatre Group and non-executive Chairman of the Southern and South Eastern Tourist Board. He is currently Chairman of the Broadcast Audience Research Board (BARB) – the research company which measures television viewing – as well as being a member of the Advertising Standards Authority and non-executive director of Passenger Focus, the statutory consumer voice of rail and bus passengers. Nigel is a member of the Quality Committee.

Dr Ingrid Prescod stepped down from her post as a non-executive director in April 2009 due to other commitments after three years at the Trust.

Executive directors

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

Deputy Chief Executive Martin Flaherty OBE joined the Service in 1979. His career has included time spent as a paramedic, followed by 20 years as a manager in a variety of

positions. He became an executive director in April 2005 and was responsible for coordinating the emergency medical response to the 7 July bombings that year. He was awarded an OBE in the 2006 New Year Honours. He became Deputy Chief Executive in May 2009.

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

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

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

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

Directors

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

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

Director of Service Development Kathy Jones joined us from the South West Thames Health Authority in November 1992. She had previously worked in the area of policy development for a local authority, a major charity, and the Trades Union Congress (TUC).

Director of Corporate Services Sandra Adams took up this newly-created 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.

Meetings

The Board meets in public eight times a year on Tuesdays from 10am in the conference room at the Trust's headquarters. Details of the meetings are published on our website, 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.

Chairman's Views

What do you see as the highlights of your first year as Chairman?

Firstly, it has been a privilege to take on the role. Visits to the emergency control centre, urgent control centre and the various ride-outs with ambulance crews have been real highlights. Those bring to life, in a way nothing else can, what we do. However, I am always aware that this is the result of a team effort from everyone in the organisation. That's the real highlight, playing a role as part of the London Ambulance Service team.

Looking to the future, what do you see as being the biggest challenges facing the Trust in the years ahead?

Two things. Firstly, the changing external environment and in particular new financial circumstances which will affect us all and to which we will have to respond. Secondly, finding new ways of dealing with increasing demand for our services whilst always maintaining the quality of care we provide.

What do you want to achieve for patients in London?

A world-class ambulance service, available when needed, which also offers the right type of care with more variety in pathways than currently, stemming from a well-trained, well-informed and motivated team of professional colleagues.

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

We continue with our plans to make an application to become a foundation trust over the next year. The final date is yet to be determined. It is the Trust Board's view that as a foundation trust the additional flexibility that this will provide over strategy, service development and funding, together with engagement with the communities we serve will all provide further positive development for our Trust.

What are the Trust's priorities for this year?

Our priorities for this year can be summarised into three themes. The first is progress in delivering clinical excellence, with safety in our approach paramount for our patients and staff. The second is improved performance and efficiency including the cost of operating across all our activities. Finally, improvements in how colleagues rate being part of and working for the Trust which translates into an improvement in 'corporate morale' despite external difficulties and challenges.

Chief Executive's views

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

Stroke, trauma and cardiac care have all improved. Added to this we have more ambulance staff and control room staff than ever before which means patients are waiting shorter times for our help, either over the telephone or face to face. We have also continued to provide increasing levels of advice to large numbers of 999 callers through the use of our own clinical telephone advisors and through our partnership with NHS Direct. Increasingly, patients have many more care options when they ring us.

How will the Trust continue to deliver excellent patient care when NHS funding is expected to get increasingly tight in the coming years?

It won't be easy but we have made it very clear that we will do all we can to protect the excellent service we provide. We all know there is more we can do to be more efficient in some of the things we do and it's only right that we focus on getting better in these areas. I believe this can be done while at the same time continuing to improve the care we provide.

The response to patients with serious illnesses or injuries is still below target, despite recruiting hundreds of additional staff over the last two years. How do you intend to improve this?

Our most important target is to get to those patients with an immediately life threatening condition as soon as possible and last year we achieved this for the seventh year in a row. We recognise we have to further improve our response to the biggest group of patients we attend, who don't have a life threatening condition, but could still be seriously ill. We have seen year on year improvements in the speed of our response to these patients and 2010/11 will see our biggest ever improvement as all the new staff we have recruited and our new ambulances are out on the streets of London.

Swine flu and snow in the capital presented the Trust with some unique challenges last year. How did you cope and what lessons did you learn?

The flu pandemic and the most severe weather for 30 years proved a significant challenge for us. We worked closely with our partners in London, other ambulance services, and the Department of Health to plan for the anticipated rise in demand.

In the end we coped very well and the winter proved an excellent test of our planning and enabled us to learn lessons. The most important of these was the need for ongoing planning around flu to ensure that there is absolutely no complacency given the prospect of it returning in coming years. We also learned that it will be essential that we have systems to divert callers with flu who are not seriously ill to the National Pandemic Flu Service, saving ambulances for those who need them most.

Demand on the ambulance service is rising year on year. How are you going to deal with this?

Demand does continue to grow and we know many patients don't need an emergency ambulance, but do need to be signposted to another agency that can help.

Along with increasing use of our own clinical telephone advice and NHS Direct, we'll continue to manage our frequent callers and keep trying to educate the public not to ring 999 when there are more suitable alternatives.

We'll also need to be more innovative in how we deal with patients whose needs might be more appropriately served by something other than and ambulance response.

Directors' Report

Our vision and strategic goals

Our vision is to meet the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do. We will do this through the achievement of three strategic goals:

- Care for patients: to improve our delivery of safe and high quality patient care using all available pathways;
- Good for staff: to have staff who are skilled, confident, motivated and feel valued and work in a safe environment;
- Value for taxpayers: to be efficient and productive in delivering our commitments and to continually improve.

During 2009/10 our Trust Board reviewed the Trust's strategy and decided upon these three strategic goals which were then shared and agreed with staff. We then developed corporate objectives (three to five year objectives) under each of the three strategic goals.

Care for patients:

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

Good for staff:

- To develop staff so that they have the skills and confidence they need to do their job
- To improve the diversity of the workforce
- To create a productive and supportive working environment where staff feel safe, valued and influential

Value for taxpayers:

- To use resources efficiently and effectively and be in the top 25% of ambulance services on efficiency measures
- To maintain service performance during major events, both planned and unplanned including the 2012 Olympic Games
- To communicate and engage with key stakeholders

From these we derive the annual objectives to which we work every year.

Over the time we have been developing these goals we have also kept in touch with our key stakeholders, including the London Ambulance Service Patients' Forum, Local Involvement Networks, the Strategic Health Authority, and our commissioners: the 31 primary care trusts in London.

As the Strategic Health Authority, NHS London manages our performance. They want to see us deliver against our targets, while at the same time delivering our contribution to their key aims on urgent and emergency care.

We have, for example, made sure that we are ready to respond to the changes in stroke and trauma hospital services in London. This change will lead to many more people surviving their health crisis, and the success of this depends greatly on our ambulance crews identifying which patients need to travel further to a specialist centre that will increase their chances of survival.

Our crews are already succeeding in getting our seriously ill and injured patients to the right place, so that we can provide a world class ambulance service to a world class health system.

Many of our most important changes are delivered through our service improvement programme. A programme is a collection of projects that, together, are designed to deliver a number of benefits. We use programme management as our means of making sense of what it is we are trying to achieve – and ensuring that it gets done.

Achievements during 2009/10

Clinical developments

We attended more patients than ever before in 2009/10, responding to more than a million incidents.

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

Stroke and trauma care

We have played a central role in the development of stroke and trauma care in the capital, and now take patients with these conditions to specialist centres for treatment.

In February we started to take patients who have suffered a stroke – a type of brain injury – to new hyper acute stroke units. There are eight of these units operating around the clock in London, and patients who are taken here receive quick access to a specialist scan and expert treatment, which will increase their chance of survival and cut the risk of long-term disability.

During the year we also prepared for the opening of specialist major trauma centres – three of these went live in April 2010. They are equipped to deal with patients who suffer life-threatening injuries, including amputations or gunshot wounds. Patients with a fractured hip or ankle, or minor head injuries, are treated at a local trauma centre which is usually at a hospital emergency department.
The decision of where to site the new centres was made after a detailed study of existing services offered to stroke and major trauma patients in London. This was carried out by Healthcare for London, which is leading a 10-year programme to transform healthcare in the capital. Ambulance journeys to these centres may take longer than a journey to the

nearest hospital emergency department, but patients will get the right treatment when they get to hospital – rather than having to be moved to a specialist centre later on.

Patients in London are no more than a 30-minute blue-light ambulance journey from a hyper acute stroke unit or 45 minutes from a major trauma centre.

Cardiac care

We have continued to improve the care we provide to patients who suffer a heart attack or cardiac arrest.

More patients who suffer heart attacks are being taken to specialist centres than ever before. Our latest figures show that in 2008/09, 1,604 patients who were diagnosed as suffering from a common type of heart attack, known as an ST-elevation myocardial infarction, were taken directly to a cardiac catheter laboratory. This is an increase of 25 per cent on the year before. These patients were taken to specialist centres to enable them to be given primary angioplasty, a procedure which involves inflating a balloon inside an artery to enable a blockage to be cleared.

Latest figures for cardiac arrests also show that Londoners whose hearts stop beating in public are over six times more likely to survive than 10 years ago.

The figures – for 2008/09 – show that just under one in six people who suffered a cardiac arrest outside of hospital, which was seen by someone else survived.

This survival rate of 15.2 per cent is up from 2.5 per cent in 1998/99. It is an increase from 12 per cent in 2007/08.

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

We now have 17 community responder and co-responder schemes in place whereby volunteers are trained to attend emergency calls in their local area and provide first aid to patients until an ambulance arrives.

We also have over 500 defibrillators – machines that are used to re-start a patient's heart with an electric shock – in public places including tourist attractions, airports and train stations. And we have trained hundreds of people working in these areas in their use.

Care for patients with less serious conditions

Many of our patients have injuries or illnesses that do need to be treated in hospital.

We have continued to look at other, more appropriate ways to provide care to them.

During the year, our clinical advisers carried out full assessments over the telephone on 47,180 patients. Of these, 12,616 were assessed as not needing ambulance staff to attend to them in person.

In addition to this, we passed a total of 64,301 calls to NHS Direct for their advisers to call back patients and provide them with clinical help over the phone.

Along with other health agencies, we advised people to get vaccinated against swine flu and seasonal flu during the flu pandemic. If people got flu they were advised to stay at home, take water and cold remedies, and get advice from NHS Direct or NHS choices.

Provision of pre-arranged patient transport

As well as our 999 service, we offer pre-arranged transport for patients to and from their hospital appointments. We carried out 336,062 of these journeys last year.

We delivered patients to hospital on time in 92 per cent of the journeys, compared with 90 per cent the year before, and 89 per cent in 2007/08. We departed hospital on time in 93 per cent of cases. This compares with 92 per cent in 2008/09, and 89 per cent in the year before that.

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

During the year, we commenced new contracts with Barnet, Enfield and Haringey Mental Health Trust, North East London Foundation Trust, South London and the Maudsley Mental Health Trust, and South West London and St George's Mental Health Trust.

We ceased providing services for the Royal National Orthopaedic Hospital NHS Trust and Renal Transport for Barts and the London NHS Trust.

Our total number of contracts at the end of the year stood at 27.

Performance against government targets

Demand on our service increased by over four per cent last year.

We received a total of 1,480,275 calls, compared to 1,423,496 in 2008/09. And we responded to a total of 1,025,366 emergency incidents, up from 973,908 the year before.

We conveyed 765,812 patients to hospital, compared to 744,754 the year before.

We also faced some major challenges in the form of swine flu, cold weather and large-scale events such as the G20 summit.
Despite this, we achieved two of the government response time targets, and improved our performance against the third.

For 2009/10, the targets were to reach:

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

The number of life-threatening calls received during 2009/10 increased by almost three per cent. We attended 328,616 of these calls – compared to 319,677 the year before. We responded to 75.45 per cent of these types of calls within eight minutes. This is a similar achievement to 2008/09 (75.5 per cent). The way in which our response times are measured changed in April 2008; therefore, it is not possible to make a direct comparison with performance in previous years.

We reached 98.7 per cent of Category A calls within 19 minutes, exceeding the target of 95 per cent. This is slightly below our performance in 2008/09, when we reached 99 per cent of patients within this time.

We saw calls to patients with serious conditions increase by over two per cent during the 12-month period, which was an additional 8,605 calls compared with the year before. Unfortunately, although our performance against the Category B target improved during the year, we were unable to achieve the 95 per cent target. We responded to 86.4 per cent of these calls within 19 minutes; this compares favourably with 84.5 per cent in 2008/09.

Emergency demand						
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
999 calls received	1,153,948	1,231,572	1,288,819	1,389,660	1,423,496	1,480,275
Incidents attended	827,415	856,659	865,537	945,776	973,908	1,025,366
Incidents categorised as life-threatening	207,106	305,300	312,377	315,744	319,677	328,616

New call handling system

We are working to implement a new system for handling 999 calls and dispatching staff and vehicles.
The new system, CommandPoint, is expected to go live in 2011 following comprehensive testing and staff training.
The system will improve our ability to handle 999 calls and meet the challenges of ever increasing demand on our service and population growth in the capital.

Regulation

We were rated ‘excellent’ for the way in which we managed our finances last year – the highest of any ambulance service. And we were given a ‘fair’ rating for our quality of services by the Care Quality Commission (CQC). This compares with a ‘good’ rating for both finance and quality of services in 2008/09.

During 2009/10 we were inspected twice for compliance with the hygiene code regulations and were commended on our action plan and our staff ‘champions’ for infection prevention and control.

In March 2010 we received an improvement notice from the Health and Safety Executive concerning refresher training for manual handling. An action plan is in place to address the notice within the first quarter of 2010/11.

Governance and risk

The Trust Board has spent an extensive amount of time considering the strategic risks facing the London Ambulance Service in the next three to five years. The Trust Board manages risk through the Risk Management Policy and Strategy, corporate risk register and board assurance framework.

In the latter half of 2009/10 the governance and risk structure was reviewed and a new structure agreed for implementation from April 2010. Work continues on the review of the risk register and board assurance framework with the aim of moving towards greater responsibility for risk at a local level.

How we prepare for emergencies

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

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

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

To help us prepare for the unexpected, we regularly take part in major incident exercises with other agencies.

We have a team specially trained to treat patients in the 'hot zone', or hazardous area, at serious or major incidents. The hazardous area response team is also well-equipped to deal with large numbers of casualties at incidents.

This year, along with a number of serious incidents, we were faced with the swine flu pandemic and extreme weather during one of the coldest winters for years, both of which made it challenging to provide our normal level of service.

Improving our service through feedback

We are committed to safety and public accountability, but at the same time believe that when something goes wrong, any mistakes or shortcomings that are identified should be used as an opportunity to learn and so reduce future risks and improve practice.

In this way, we recognise the value of feedback as a way of driving changes and improvements, and we are committed to becoming an organisation where feedback in all its forms is valued and acted upon. We also believe that it is a vital part of being able to involve our patients and the wider public in developing our services.

Feedback comes to us from those who use our service, relatives, carers, partner

organisations such as other NHS trusts and social care agencies, and also our own staff. As well as enabling lessons to be learnt by individual staff and our service as a whole, we will also look to share feedback, where appropriate, so that improvements can be made in other parts of health and social care.

Every year we receive approximately 500 complaints, up to 6,000 enquiries to our Patient Experiences Department, and 200 incident reports from other health and social care agencies.

We believe that we need to focus on all of the feedback we receive, rather than just that which is made as a complaint. We believe the issues raised are important rather than the process which is used to report it. By treating all the feedback we receive seriously we can gain a better picture of any emerging trends and incidents of particular importance to patient care.

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

As best practice we now publish case studies on our website – www.londonambulance.nhs.uk – illustrating the lessons we have learned from different situations.

Our workforce

Last year saw the second year in a major recruitment drive which has seen our workforce grow significantly, with over 700 people joining us in the new role of student paramedic.

The rate of sickness among our staff for 2009/10 was 4.54 per cent, which was within our target of below five per cent for the year as a whole.

How we inform and consult with our staff

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

Partnership working with the unions: We have long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place. This relationship has been strengthened over recent years as we have worked together on major change programmes, including the implementation of Agenda for Change terms and conditions, and new cover arrangements for frontline staff that places them where historical data indicates the next 999 call will come from.

As well as formal diarised meetings at corporate and local level, we hold a partnership conference that brings all managers and staffside representatives together to discuss service development issues. Our recent conference addressed issues including swine flu, planning for the Olympic and Paralympic Games and our application for foundation trust

status. We plan to maintain these working relationships when we become a foundation trust.

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

New ways of working initiative**:** We have an initiative to develop clinical leadership at local level which will improve the care we give to patients and improve job satisfaction for staff. Two operational sites are currently focused on identifying new ways of working to achieve these objectives. Staff at all levels locally are actively encouraged to be involved in this work which ranges from improving clinical training and leadership skills to introducing team based working with supporting rotas and increasing community engagement. This initiative will roll out across all local operational areas in due course.

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

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

Representation on the Council of Governors: When we achieve foundation trust status, staff will be able to stand for election to our Council of Governors. We are proposing three seats for staff representatives.

Our approach to equal opportunities

We wholeheartedly welcome our obligations under equalities legislation. Our aim is to ensure that equality and inclusion is embedded and absolutely integral to everything we do.

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

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

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

All our staff are expected to promote these values at all times and behaviour that does not meet this exacting standard is dealt with promptly and rigorously.

As a provider of healthcare to the people living, working in and visiting our capital city, we seek to provide state-of-the-art care, which addresses the individual needs of our diverse patients and customers.

We aim to ensure that:

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

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

Our aim is to:

- celebrate and encourage the diversity of our workforce and to create a working environment where everyone feels included and appreciated for their work
- promote and provide our training and employment opportunities without regard to the age, disability status, gender, race, religion or belief, sexual orientation or any other aspect of an individual person's background
- foster creativeness and innovation in our working environment, to ensure that each member of staff can give of their best and move the Trust forward in our equality and inclusion goals.

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

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

Severance payments

One employee left the Trust under terms that required Treasury approval, which was duly sought and obtained.

Sustainability

In March 2010 our Trust Board approved the Carbon Reduction Policy, committing us to reduce our 2007 carbon footprint by 10 per cent by 2015.
A working group will be established in early 2010-11 to deliver this objective. We have already taken steps to reduce our carbon footprint through a number of initiatives, including:

- the increased use of clinical telephone advisers and the transfer of calls to NHS Direct to 'hear and treat' when the initial assessment indicates that the caller requires advice rather than an emergency response by a crew.
- the increased use of bicycle responders in central London, who are able to respond quicker than vehicles in areas of dense traffic and deliver emergency assistance.
- a cycle loan scheme, launched in March 2009, which has been taken up by 110 members of staff. We are currently investigating the merits of the other cycling promotion schemes.
- our new ambulances are almost 90 per cent recyclable (by weight), which is a vast improvement on our old ambulances. The regular servicing of our vehicles ensures that, when required, tyres are replaced with those which are more economical to run, with approximately 20 per cent more mileage per litre of fuel. Decreasing the use of fuel is a key area for improving the impact our fleet has on the environment.
- investigating acquiring electric/hybrid vehicles when we replace our tender lease vehicles.
- changing our electricity supplier, so that 25 per cent of the energy supplied to us will be from green sources.
- reducing the use of paper forms in favour of web-based systems.
- replacing 14 inefficient heating boilers with high efficient units and garage lighting with energy efficient lamps and controls at five ambulance stations.
- establishing recycling facilities across the Trust. This year we recycled 13 tonnes more than in 2008-09. Our compactor at headquarters has been exchanged from landfill to recycling.
- planning to introduce a stock management system that will reduce the amount of stock we need to hold and reduce the amount of wastage incurred as a result of 'out of date' clinical stock.

2009/10 financial summary statements

Financial review

We fulfilled four of our statutory financial duties in 2009/2010:

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.

Income and Expenditure £000s

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Surplus/deficit(-) in year	46	94	89	332	1,258	113	398	725	-420
Cumulative surplus/deficit(-)	-440	-346	-257	75	1,333	1,446	1,844	2,569	2,149
Cumulative deficit permitted (0.5%)	-678	-804	-843	-963	-1,080	-1,080	-1,180	-1,308	-1,399

The deficit in 2009/2010 meant that the cumulative position remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

1. On income and expenditure we reported a deficit of £420,000 for the year; this is a technical deficit as the impairment figure of £1,845,000 is excluded when calculating the break-even performance as per HM Treasury guidance for 2009/10. The adjusted financial position is a surplus of £1,425,000.

2. We had an £11,812,000 undershoot against our external financing limit (EFL) for the year, which we are permitted to do. The EFL undershoot was due to slippage in the capital programme that allowed the purchase of new ambulances to be funded using internally generated funds. The ambulances were originally planned to be purchased using a finance lease.

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

4. In the capital programme £24.9 million was spent on a range of projects, including ambulances, new technology projects, and projects to improve the estate. Overall we underspent by £4,316,000 against our capital resource limit, which we are permitted to do.

We were able to pay 86 and 87 per cent of our non-NHS and NHS trade invoices respectively within 30 days, which was below the 95 per cent target set for us by the Department of Health.

Balance sheet

The largest item on the balance sheet is £144 million of fixed assets (£129 million in 2008/09) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. We fund the investment in capital assets through our capital programme. In 2009/10 we invested £24.9 million (£14.6 million in 2008/09). The most significant addition was related to the project to replace the emergency operational control computer system, Mercedes ambulances, hazardous area response team vehicles, and defibrillators. The financing for capital projects was achieved by obtaining a £10 million loan and through internally generated funds, i.e. retained surpluses.

We have a net working capital of -£6.7 million (-£2.6 million in 2008/09) and long term creditors and provisions of £38.6 million (£35.7 million in 2008/09). We had £5.1 million cash in the bank as at 31 March 2010 (£2.7 million in 2008/09).

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

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 £60.9 million (£57.5 million in 2008/09) of the equity - this represents the Department of Health's investment in us and annual dividends are payable on this sum. A further £35.5 million (£32 million in 2008/09) is held in a revaluation reserve representing the accumulated increase in value of our estate.

Pension Costs

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

Financial Plan 2010/11

We have formally submitted a plan for 2010/11 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 £0.5 million.

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

Financial risk

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

International Financial Reporting Standards (IFRS)

The Treasury has announced that public sector bodies are required to prepare their accounts under International Financial Reporting Statements (IFRSs) from 2009/10. This will be the first year that we have prepared our accounting under IFRSs; the 2008/09 results have been reworked to act as prior year comparators in the 2009/10 accounts.

During the financial year, we adopted IAS 16 Property, Plant and Equipment and IAS 19 Employee Benefits, which has a material impact on our financial statements. The adoption of IAS 16 requires all tangible assets to be carried at valuation at the end of the financial year - that is, the option to carry at cost is withdrawn. Professional valuation was carried out by the district valuers of the Revenue and Customs government department on 31 March 2010 for all land and buildings. The net gain and loss on revaluation and

impairments was £15,315,000 and £10,692,000 respectively, resulting in a positive movement in the revaluation reserve by £3,869,000.

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 £1,250,000 for the current financial year.

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 2009/2010 financial statements. However, in May 2010, we sold 72 units of Mercedes ambulances to De Lage Landen Leasing Ltd and leased them back under a five year leasing arrangement. The company paid us £5,946,000 plus VAT. The proceeds will be used to fund our future capital investments.

Other information

The Audit Commission was our external auditor for the year-ending 31 March 2010. We paid the Audit Commission £150,864 for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our audit committee.

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

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

I have examined the summary financial statements which comprises who we are, the Trust Board, the Chairman's and Chief Executive's views, our vision and strategic goals, our achievements in 2009/10, and the financial summary statements, set out on pages 35 to 44.

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 49 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the annual report.

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

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

Basis of audit opinion

I conducted my work in accordance with Bulletin 1999/6 'The auditors' statement on the summary financial statement' issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of our audit opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of the Trust for the year ended 31 March 2010.

…….
Philip Johnstone
District Auditor

Audit Commission
1st Floor, Millbank Tower
Millbank
London
SW1P 4QP
June 2010

Related party transactions

London Ambulance Service NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with London Ambulance Service NHS Trust.

The Department of Health is regarded as a related party. During the year we obtained a £10 million capital investment loan from the department, we also had a significant number of material transactions with the department, and with other entities for which the department is regarded as the parent department. These entities are listed below:

London Strategic Health Authority
Richmond and Twickenham Primary Care Trust
London Primary Care Trust
Whipps Cross University Hospital NHS Trust
South London Healthcare NHS Trust
South West London and St George's Mental Health NHS Trust
NHS Litigation Authority
NHS Business Service Authority

For 2009/10 Richmond and Twickenham Primary Care Trust was the host primary care trust and received an administration fee of £2,500 (2008/09, £2,500) from the London Ambulance Service Charitable Fund.
The London Ambulance Service NHS Trust is the corporate trustee of the funds.

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to us;

- our expenditure and income has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place and annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

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

Signed

Peter Bradley
Chief Executive
29 June 2010

Statement of Directors' responsibilities in respect of the accounts

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

- 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;
- apply on the consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury.

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

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

By order of the Board
Signed

Peter Bradley
Chief Executive
29 June 2010

Mike Dinan
Finance Director
29 June 2010

STATEMENT ON INTERNAL CONTROL 2009/10
Scope of responsibility

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

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

As part of London's local health economy we work with our partners to minimise the risks to patient care. To do so we meet routinely with our lead commissioners and with the performance team at NHS London, and strive to meet and maintain the key performance targets set for ambulance services. We work in partnership with health and social care organisations in the development and implementation of Healthcare for London. In 2009/10 this has included the development of pathways for stroke, cardiac and major trauma care across London, as well as developing pathways for urgent and emergency care in local areas.

The purpose of the system of internal control

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

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

The system of internal control has been in place in the London Ambulance Service NHS Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The management of risk is delegated by the Trust Board to the Chief Executive as accountable officer and to two board committees: Audit and Clinical Governance. An executive committee, Risk Compliance & Assurance (RCAG), is chaired by the Chief Executive with delegated authority from the Trust Board to take an overview of our risk management activities.

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

- Director of Finance – financial risk management
- Medical Director – clinical risk management & clinical governance
- Director of Human Resources & Organisational Development – operational risk management such as health & safety, occupational health, training, and human resources
- Director of Operations – operational risk management such as frontline ambulance services and control rooms which could impact upon patient care
- Director of Service Development – service development and new business opportunities
- Director of IM&T – IM&T and information risk management
- Director of Corporate Services – corporate risk management such as regulation and compliance and overall responsibility for ensuring that corporate risk processes and controls are in place.

The Directors of Finance and Corporate Services routinely attend the Audit Committee and are members of RCAG as is the Medical Director who is a member of the Clinical Governance Committee and is the nominated director for infection prevention and control and for safeguarding (vulnerable adults and children). The Director of Human Resources and Organisational Development is the nominated director for security management.

A mandatory training plan is in place for our employees and covers elements of the NHSLA training needs analysis requirements 2009/10. New staff attend induction which covers the basic risk and safety management responsibilities and arrangements. Staff are trained to the level and for the areas appropriate to their role. The Service-wide bulletin system is used to communicate changes to practice and there are clinical and training updates published for all staff via the intranet. Individual managers are responsible for ensuring their staff receive such information and undertake the training and development required for them to safely undertake their role.

We have reviewed the risk management structure and governance arrangements during 2009/10 and have agreed a new structure to commence from April 2010, replacing the Clinical Governance Committee with the Quality Committee at board level.

The risk and control framework

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

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

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

We have been registered with the Care Quality Commission (CQC) since April 2009 to meet the requirements of the *'Code of Practice for health and adult social care on the prevention and control of infections and related guidance'* under the Health and Social Care Act 2008. We were inspected twice during 2009/10 and a number of recommendations were made that have been built into a 12-point action plan. The action plan and the infection prevention and control champions for complexes were highlighted by the CQC inspectors as examples of good practice.

In March 2010 we received unconditional registration from the CQC to provide the following regulated activities:

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

During 2009/10 our Trust Board reviewed the strategic risks facing us in the next three to five years and these have since been mapped to the updated strategic goals and corporate objectives for the same period.

We have also mapped the most significant risks from the Corporate Risk Register against the standards contained within the Care Quality Commission annual health check, identifying the key controls in place that are managing these risks and listing assurances (positive or negative) that we have received assuring the effectiveness of these controls.

Progress with mitigating the risks is reviewed by the Risk Compliance and Assurance Group. The Board Assurance Framework (BAF) is a key tool in examining the system of internal control that is in place to manage our risks. During the year the BAF comprised of the 25 highest scoring risks cross referenced to the seven domains of the core standards for better health.

The Standards for Better Health Group updated the controls as they reviewed the evidence of compliance for the core standards in 2009/10. The BAF was updated by the end of March 2010 for the year 2010/11 to reflect the changes to the strategic risks and goals for the next three to five years as well as the move to the Care Quality Commission registration system, replacing the core standards for better health.

Both the corporate risk register and the board assurance framework support the evidence reported in this Statement on Internal Control. The significant control issues are captured in both documents and are closely monitored for improvements.

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

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

We have 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 our obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

We are fully compliant with the core standards for better health. A declaration of compliance against all but two standards was made in December 2009 with insufficient evidence against two standards: C4d management of medicines and C11b mandatory training. These were subsequently reviewed by the Trust Board in March 2010 with satisfactory evidence in place to support compliance.

We reported one information governance serious untoward incident (SUI) during the year. This concerned the loss of personal identifiable data when a member of staff's vehicle was broken into. The SUI procedure was followed and there have been no further issues of concern from this incident.

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

Human resources and organisation development

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

Clinical care

- We have acquired 390 new model defibrillators to help support the improvement in the cardiac survival rate in London.
- We continue to provide cardio-pulmonary resuscitation (CPR) training to the public and businesses.
- We have improved the delivery of our clinical care fleet with the acquisition of 72 modern ambulances as part of a rolling programme.
- Clinical care pathways are being developed to support the rollout of Healthcare for London.

Control services

- During the peak in swine flu related calls we worked closely with NHS Direct to ensure that ambulances were despatched appropriately.
- Resilience in our control room has been improved with the deployment of increased resources to meet demand.

- Pressure levels within our resourcing escalatory action plan were refined during the year, and contingency plans developed in the event of significantly higher demand as a result of swine flu.

Information management and technology

- We protect data through administrative and technical controls.
- Administrative controls include:
  - data handling policies
  - regulatory compliance, e.g. Caldicott recommendations, NHS Code of Practice, Data Protection Act 1998, Freedom of Information Act 2001 and ISO 27001.
  - security awareness training
  - employee background checks.
- Technical controls include:
  - edge security, eg firewalls and content filtering appliances
  - access control mechanisms
  - laptop encryption
  - removable media encryption.
- Work in implementing the new control system which will significantly enhance resilience and capability remains on track.
- Work has begun on building a dedicated events control room which will provide coordination support to annual events such as the Notting Hill Carnival.

Business continuity

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

Accounting

- During the year controls over bookkeeping were strengthened after instances of journals being inputted and authorised by the same individual were found. In addition instances where the matching concept was not applied leading to an understatement of expenditure in some areas during the year were discovered. Corrective action was taken during the year through journal control reconciliation.

Public involvement

- Complaints, incidents, public advice and liaison, and claims are all indicators of risk and are managed and reported in line with Trust policy. We operate a policy of openness and transparency and seek to engage the public in resolving issues and managing risks. We work in partnership with the LAS Patients' Forum to consider issues of concern about service provision. During 2009/10, our feedback and learning

from improvement group has managed this and is being replaced by the learning from experience group from April 2010.

Control Issues

The Head of Internal Audit's opinion is as follows:
Based on the work undertaken in 2009/10, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that the controls are generally being applied consistently. However, some weakness in the consistent application of internal controls put the achievement of particular objectives at risk.

The control issues identified during the year by our internal auditors were as follows:

A) Management of controlled drugs:
Following an audit review undertaken on 2008/09, the auditors undertook a further review in July 2009 and found a number of control weaknesses leading to an audit opinion of 'limited assurance'. We have implemented a robust action plan and progress has been made in the latter part of the year. As a result of the audit opinion, our Trust Board considered there to be insufficient evidence against the core standard for medicines management in the December 2009 declaration. The Trust Board has since received evidence of progress made and has the assurance that there are no significant lapses that could cause a risk to patient safety. The BAF identifies the gaps in controls and assurance specifically as failure to comply with policies and procedures relating to the management of controlled drugs.

B) Records management (patient report forms):
Internal audit undertook a review of patient record forms and identified that these were not being completed in accordance with Trust policy in certain cases and that this was not being followed up at a local level. The review also identified that there was a risk of unauthorised access to patient report forms, and therefore patient data, due to a lack of security with the boxes. The BAF has identified gaps in control and assurance and action is being taken to address these.

C) Patient Transport Service journeys were not always supported by booking forms with journey and price information. Signed agreements were not in place for all contracts. We have put an action plan in place to resolve these issues.

D) Medical devices: an audit identified a number of weaknesses in respect of stock holding, reporting of losses and monitoring of losses of these items of equipment. An action plan is being prepared to address and resolve these issues.

Review of effectiveness

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development

and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by bodies such as external auditors, the core standards declaration, registration under the Care Quality Commission, and the Health and Safety Executive.

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

The Trust Board delegates authority for risk management to two committees:

- Audit Committee
- Clinical Governance Committee (Quality Committee from 1 April 2010)

The Chairs of these committees provide an oral report to the Trust Board following the most recent meeting providing assurance on risk management and the effectiveness of the systems and controls that are in place. The minutes are then circulated to Trust Board members.

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

The Clinical Governance Committee has had responsibility for ensuring the provision of high quality clinical care in the Trust. This is achieved through monitoring and making appropriate recommendations on performance in areas of clinical governance reviewed by the Care Quality Commission. From April 2010 the Quality Committee will provide this assurance to the Trust Board.

The Risk Compliance and Assurance Group has delegated responsibility for taking a general overview of all risk management activities within the Trust and to pick up any specific risk management issues which are not covered by the specific Audit and Clinical Governance committees. This committee also receives a report on the management of all identified high priority risks that have been identified by Trust systems and processes. One information governance SUI concerning the loss of personal identifiable data was discovered and reported in the year in line with national and local guidance. This was investigated and action taken to learn from the incident and there have been no further causes for concern. The Information Governance group has been re-formed with new membership from April 2010 and will report to the Risk Compliance and Assurance Group.

The Trust Board receives regular reports from the Director of Finance and the Medical Director, and my report as Chief Executive provides assurance about the performance of the organisation and any key strategic, regulatory or compliance issues arising during the reporting period. The Trust Board receives a quarterly report on clinical quality and safety.

In addition, the Trust Board receives an annual report from the Audit Committee and on equality and inclusion, and routine reports on patient experience.

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

Peter Bradley
Chief Executive Officer
29 June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2010

	2009/10	2008/09
	£000	£000
Revenue		
Revenue from patient care activities	**269,557**	251,378
Other operating revenue	**10,307**	10,154
Operating expenses	**(275,633)**	(255,438)
Operating surplus (deficit)	**4,231**	6,094
Finance costs:		
Investment revenue	**577**	1,287
Other gains and (losses)	**(128)**	(52)
Finance costs	**(1,540)**	(1,581)
Surplus/(deficit) for the financial year	**3,140**	5,748
Public dividend capital dividends payable	**(3,560)**	(4,414)
Retained surplus/(deficit) for the year	**(420)**	1,334
Other comprehensive income		
Impairments and reversals	(10,692)	(17,510)
Gains on revaluations	15,315	0
Receipt of donated/government granted assets	0	0
Net gains/(losses) on available for sale financial assets	0	0
Reclassification adjustments:		
- Transfers from donated and government grant reserves	(2)	(62)
- On disposal of available for sale financial assets	0	0
Total comprehensive income for the year	**4,201**	**(16,238)**

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2010

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets			
Property, plant and equipment	**131,434**	122,287	139,814
Intangible assets	**12,639**	6,752	3,765
Investment property	**0**	0	0
Other financial assets	**0**	0	0
Trade and other receivables	**10,526**	10,961	22,948
Total non-current assets	**154,599**	140,000	166,527
Current assets			
Inventories	**2,783**	2,600	1,930
Trade and other receivables	**16,448**	14,081	10,347
Other financial assets	**0**	0	0
Other current assets	**0**	0	0
Cash and cash equivalents	**5,141**	2,651	10,478
	24,372	19,332	22,755
Non-current assets held for sale	**650**	0	0
Total current assets	**25,022**	19,332	22,755
Total assets	**179,621**	159,332	189,282
Current liabilities			
Trade and other payables	**(25,026)**	(16,915)	(19,847)
Other liabilities	**0**	0	0
DH Working capital loan	**0**	0	0
DH Capital loan	**(1,244)**	0	0
Borrowings	**(3,504)**	(3,721)	(5,275)
Other financial liabilities	**0**	0	0
Provisions	**(1,938)**	(1,280)	(2,954)
Net current assets/(liabilities)	**(6,690)**	(2,584)	(5,321)
Total assets less current liabilities	**147,909**	137,416	161,206
Non-current liabilities			
Borrowings	**(21,558)**	(25,001)	(28,604)
DH Working capital loan	**0**	0	0
DH Capital loan	**(8,075)**	0	0
Trade and other payables	**0**	0	0
Other financial liabilities	**0**	0	0
Provisions	**(8,949)**	(10,651)	(15,635)
Other liabilities	**0**	0	0
Total assets employed	**109,327**	101,764	116,967
Financed by taxpayers' equity:			
Public dividend capital	**60,885**	57,523	56,488
Retained earnings	**12,943**	12,609	10,225
Revaluation reserve	**35,914**	32,045	50,605
Donated asset reserve	**4**	6	68
Government grant reserve	**0**	0	0
Other reserves	**(419)**	(419)	(419)
Total Taxpayers' Equity	**109,327**	101,764	116,967

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 31 March 2008							
As previously stated	56,488	10,225	50,605	68	0	(419)	116,967
Prior Period Adjustment	0	0	0	0	0	0	0
Restated balance	56,488	10,225	50,605	68	0	(419)	116,967
Changes in taxpayers' equity for 2008/09							
Total Comprehensive Income for the year:							
Retained surplus/(deficit) for the year	0	1,334	0	0	0	0	1,334
Transfers between reserves	0	1,050	(1,050)	0	0	0	0
Impairments and reversals	0	0	(17,510)	0	0	0	(17,510)
Net gain on revaluation of property, plant, equipment	0	0	0	0	0	0	0
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Net gain on revaluation of non current assets held for sale	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	0	0	0	0
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(62)	0	0	(62)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	1,035	0	0	0	0	0	1,035
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2009	57,523	12,609	32,045	6	0	(419)	101,764

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY (Continued)

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2009/10							
Balance at 1 April 2009	57,523	12,609	32,045	6	0	(419)	101,764
Total Comprehensive Income for the year							
Retained surplus/(deficit) for the year	0	(420)	0	0	0	0	(420)
Transfers between reserves	0	754	(754)	0	0	0	0
Impairments and reversals	0	0	(10,692)	0	0	0	(10,692)
Net gain on revaluation of property, plant, equipment	0	0	15,315	0	0	0	15,315
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Net gain on revaluation of non current assets held for sale	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	0	0	0	0
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(2)	0	0	(2)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	3,362	0	0	0	0	0	3,362
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2010	60,885	12,943	35,914	4	0	(419)	109,327

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2010

	2009/10	2008/09
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit)	**4,231**	6,094
Depreciation and amortisation	**12,002**	11,648
Impairments and reversals	**1,845**	0
Net foreign exchange gains/(losses)	**0**	0
Transfer from donated asset reserve	**(2)**	(62)
Transfer from government grant reserve	**0**	0
Interest paid	**(1,366)**	(1,421)
Dividends paid	**(3,360)**	(4,414)
(Increase)/decrease in inventories	**(183)**	(670)
(Increase)/decrease in trade and other receivables	**(1,136)**	4,960
(Increase)/decrease in other current assets	**0**	0
Increase/(decrease) in trade and other payables	**1,130**	(2,102)
Increase/(decrease) in other current liabilities	**0**	0
Increase/(decrease) in provisions	**(1,217)**	(6,818)
Net cash inflow/(outflow) from operating activities	**11,944**	7,215
Cash flows from investing activities		
Interest received	**53**	625
(Payments) for property, plant and equipment	**(15,064)**	(11,082)
Proceeds from disposal of plant, property and equipment	**323**	3,912
(Payments) for intangible assets	**(3,867)**	(4,375)
Proceeds from disposal of intangible assets	**0**	0
(Payments) for investments with DH	**0**	0
(Payments) for other investments	**0**	0
Proceeds from disposal of investments with DH	**0**	0
Proceeds from disposal of other financial assets	**0**	0
Revenue rental income	**0**	0
Net cash inflow/(outflow) from investing activities	**(18,555)**	**(10,920)**
Net cash inflow/(outflow) before financing	**(6,611)**	(3,705)
Cash flows from financing activities		
Public dividend capital received	**3,362**	1,035
Public dividend capital repaid	**0**	0
Loans received from the DH	**10,000**	0
Other loans received	**0**	0
Loans repaid to the DH	**(681)**	0
Other loans repaid	**0**	0
Other capital receipts	**0**	0
Capital element of finance leases and PFI	**(3,522)**	(3,762)
Cash transferred to NHS Foundation Trusts	**0**	0
Net cash inflow/(outflow) from financing	**9,159**	(2,727)
Net increase/(decrease) in cash and cash equivalents	**2,548**	(6,432)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**2,533**	8,965
Effect of exchange rate changes on the balance of cash held in foreign currencies	**0**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**5,081**	2,533

Remuneration report

The Trust's 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 executive and non-executive directors of the Trust. Details of remuneration, including salaries and pension entitlements, are published on page 42**.**

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 the Trust's External Auditors.

Salary and pension entitlements of senior managers

A) Remuneration

Name and Title	2009-010			2008-09		
	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
Sigurd Reinton, Chairman	£5,001-£10,000	£0		£20,001-£25,000	£0	
Richard Hunt, Chairman	£15,001-£20,000	£0		£0	£0	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Sarah Waller, 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	
Ingrid Prescod, Non-Executive Director	£0-£5,000	£0		£5,001-£10,000	£0	
Brian Huckett, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Nigel Walmsley, Non-Executive Director	£0-£5,000	£0		£0	£0	
* Peter Bradley, Chief Executive	£110,001-£115,000	£0	£3,448	£105,001-£110,000	£0	£3,700
Michael Dinan, Director of Finance	£115,001-£120,000	£0		£120,001-£125,000	£0	
Martin Flaherty, Director of Operations	£115,001-£120,000	£0	£1,300	£115,001-£120,000	£0	£1,300
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£100,001-£105,000	£0	
** Fionna Moore, Medical Director	£70,001-£75,000	£0		£80,001-£85,000	£0	

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

* Excludes remuneration recharged to the Department of Health for role as National Ambulance Advisor.
* * Fiona Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.
Sigurd Reinton resigned from the post of Chairman on 30 June 2009. Ingrid Prescod resigned from the post of Non-Executive Director on 30 April 2009.
Richard Hunt was appointed Chairman on 1 July 2009. Nigel Walmsley was appointed a Non-Executive Director on 8 March 2010.

Salary and pension entitlements of senior managers

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 2010 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Sigurd Reinton, Chairman	**	**	**	**	**	**	**	
Barry MacDonald, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Non-Executive Director	**	**	**	**	**	**	**	
Ingrid Prescod, Non-Executive Director	**	**	**	**	**	**	**	
Caroline Silver, Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£2,501-£5,000	£10,001-£15,000	£30,001-£35,000	£288,254	£301,436	-£14,502	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£5,001-£10,000	£20,001-£25,000	£139,828	£106,371	£21,559	
Martin Flaherty, Director of Operations	£2,501-£5,000	£7,501-£10,000	£40,001-£45,000	£130,001-£135,000	£916,919	£788,142	£76,351	
Caron Hitchen, Director of Human Resources	£0-£2,500	£5,001-£7,501	£25,001-£30,000	£75,001-£80,000	£471,771	£386,437	£52,971	
Fionna Moore, Medical Director	£2,501-£5,000	£7,501-£10,000	£45,001-£50,000	£135,001-£140,000	£1,137,365	£968,526	£101,238	

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Salary, expenses and pension entitlements of senior managers

C) Expenses

Name and Title	Travel - UK £	Travel - Overseas £	Provision of Lease Cars £	Mobile Phones £	Subscription £	Hospitality £	Total £
Sigurd Reinton, Chairman	740	-	-	-	-	127	**867**
Richard Hunt, Chairman	2,561	-	-	-	-	-	**2,561**
Beryl Magrath, Non-Executive Director	69	-	-	-	-	-	**69**
Sarah Waller, Non-Executive Director	-	-	-	-	-	-	**-**
Roy Griffins, Non-Executive Director	-	-	-	-	-	-	**-**
Ingrid Prescod, Non-Executive Director	-	-	-	-	-	-	**-**
Brian Huckett, Non-Executive Director	-	-	-	-	-	-	**-**
Caroline Silver, Non-Executive Director	-	-	-	-	-	-	**-**
Nigel Walmsley, Non-Executive Director	-	-	-	-	-	-	**-**
Peter Bradley, Chief Executive	2,448	-	8,167	813	-	237	**11,665**
Michael Dinan, Director of Finance	1,363	-	-	225	88	107	**1,783**
Martin Flaherty, Director of Operations	588	2,263	7,922	172	229	90	**11,264**
Caron Hitchen, Director of Human Resources	2,546	2,900	-	186	350	201	**6,183**
Fionna Moore, Medical Director	2,349	-	5,752	273	-	-	**8,374**
Total	**12,664**	**5,163**	**21,841**	**1,669**	**667**	**762**	**42,766**

Sigurd Reinton resigned from the post of Chairman on 30 June 2009. Ingrid Prescod resigned from the post of Non-Executive Director on 30 April 2009.
Richard Hunt was appointed Chairman on 1 July 2009. Nigel Walmsley was appointed a Non-Executive Director on 8 March 2010.

The Trust Board approves all travel outside of the European Community. There is no prior year comparator as this is the first time the Trust has prepared this information.

The above expense figures have not been audited.

Management costs

	2009/10 £000	**2008/09** £000
Management costs	19,300	17,414
Income	271,143	253,399

Better payment practice code – measure of compliance

	2009/10		2008/09	
	Number	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	**64,530**	**87,130**	62,971	78,469
Total non NHS trade invoices paid within target	**55,518**	**80,160**	53,776	70,888
Percentage of non-NHS trade invoices paid within target	**86%**	**92%**	85%	90%
Total NHS trade invoices paid in the year	**525**	**3,038**	489	3,001
Total NHS trade invoices paid within target	**459**	**2,606**	436	2,798
Percentage of NHS trade invoices paid within target	**87%**	**86%**	89%	93%

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 goods or a valid invoice, whichever is later.

EXTERNAL FINANCING

The Trust is given an external financing limit which it is permitted to undershoot.

	£000	**2009/10** **£000**	2008/09 £000
External financing limit		**18,423**	7,467
Cash flow financing	6,611		7,467
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**6,611**	7,467
Undershoot/(overshoot)		**11,812**	0

The external financing requirement is the equivalent of the 'Net Cashflow before Financing' in the Cashflow Statement.

This summary financial statement does not contain sufficient information to allow as full an understanding of the results of the Trust and state of affairs of the Trust and of our policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. Where more detailed information is required a copy of our full accounts and reports are obtainable free of charge.

A copy of our full accounts is available from the financial controller at the following address:

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

Explanation of statutory financial duties

Break-even duty

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

External financing limit (EFL)

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

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

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

Capital resourcing limit (CRL)

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

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

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

Capital Cost Absorption Duty

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