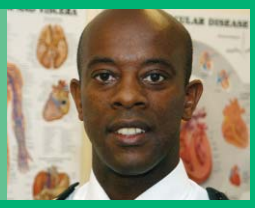
London Ambulance Service
NHS Trust

ANNUAL REPORT 2002/2003

VISION & VALUES

A world-class ambulance service for London staffed by well-trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.

C **Clinical excellence** – We will demonstrate total commitment to the provision of the highest standard of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients' needs.



R **Respect and courtesy** – We will value all colleagues and the public, treating everyone as we would wish to be treated, with respect and courtesy.

I **Integrity** – We will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right.

T **Teamwork** – We will promote teamwork by taking the views of others into account. We will take a genuine interest in those who we work with, offering support, guidance and encouragement when it is needed.

I **Innovation and flexibility** – We will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to.

C **Communication** – We will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on.

A **Accept responsibility** – We will be responsible for our own decisions and actions as we strive to constantly improve.

L **Leadership and direction** – We will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

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Sigurd Reinton, Chairman of the London Ambulance Service

Chairman's Views

Looking back, what kind of year has the Service had?

It has been another good year, with progress on many fronts. By the end of November we met the Government's target of getting to 75 per cent of Category A calls within eight minutes – compared to only 32 per cent three years ago. This was a tremendous achievement and I would like to thank everyone in the Service – and our outside supporters – for their exceptional efforts.

At the same time, we were able to introduce mobile data transfer and satellite navigation to our rapid response units, make the cycle response unit in central London permanent, extend the use of clinical telephone advice as an alternative to sending an ambulance and begin the introduction of new National Clinical Guidelines. We also introduced important measures to improve crew safety and carried out numerous smaller improvements.

What has been the impact of the Service Improvement Programme on the quality of care delivered to people in our capital city?

It has been significant. We are responding faster and better, and our crews have better training and better equipment, enabling them to deliver much improved clinical care to patients in serious trouble. For example, the survival rate to discharge from hospital for patients in cardiac arrest in London is now around five per cent where three years ago it was under two per cent.

Similarly, by using the diagnostic capabilities of the 12-lead ECG machines, the majority of patients with myocardial infarction – commonly referred to as heart attacks – now receive vital clot-busting drugs (thrombolysis) within an hour of calling for help.

How crucial is funding to the success of the Programme?

It is essential that we receive a significant increase in funding for the next two years – for three reasons. Firstly, the level of funding provided for the first three years of the Improvement Programme – up to and including 2003/04 – while significant and welcome, fell short of what was actually needed obliging us to postpone some projects and extend the Programme from four years to five. Secondly, 'Agenda For Change', the new pay deal between the NHS and its staff, recognises the responsibilities and anti-social hours of ambulance service staff but the resulting higher pay has to be funded. Thirdly, we will be taking on the wider set of roles and responsibilities referred to earlier. We are able to provide the most appropriate and cost-effective care for large groups of NHS patients but the work has to be funded.

How do you see the role of the Service in pre-hospital emergency care developing in the coming years?

We will take up a central role as a key 'entry point' to the NHS for people with medical emergencies. We shall be differentiating more between those that require an immediate life-saving response; those that need to be assessed by a qualified practitioner who can decide the best 'pathway' for each patient, and those that can safely be helped by offering advice over the telephone.

For all three – but particularly the middle category – we shall be working much more closely than we have in the past with the full range of NHS and local authority partners to ensure that the most appropriate care is arranged in each case. As a result, many of our patients will receive the right care at home or in the local community, avoiding the distress and inconvenience of being taken to the A&E department of a major hospital.

Sigurd Reinton
Chairman

Peter Bradley, Chief Executive and Chief Ambulance Officer

Chief Executive's Views

What were the biggest challenges faced by the Service during the past year?

Without doubt the biggest challenge of 2002/03 was to continue delivering on the many and varied elements of our Service Improvement Programme while striving to meet the demanding performance targets set by the Government.

In November 2002 we achieved our main target of responding to 75 per cent of life-threatening calls within eight minutes. While maintaining that level of performance will require considerable effort and further financial investment, this achievement was an important moment in our history and my personal thanks go to everyone in the Service for their hard work, dedication and commitment.

During the year, Central Ambulance Control (CAC) was awarded Centre of Excellence status for our 999 call taking. This was another notable milestone as only a small number of ambulance services round the world have received this prestigious recognition.

As well as facing the continuing challenges of improving our performance and our internal systems and processes, we have faced the task of dealing with the constant threat of terrorism in our capital city. Training, obtaining equipment, testing and exercising has involved an unprecedented amount of management and staff time. Our emergency planning skills and experience have been shared with other organisations throughout London and the UK.

How have things changed for patients?

Responding faster than ever before to life-threatening and serious calls has in itself enabled us to provide better care to our growing numbers of patients but, specifically, the care we have been able to provide to cardiac patients has improved. Our 12-lead ECG defibrillator programme has continued in earnest and a further 800 staff were trained in 12-lead ECG rhythm recognition. This has enabled patients suffering heart attacks to receive the right treatment much quicker than ever before.

In the face of growing competition for contracts, our Patient Transport Service (PTS) continues to work hard to improve the quality of service delivered to hundreds of thousands of patients throughout London.

How have things changed for staff?

Our staff survey results showed that for the third year running staff think that things are getting better. Fewer staff are leaving, absence levels are falling and there seems to be a genuine belief that many aspects of the Service are improving, even if it is slower than we would all like.

Our working relationship with the trade unions has continued to improve and that must be good for the organisation. During the year we signed a ground-breaking partnership agreement which commits management and the trade unions to continue working together to improve the Service.

During the year pay improved for most staff, we introduced stab vests for frontline crews and improved our support for staff through better counselling arrangements and the introduction of an employee assistance scheme. In addition we continued to build on our recognition of staff through passing-out ceremonies for new recruits and paramedics, commendation ceremonies, long service presentations and the introduction of the new induction course for all staff that join the Service.

I am particularly proud of our annual round of consultation meetings. By December last year, at the end of the fourth series of meetings, we had spoken with over 1,200 staff. Being able to discuss issues with staff from all areas of the organisation and listen to their views is invaluable as we continue to develop and improve the Service.

What are your thoughts on the coming year?

The coming year promises to be a very good one. Our response times will continue to improve, and we will deliver on a number of key elements in the Service Improvement Programme. These include the introduction of new ambulances, roll-out of the new uniform, the installation of mobile data transfer and satellite navigation to all frontline ambulances, the completion of our 12-lead ECG training and installation programme, and the recruitment of up to 100 additional frontline staff. The third year of our Improvement Programme promises to be a successful one. The emerging challenge for us is to ensure that our improvements impact on all aspects of our service.

Peter Bradley
Chief Executive & Chief Ambulance Officer

ORGANISATION

The Board

The London Ambulance Service became an NHS Trust in April 1996. We provide the emergency ambulance service for the Greater London area and patient transport services for about half the hospitals in the capital. Our Trust Board comprises a non-executive chairman, five executive directors (including the Chief Executive) and five non-executive directors. The Chairman is Sigurd Reinton, who took up his post in October 1999. Peter Bradley was appointed Chief Executive in August 2000.

The five non-executive directors – each of whom bring considerable experience in their respective fields – are Suzanne Burn, Colin Douglas (Vice-Chairman), Lord (Toby) Harris, Barry MacDonald and Sarah Waller.

The four executive directors are: Wendy Foers, Director of Human Resources and Organisation Development; Mark Jones, Director of Finance and Business Planning; Fionna Moore, Medical Director; and Ian Tighe, Director of Technology and Trust Secretary. Our other directors are Keith Andrews, Director of Patient Transport Services (PTS) and David Jervis, Director of Communications.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. All appointments are permanent and subject to normal terms and conditions of employment.

Our Audit Committee comprises Barry MacDonald as Chairman and Sarah Waller. The Trust Chairman chairs the Service Development Committee, while he and the non-executive directors comprise the Remuneration Committee. Our Clinical Governance Committee is chaired by Suzanne Burn and our Charitable Funds Committee includes Barry MacDonald and the Director of Human Resources and Organisation Development.

Non-executive directors

Sigurd Reinton is a former director of international management consultancy McKinsey & Co and became Chairman in October 1999 after having held the same post with Mayday Healthcare NHS Trust for two years.

Suzanne Burn is an experienced litigation solicitor, now working as a legal and training consultant, author and a deputy district judge. For five years she was the Law Society's civil litigation adviser and prior to becoming a solicitor worked for the local government ombudsman and as a town planner.

Colin Douglas is the Director of Communications at the Audit Commission, having previously worked in a similar post at Transport for London and Sport England and for a range of London local government and public service organisations. His skills and experience include communications, business knowledge, marketing and a reputation for and commitment to minority ethnic concerns.

Toby Harris was appointed a working peer in 1998 and was elected as a member of the Greater London Assembly in May 2000. Formerly leader of Haringey Council, he now chairs the Metropolitan Police Authority and also used to chair the Association of London Government.

Barry MacDonald is the Director of Resources and Corporate Development at the Human Fertilisation and Embryology Authority. He chairs the Trust's audit committee and has previously been finance director of COI Communications (formerly the Central Office of Information) and of Scope and Reuters Television.

Sarah Waller has held a variety of nursing and human resources director level appointments in the NHS and civil service and has been both a local councillor and a health authority member. A former director of standards at the UKCC, she is now an independent healthcare consultant. She is also member of the London Modernisation Board.

The Senior Management Team

Executive directors

Chief Executive **Peter Bradley** joined us in May 1996 after completing an MBA at the University of Otago in Dunedin, New Zealand. He worked for 20 years in a variety of posts with ambulance services in New Zealand, latterly as Chief Ambulance Officer of the Auckland Ambulance Service.

Director of Human Resources and Organisation Development **Wendy Foers** held several senior HR and management positions within the NHS and private healthcare sector before joining us as Personnel Manager in April 1994. She was promoted to her current post in December 1997.

Director of Finance and Business Planning **Mark Jones**, who has spent most of his career within the health service, joined us in February 2000 from a similar post at Wiltshire and Swindon Healthcare NHS Trust.

Medical Director **Fionna Moore** was appointed in December 1997 and was made an executive director in September 2000. Dr Moore has 15 years' experience as an A&E consultant, currently with Charing Cross Hospital. She has previously worked at University College and John Radcliffe Hospitals and also chairs the Service's Paramedic Steering Group.

Director of Technology **Ian Tighe** joined us in January 1994 from the West Midlands Police Authority, where he held the post of Head of IT. Ian had previously worked for West Midlands County Council and is a fellow of the British Computer Society.

Directors

Director of PTS **Keith Andrews** joined us in March 1999. He had previously worked in the private sector in the areas of production and logistics. He was made a director in September 2000.

Director of Communications **David Jervis** was the Head of the Press Bureau at the Metropolitan Police before joining us in 1995. He had previously worked as a journalist in Cornwall and north London, latterly as a freelance crime reporter.

Assistant chief ambulance officers

ACAO Sector Services **Martin Flaherty** joined us in 1979, having gained a BSc in Biochemistry/Biology from the University of London. His career has included some time spent as an operational technician and paramedic, followed by some 15 years as a manager in a variety of positions. Martin was appointed Assistant Chief Ambulance Officer in September 2000.

ACAO Control Services **Philip Selwood** joined us in January 1998 after serving 32 years with the Metropolitan Police Service, latterly as a chief superintendent. He is the Service's senior representative at all London Resilience and Civil Contingencies Committee meetings at the Cabinet Office.

Assistant Director A&E 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 TUC. Kathy was appointed to her current post in November 2000.

Head of Operational Support **Mike Boyne** joined us in June 2000 following 13 years' service in the British Army, latterly as an infantry captain. Initially appointed Strategic Health Emergency Planning Adviser, responsible for disaster planning for the NHS in London, Mike took up his current post in May 2002.

The Trust Board meets on Tuesdays from 10am in the conference room at London Ambulance Service headquarters.

The remaining meetings of 2003 will be held on 30 September (plus AGM at 2pm) and 25 November. This will be followed by meetings on 27 January, 30 March, 25 May, 27 July, 28 September 2004 (plus AGM at 2pm) and 30 November 2004.

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.

SERVICE IMPROVEMENT PROGRAMME

Improving our Service

Our Improvement Programme was introduced in 2000 as a radical, modernisation programme aimed at developing us into a world-class service.

The vast majority of initiatives and developments outlined in this annual report flow directly from the Improvement Programme, which is our version of the NHS Plan – the strategy for bringing health services up to the standards patients and staff want and deserve in the 21st century.

The Programme is is based on, and continues to be developed through, extensive consultation with our staff, most of whom are in daily contact with patients and know what changes and improvements are required. Hundreds of staff have been closely involved in a host of developments ranging from the design of new ambulances to changes in clinical procedures.

Our Improvement Programme consists of more than 250 initiatives under the following headings:

- Organisation development
- Bringing resources in line with demand
- Strengthening management
- Improving support for staff
- Improving staff safety
- Managing demand
- Improving clinical effectiveness
- Improving productivity and response times
- Developing and modernising the patient transport service
- Improving staff involvement
- Implementing NHS policy
- Improving risk management

During the second year of the Programme, we made progress in a number of areas. As well as achieving our target response times, we further developed the clinical care we offer patients and improved the working lives of our staff.

By the end of March 2003, 134 out of 256 initiatives had been achieved (52 per cent). During the period 2002/03 we completed 61 initiatives (compared to 73 for the period 2001/02).

We recognise, however, that some of our biggest challenges lie ahead. We must consistently achieve and maintain the highest standards of performance and we will work with our NHS colleagues and other partners – including social services, voluntary organisations, and the other emergency services – in London local boroughs to develop new ways of delivering emergency care.

We shall also be developing the appropriate systems for encouraging patient and public involvement and ensuring that we take account of feedback from patients as we develop our services. We are confident that delivering the Improvement Programme is transforming the Service, but it has required much extra investment after years of under-funding. We have worked hard with our commissioners and with the former London Regional Office of the NHS to secure this extra funding.

During the year 2002/03 we gained almost £20 million additional funding (£11.6 million in 2001/02). This enabled a number of key parts of the Improvement Programme to go ahead, although it was less than we needed to deliver all initiatives planned for its second year.

Staff consultation meetings

Our staff consultation meetings are seen as an integral part of the Improvement Programme. More than 1,250 members of staff attended the meetings, held by the Chief Executive between September and November 2002, in what is believed to be the largest internal communications programme of its kind in the NHS.

Some 30 meetings were held across London, offering an opportunity for staff to ask about the issues that affect them. Presentations by Chief Executive Peter Bradley and Medical Director Fionna Moore provoked a range of questions, comments and debates on many areas of work.

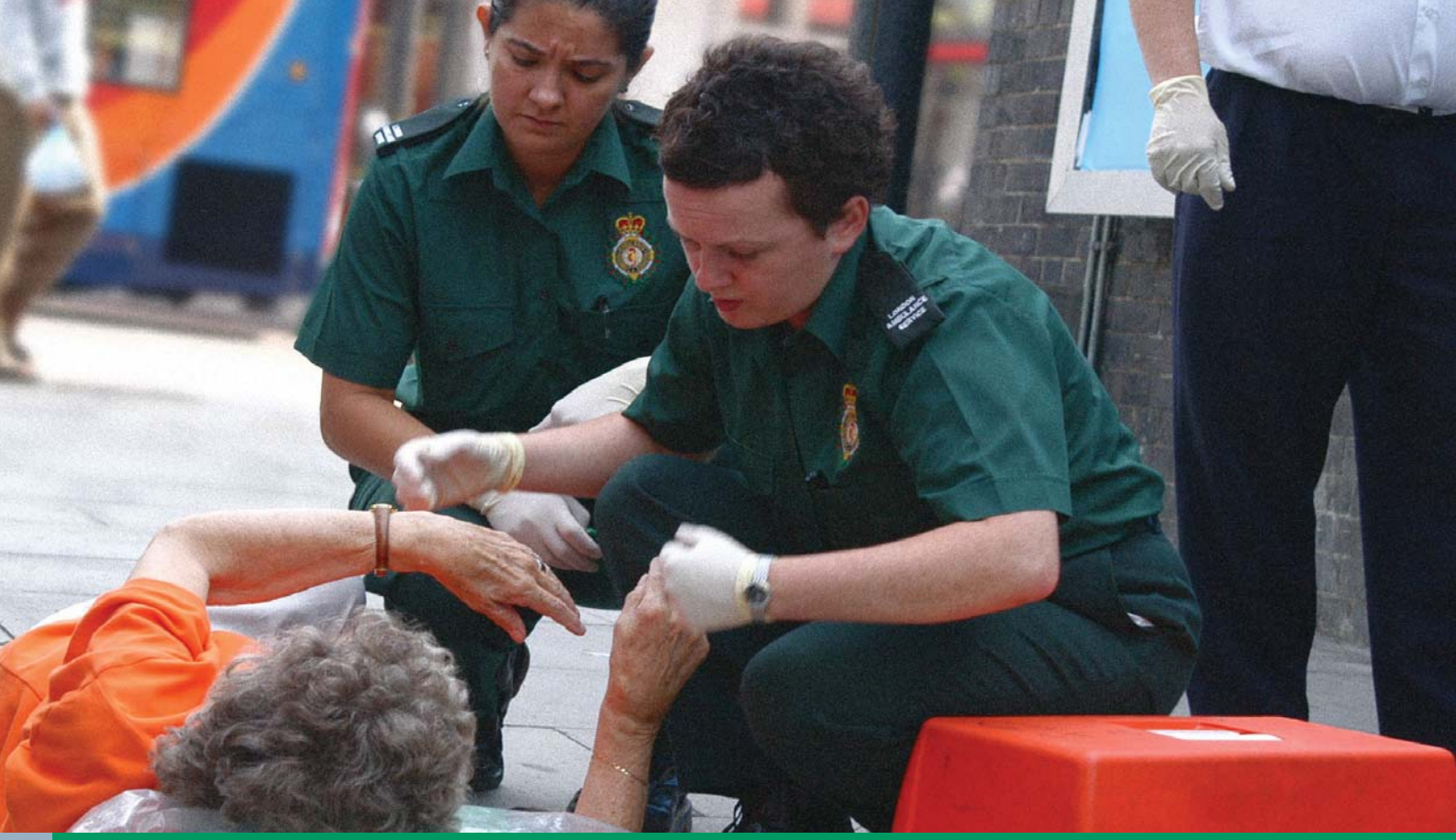
While staff welcomed the idea of the less serious Category C calls being put through clinical telephone advice in CAC, concerns were expressed about the inappropriate use of the 999 system by both the public and by GPs and other healthcare professionals.

Operational issues, such as equipment, training, crew safety, pay, uniform and 24-hour management cover were also raised, as were patient-care issues such as the need for additional training, problems with accessing other parts of the healthcare system around the clock, the medical advice we give to 999 callers, and the range of drugs currently administered by our frontline staff. The need to both care more for older staff and to look at lowering the retirement age for ambulance workers was also raised.

Following the round of meetings, feedback is shared widely with staff. Many of the issues raised are linked to future staff surveys and fed into the Improvement Programme. Those matters that can be quickly dealt with are, and actions taken as a result of the meetings are also communicated to staff.

How the additional £20 million funding was spent

Additional frontline and Central Ambulance Control (CAC) staff, fast response cars, national pay award and additional pay rise	£10.4m
Inflation and full costs of last year's improvements including last year's additional pay rise	£4.1m
Improvements to support services including mobile data terminals, trainers, fleet, resource centres, station and IT support and CAC	£2.9m
Staff support, additional team leaders, staff safety, equipment and supplies, manual handling and estates improvements	£2.6m



PATIENTS

Clinical governance

Clinical governance is the framework through which we are accountable for continually improving the quality of our services so that we can provide the best possible care to our patients. Every member of staff is involved in delivering our clinical governance strategy, which supports the aims and objectives of our five-year Improvement Programme.

In the past year, many improvements in patient care have been achieved by using clinical audit and research. For example, following our asthma re-audit, the drug epinephrine (1:1,000) is now administered to patients who do not respond to oxygen and nebulisation. We have increased the level of clinical supervision and training at a local level and, in the current year, we will be using the development of our Patient Advice and Liaison Service to learn from the experience of our patients to ensure that our service develops with their full involvement.

Risk management

During the year we revised our risk management strategy, which is aimed at limiting the potential risk of harm to patients, members of staff and the public. We reconfirmed that all members of staff have a part to play in identifying and minimising both the clinical and non-clinical risks which are inherent in our day-to-day work. We also formed a Risk Management Committee with the remit to oversee all aspects of risk management.

In March, the Service was externally assessed against the NHS Litigation Authority Risk Pooling Scheme for Trusts, for which we received a rating of excellent at level one. We achieved 100 per cent compliance in six out of eight different types of risk identified in the report.

Patient & Public Involvement (PPI)

As an organisation that cares for more than one million patients a year, Patient and Public Involvement (PPI) is of great importance to us. We are legally bound, under Section 11 of the Health and Social Care Act 2000, to make arrangements to involve and engage with patients and the public in the planning of services and decision-making processes about service delivery.

PPI is a key element of the modernisation programme laid out in the NHS Plan. Its introduction has led to both national and local changes within the NHS. Locally, every NHS trust is required to:

- consult patients and the public on service changes
- introduce a Patient Advice and Liaison Service (PALS), and
- work with a Patients' Forum.

In 2002 we convened a working group to develop, plan and make recommendations for PPI. By March 2003, progress had been made in several areas. A PALS team was established and a pilot patient survey was initiated, to be undertaken by the Picker Institute Europe in summer 2003, to establish patients' experience of using the 999 service in London. Work was also started on a staff handbook about patient and public involvement and an action plan was produced. Distinct pilot PPI models are being implemented as a prelude to developing a working structure for PPI across the Service.

Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service (PALS) team provides information, advice and support to patients and staff on issues that affect their experience of receiving and providing emergency care and patient transport services around London. PALS can offer a range of support to patients, such as providing them with information about our service and administering letters of thanks – of which there were 485 last year – and handling lost property. In addition, it undertakes clinical reviews of the care we provide to individual patients; works with other social and health providers to achieve appropriate care pathways for patients; and contributes to change and improvement in our service by identifying emerging themes from concerns presented by patients.

Patient information

In November 2002, we introduced a data protection policy concerning the use of personal and patient-identifiable information. This policy ensures that these details are held and processed in accordance with the Data Protection Act 1998. A more user-friendly version is to be produced in the future for patients and other external audiences. It is anticipated that the policy will be reviewed when the Freedom of Information Act comes into effect in autumn 2003.

Complaints

We treat complaints as an important source of feedback that can lead to key service improvements. To strengthen this area, a new department – the Professional Standards Unit (PSU) – has been formed, combining the functions of complaints and investigations, including serious untoward incidents and all driving and traffic issues. A Head of PSU has been appointed as have four investigations officers who work alongside two professional standards officers.

During the 2002/03 period:

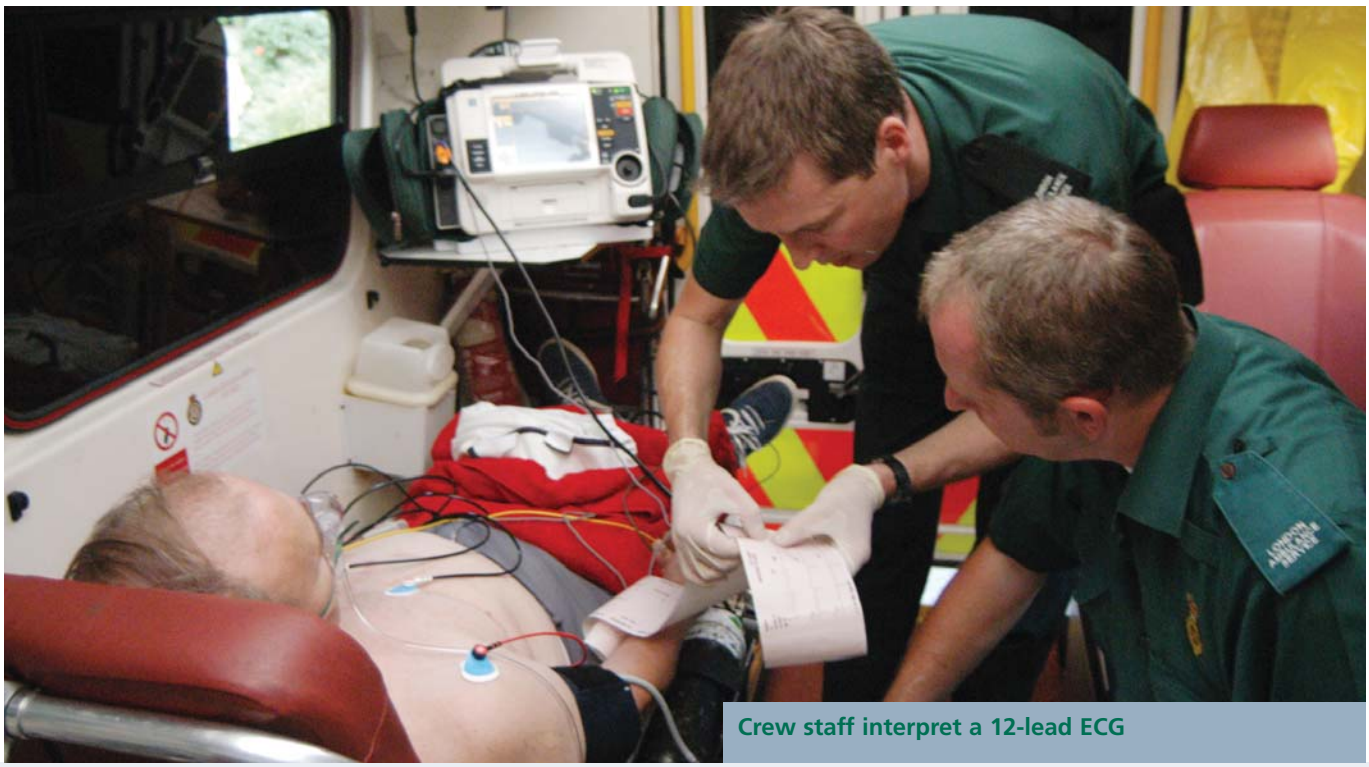
- 496 external complaints were received, 425 of which were resolved within the Trust
- 234 written complaints were received, of which 125 were concluded within 20 working days, and
- six requests were received for referrals to independent review, of which three were turned down. Two went to review and one, at the time of publishing, is still being decided.

We are planning to introduce a grading system for complaints, and are also working towards compliance with the new Department of Health complaints procedure, 'Making Things Right', due for implementation in 2004.

Clinical audit & research

- **Research**

  Our research projects include those in which our research team is the principal investigator, those which are undertaken by individual members of staff, and those which we undertake in partnership with acute hospital trusts and universities across the UK.



Crew staff interpret a 12-lead ECG

A major part of the work of the clinical audit and research team is to offer support and guidance to staff who are undertaking research and to make sure that each project complies with Department of Health research governance guidelines.

During the year, the findings of two key research projects were published – on 'treat and refer', and on minor injuries units – which paved the way for a major emergency care practitioner project in 2003. Our staff have published research papers in a number of peer-reviewed journals, and two awards were won by staff in the '999 EMS Research Forum' at Ambex 2002. A number of monthly research seminars and surgeries for staff were held internally and, during the year, a research governance handbook was distributed to staff.

Audit

During the year, our clinical audit annual report 2001/02 was published, as were clinical audits on asthma, furosemide, intraosseous infusion, priority calls for acute coronary syndrome and the assessment and management of abdominal pain. A 'Best Practice in Clinical Audit' handbook was also produced for staff. We implemented a computerised system for clinical performance indicators, enabling us to monitor if key clinical actions are being fully recorded by staff on their patient report forms.

In support of the coronary heart disease National Service Framework, we took part in national audit projects for coronary heart disease and survival from out of hospital cardiac arrest and will be a trial site for the national cardiac arrest project.

We are involved in a national audit regarding paediatric resuscitation, and, as part of the South East Region Ambulance Service Clinical Governance Advisory Group, a national benchmarking exercise on documentation and quality assurance among ambulance services.

Cardiac care

We made good progress in respect of the Coronary Heart Disease National Service Framework (CHD-NSF). Under the framework:

- people with symptoms of a possible cardiac arrest should receive help from an individual equipped with, and appropriately trained in, the use of a defibrillator within eight minutes of calling for help
- people thought to be suffering from a heart attack should be assessed professionally and, if indicated, receive aspirin. Thrombolysis (clot-busting drugs) should be given within 60 minutes of calling for professional help – the so called 'call to needle' time.

Our 12-lead ECG programme, in which our paramedics and qualified ambulance technicians are trained to use

equipment to diagnose the presence and type of heart attacks, continued throughout the year. During 2002/03, we trained a further 800 staff at 30 stations and we are aiming for completion of this project by June 2004.

The CHD-NSF 'call to needle' time of 60 minutes was met by a large number of London hospitals, in part due to our successful use of 'blue' (priority) calls for patients where pain, and where possible ECG changes, suggest an acute coronary syndrome.

April 2003 saw the start of direct admissions to the London Chest Hospital Cardiac Catheterisation Laboratory for patients with ST elevation myocardial infarction confirmed by 12-lead ECG, and we are now in talks with other London hospitals regarding direct admission to their specialist units.

Our community resuscitation training scheme continued to expand and by April 2003, we had five full-time resuscitation officers in post with plans to recruit more in the future. We have since appointed a training scheme manager. This team offers advice and training to organisations such as Primary Care Trusts and private businesses. It also supports our Heartstart schemes throughout London, allowing frontline staff to deliver free training to a variety of community groups.

We continued to support the Department of Health 'Defibrillators in Public Places' initiative during the year and assisted at the launches of new schemes across the capital. In April 2002, we joined forces with the Greater London Authority to launch a campaign to make Londoners aware of the signs and symptoms of a heart attack, and to stress the importance of dialling 999 as soon as possible.

In the same month, we received £1.2 million from the New Opportunities Fund towards the purchase of 200 LifePak 12 defibrillators.

National clinical guidelines

We are committed to implementing the Pre-Hospital Guidelines for use by UK Ambulance Services (or National Clinical Guidelines as they are commonly known) by April 2004. Developed by the Joint Royal College Ambulance Liaison Committee in conjunction with the University of Warwick, these are a comprehensive set of up-to-date and, where possible, clinically-evidenced patient care guidelines.

CLINICAL EXCELLENCE

"Our staff are trained in the best available procedures for the care of patients. We encourage staff to tailor the treatment to the needs of the patient and where possible their wishes".

Anthony Allen Senior Training Manager

They will help to ensure uniformity of practice across the UK by replacing the local treatment protocols which were developed by many ambulance services and which sometimes resulted in different treatment practices being used across the country. In addition, using guidelines – as opposed to protocols – allows ambulance staff the flexibility to draw on their training and experience to tailor their treatment to best meet the patient's needs, and where possible their wishes.

In 2002 we conducted a pilot study involving 380 staff, to establish the best way to deliver guidelines training and documentation to staff.

During the roll-out, staff across London will receive two days' training in the use of guidelines, which is followed by a day working under supervision for less experienced staff. They will be issued with the guidelines in an A4 folder format and a set of pocket-size aide-memoiré cards.

PEOPLE

Improving working lives

A range of initiatives has been developed during the year, aimed at providing better employment opportunities and conditions for staff. These have included:

- a scheme enabling staff to choose to exchange part of their salary for childcare vouchers which are exempt from National Insurance contributions
- a peer support network pilot known as LINC – listening, informal, non-judgemental, confidential – aimed at allowing staff to share in confidence with a colleague who understands our working environment any concerns or problems they may be having. The 24-hour service is provided by members of staff who have been selected and specially trained
- continued promotion of the Government's Starter Home Initiative. A number of staff were able to purchase a home through the scheme in which housing associations help arrange loans and provide other home-buying services to 'key' workers in the capital
- Work which identified the need for improved support for pregnant staff and those on maternity leave, for staff with caring responsibilities, and a need for 24-hour advice and assistance to employees generally. Work is underway in all of these areas, with a significant development being the introduction of a round-the-clock employee assistance programme at the beginning of May 2003.

We have used the NHS Improving Working Lives (IWL) initiative to help support these projects. We successfully gained Practice Status of the IWL Standard in April 2003. This is the second of the three quality measures and an action plan is already being developed to address the challenge of obtaining the Practice Plus level by 2005.

Modernisation and pay

In September 2002, management and the trade unions signed a partnership agreement which commits both parties to modernisation of working practices over the next three years to improve pay, the quality of working life for staff and to continuing to redesign and modernise the way we work. We held our first joint conference between management and trade unions in support of our commitment to work together to improve the Service.

Linked to the modernisation agenda, staff received pay rises in excess of the cost-of-living increase for the second year running in recognition of more flexible working practices.

In February we responded to the introduction of congestion charging in central London. The charge particularly affected frontline staff for whom public transport is not always a viable alternative. As an interim measure, operational staff on rotating shifts and working within the zone were offered an allowance to assist them with travel arrangements.

Recruitment

A total of 360 trainee qualified ambulance technicians and 35 trainee emergency medical dispatchers were recruited in 2002/03. Our award-winning recruitment campaign had a key role to play in this, with almost 2,000 people requesting application packs during the campaign's first month.

Training

During the year, some 335 new recruits were trained as qualified ambulance technicians at our training centres, while a further 80 staff achieved the paramedic qualification.

The appointment of 25 training officers as station complex trainers in 2001/02 has enabled us to provide more training support at local level, such as training updates and mentoring for team leaders and new staff.

During the year a trial started in west London to replace post-proficiency training, currently provided every five years to frontline staff, with a programme of continuing professional development. Under the new scheme, staff will be updated on new procedures and clinically appraised on a quarterly basis.

RESPECT AND COURTESY

"As an HR assistant, working in an environment where peoples' differences are respected makes me feel valued. It encourages me to build good working relationships and learn from others".

Toro Isola-Jagun HR Assistant

We continued to play a key role in developing national training standards for ambulance services and are represented on a number of groups. Ongoing work includes a complete review of the technician course, with a pilot study to be run during the current year.

Staff safety

A report published by the Audit Commission in March 2003 showed that NHS staff working in ambulance services, along with those in A&E departments and acute mental health units, face the highest risk of violence and aggression.

During the year there were 556 reports of physical violence against staff and there were an additional 1,711 reported cases of non-physical abuse. We continue to offer a one-day personal safety training course, which was attended by 500 staff during the year. A key development was the issue of made-to-measure stab-proof vests to all frontline staff in March 2003.

COMMUNICATION

"A challenge in my job is to give the ambulance crew all the information they need to know before they get to the patient".

Karen Turnball Emergency Medical Dispatcher

Staff uniform

A review of staff uniform in April 2002 highlighted that they wanted to look more professional and smart reflecting their key role in the NHS in London. Feedback showed that cargo trousers were favoured by most uniform wearers; skirts were not favoured by 92 per cent of female respondents and PTS staff wished their uniforms to resemble that of their A&E counterparts.

Following the review, a new range of uniforms was designed and trialled in March 2003. In the eight-week trial, 170 staff from PTS, A&E and officers tried out the new range of clothes and were asked to evaluate them. Subject to funding, the new uniforms will be introduced across the Service from late 2003.

Team leaders

The purpose of the team leader role is to provide clinical leadership and support to frontline staff, with more than two thirds of their rota spent working on operational duties. By the end of the year there were 140 team leaders in place across the Service. Our aim is to reach a total of 175 team leaders in post across our seven operational sectors.

Corporate induction

Work took place throughout the year on the development of a new corporate induction programme. The first two-day course was held at the end of March 2003 and now all new staff attend the programme to learn about our structure and that of the wider NHS, the support they can expect to receive and what is expected of them. More practical teaching in manual handling and health and safety is also provided, as well as a session in basic life-support training.

HR development

During the year, more than 300 staff enrolled onto a range of e-learning courses and programmes following the launch of the Learndirect bus. Twelve two-day workshops for administrative and clerical staff were held, attended by more than 130 staff and aimed at raising self-awareness and offering an opportunity for personal development.

During the year there were four modular Leadership and Management for Officers Programmes, aimed at developing the leadership, managerial and interpersonal skills of operational and support services managers from across the Service. Our first training prospectus was also published to make staff more aware of the learning and education opportunities available within the organisation.

Staff recognition

The post of Awards Manager was created last year as part of the Improvement Programme with the aim of recognising the contribution that individuals make to our Service and to the community. Following the decision in the Queen's Golden Jubilee year to recognise the contribution of those who put their lives at risk in the line of duty, 1,600 of our staff were awarded the Jubilee Medal in January 2003. A number of events were also arranged during the year, including:

- 20 passing-out parades for newly-qualified ambulance technicians, paramedics, training officers and graduates

- two long service and two retirement ceremonies
- two Chief Ambulance Officer's Commendation ceremonies – for staff and members of the public who have acted above and beyond the call of duty
- one Childrens 999 award ceremony – for children who have correctly used the 999 service to help another person, and
- recognition of 246 members of staff who reached 10, 15, 20, 25, 30, 35 and 40 years' service.

Internal communication

In March 2002 a new internal bulletins system was introduced. As part of this, an expanded version of our weekly staff bulletin was re-launched and managers were given more support in producing departmental and local bulletins.

Work also began on our new intranet site, *The Pulse*. Staff from across the Service were involved in developing the structure and content of the site, which was well received by staff when it was launched in April 2003.

Equality

We are committed to promoting equality and diversity and to eliminating discrimination within the workplace. A key part of the work in this area are the ongoing actions being carried out as part of our Race Equality Scheme, as outlined opposite.

During the forthcoming year, we are again planning to link up with the charity EnRé, to develop closer links with community groups across London with the aim of improving equality of access to the healthcare system. We have recently submitted a joint funding bid to the Home Office to support this work.

We continue to meet the criteria to use the Employment Service's 'two ticks' disability symbol, and have in place a disability discrimination policy to protect the rights of disabled employees.

Other ongoing work includes:

- targeted recruitment advertising in the ethnic minority press
- reviewing staff training on equality and diversity
- improving access to policies and benefits affecting staff, by publishing them on our intranet
- developing greater support for staff both during pregnancy and on maternity leave, and
- providing a framework to assist staff with learning difficulties.

Race Equality Scheme

During the year we published our Race Equality Scheme and Action Plan to help us meet our duties under new legislation and to provide a robust, systematic approach to the way that we address issues of race equality.

Key achievements in the first year of the Scheme have included:

- increased resources given to the promotion of equality and diversity, including the creation of a new diversity team to take the lead on the development, implementation and management of all equality and diversity issues
- the review of the recruitment and selection process to ensure that it is not discriminatory
- the creation of a database of all Black and Minority Ethnic (BME) community groups which will be placed on our intranet and distributed to all our work sites as part of our public and patient involvement programme so that all patient guidance can be influenced by these groups
- both our multi-lingual phrasebook and our ethnic health and cultural awareness information handbook were adopted by the Department of Health for national use
- participation in a national study through Birmingham University, regarding the morale of BME staff, asking why they join ambulance services and why they leave, in order to understand what positive action will be most effective in recruiting and retaining BME staff, and
- extension of our professional interpretation service, Language Line, to frontline crew staff.

PERFORMANCE

Category A performance – achieving 75 per cent

In line with Government guidelines, all emergency calls are categorised as either Category A (immediately life-threatening) or Category B/C (serious or not-serious illness or injury).

Each is responded to by the nearest available ambulance, with an additional resource such as a motorcycle or fast response car often despatched to the Category A calls.

We successfully achieved our target of reaching 75 per cent of Category A calls within eight minutes by December 2002. Three years ago we were only reaching 32 per cent of these calls within the target time.

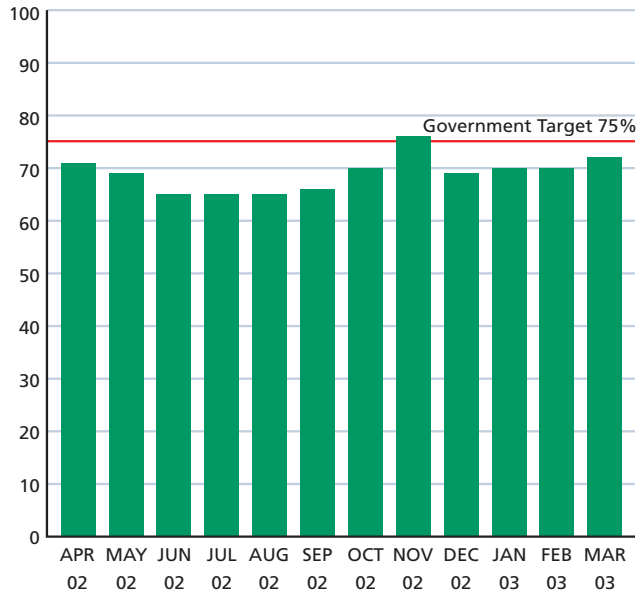
Prior to achieving the 75 per cent performance standard we achieved 55 per cent by March 2001 and 65 per cent by March 2002 and a revised Performance Improvement Plan was introduced, giving local managers ownership of how they achieved response times.

The clinical telephone advice service was stepped up, with a target of giving 100 callers per day telephone advice, and an additional 25 fast response cars were purchased to be sent to Category A calls in addition to the ambulance.

Key facts

In 2002/03:

- The number of Category A emergency calls we responded to within eight minutes rose 24 per cent to 122,048 (98,604 in 2001/02)
- The total number of emergency calls received fell one per cent from 1,040,900 to 1,030,600
- The number of emergency responses rose by 3.5 per cent from 713,200 to 738,300
- 69 per cent of Category A calls resulted in an emergency response arriving at the scene of the incident within eight minutes (57 per cent in 2001/02).



Other response times

For the period 2002/03:

- **Category A calls** – 89 per cent were responded to within 14 minutes (86 per cent in 2001/02)
- **Category B/C calls** – 44 per cent were responded to within eight minutes (40 per cent in 2001/02)
- **Category B/C calls** – 79 per cent were responded to within 14 minutes (79 per cent in 2001/02).

Urgent and special/planned patient journeys

Urgent responses are those where an ambulance must arrive within a definite time period to collect a patient for admission to hospital at the request of a doctor. Special/planned responses are any other type of call, such as a pre-booked hospital transfer. During the period 2002/03 there were 58,300 urgent patient journeys (61,400 in 2001/02) and 682,700 special/planned patient journeys (701,700 in 2001/02). We are not happy with the speed with which we respond to these calls and plan to improve it.

NHS star ratings

The star ratings for ambulance services were published for the first time in July 2002. We were one of 15 trusts to achieve two stars, while four achieved one and 12 achieved three. Unfortunately we received only one star when new ratings were awarded in July 2003, which was in part due to a drop in response times during the period assessed for the ratings.

Commission for Health Improvement (CHI) review

Our first review by the Commission for Health Improvement (CHI) was underway at the time of publication. We will be assessed against CHI's 'seven pillars' of clinical governance to determine what steps and procedures we have adopted to ensure that our patients receive the highest possible standard of care. We are required to provide supportive documentation for the assessment and there will be public consultation as well as a visit to the Service in January 2004.

Central Ambulance Control (CAC)

Central Ambulance Control (CAC) receives all 999 calls for ambulances in the Greater London area as well as requests for inter-hospital transfers and doctors' urgent admissions to hospital by ambulance, and handles more than one million calls each year. CAC uses the Advanced Medical Priority Dispatch system (AMPDS) to categorise emergency calls and then dispatch the nearest available ambulance to them. They can also send rapid response units, motorcycles, doctors, and the Helicopter Emergency Medical Service (HEMS) in addition to an ambulance to the most serious calls.

Providing emergency cover for London during the New Year's Eve celebration presented us with a significant challenge again this year. Some 5,191 emergency calls were received between midday on New Year's Eve to midday on New Year's Day – during the busiest hour, an emergency call was taken every four seconds in CAC. The number of emergency responses made during the above 24-hour period rose by 15 per cent to 2,589 (2,256 in 2001/02).

March 2003 proved to be one of the busiest months on record, with an average of 2,096 emergency responses per day.

During 2002/03, new mobile data terminal software was piloted on the fast response unit desk prior to being implemented throughout CAC in the current year.

A successful one-day pilot took place in February 2003 where a separate, dedicated dispatch desk was used to allocate the less-serious 999 calls to Category C vehicles, other alternative response units and, where appropriate, PTS vehicles, in order to reduce the demand for ambulances.

AMPDS Centre of Excellence award

CAC was acknowledged as an AMPDS Centre of Excellence, gaining a 97 per cent 'compliance' rate, well above the 90 per cent required for the award. The award was judged on criteria including the quality of call takers' questioning, the accuracy of the priority level subsequently attached to the call and the quality of the clinical advice given by call takers – the 'pre-arrival instructions' such as talking someone through CPR or delivering a baby. In addition, to gain the award a percentage of calls has to be quality-assured.

With more than 3,000 ambulance services world-wide using this system, we are one of only 58 to have achieved the Centre of Excellence accreditation.

Resource centres

Our three resource centres at Bow, Croydon and Ilford contributed to improved performance during the year. As well as maintaining good levels of ambulance and fast response unit staffing, they successfully resourced a number of additional activities, such as public order events, chemical and biological exercises and alerts.

Fleet

During the year, workshop staff contributed to our achievement of the 75 per cent performance standard by providing an out-of-hours service, repairing and maintaining vehicles at evenings and weekends as well as during the week. They also undertook additional training in order to support a range of new vehicles, and preparations continue for the arrival of the new A&E ambulances.

New ambulances

Plans to update our fleet of 400 ambulances progressed with an order being placed during the year for 130 new vehicles. Following the purchase of four prototype vehicles which staff were given the opportunity to test-drive, the final specification was developed and an order placed with Daimler Chrysler for an ambulance with automatic transmission.

The new vehicles will be in the distinctive all-yellow paint finish complete with the new corporate identity and high-visibility Battenburg design. Other features include a hydraulic tail lift, a side access door and new storage arrangements for equipment that comply with current European standards. All 130 of the vehicles will be delivered by December 2003.

Fast response units

During the year, our motorcycle response unit reached more than 90 per cent of life-threatening calls within eight minutes. We also replaced six of our frontline motorcycles with all-yellow models. The new 1100cc Honda Pan European bikes now operate alongside our other four motorcycles, which carry the traditional white, green and yellow markings.

Achieving the 75 per cent Category A performance target was helped by the purchase of an additional 25 fast response cars – single-crewed vehicles staffed by a paramedic or qualified ambulance technician – bringing our fleet to a total of 59.

Fast response cars, which when sent are always dispatched in addition to an ambulance, regularly reach more than 90 per cent of Category A calls in eight minutes.

Mobile data terminals

In October 2002, work began to prepare our ambulances for the fitting of mobile data terminals (MDTs) and satellite navigation. This logistically-challenging task was seen as an essential part of the Improvement Programme geared to maintaining the 75 per cent performance target set for the year.

MDTs allow information about 999 calls to be transferred electronically to vehicles, thereby reducing the need for crews to write down details about the patients they are being sent to treat. As staff make their way to a scene, they can be guided by an electronic voice and mapping system and will be updated via the terminals if further patient or scene data becomes available.

The main benefits of MDTs are that ambulance crews can be activated more quickly. They are also better informed about the emergency calls they are attending and will be able to find them more easily, especially when they are in unfamiliar areas. It is anticipated that MDTs, which are already fitted to rapid response cars, will be introduced to all ambulances by December 2003.

ACCEPT RESPONSIBILITY

"It's down to staff at all levels to accept responsibility for themselves and representing their colleagues. It's about offering a helping hand so that we can become the most recognisable ambulance service in the world".

Mohammed Akbar Ambulance Person

Inappropriate use

In July 2002, Health Minister David Lammy announced new guidance for ambulance services for tackling hoax calls and inappropriate use of the 999 system.

The guidance stated that ambulance services should make full use of the law by reporting hoax callers to the police and pressing for prosecution; should consider private prosecution where there is evidence that a conviction is likely and it is in the public interest to do so; and should not have to respond to inappropriate 999 calls, but instead give people the NHS services that most closely match their needs.

We, along with other ambulance services in England, were invited to develop protocols for dealing with inappropriate calls, agreed with our local health authorities and Primary Care Trusts. We are currently reviewing our procedures to ensure that we can provide the most appropriate response to all those who call us on the 999 system.

Our 'Only one of these is a taxi service' campaign that encouraged the public to use the 999 system appropriately, won two prestigious communications awards during the year. In October it took the best Public Sector campaign category in the PR Week Awards and this was followed a few weeks later with victory in the Health Service Journal Management Awards.

Managing demand

Several new schemes were introduced during the year to help us release ambulances to respond to the life-threatening and serious calls. Central to all of the initiatives is the need to give the patient the most appropriate form of care:

Category C trial

Category C calls currently account for approximately 20 per cent of our workload. Our Category C car initiative, piloted first in south west London in May 2002, led to nearly 400 ambulance

TEAMWORK

"Teamwork is about being able to rely on each other, especially when the pressure is on".

Paul Jackson Maintenance Fitter

journeys being saved in its first three months. The pilot involved dispatching a response car, staffed by a specially trained paramedic or qualified ambulance technician, to selected Category C calls. Patients were fully assessed and the most appropriate form of onward care arranged for them, such as a referral to a GP or district nurse. Evaluation of the pilot revealed that 97 per cent of patients were satisfied or very impressed by the treatment they received. The scheme was extended to west London later in the year and more work is underway to evaluate its full benefits to the wider NHS.

Clinical telephone advice

Based in CAC, the clinical telephone advice unit handles Category C calls, offering advice to callers with non-urgent queries. We are the only ambulance service in the UK to offer this form of telephone advice, which makes a direct contribution to freeing up ambulances to attend the more serious calls.

During 2002/03, the unit formed a referral service with the Kensington and Chelsea Night District Nursing Service and made use of the Category C cars operating in south west and west London.

Cycle response unit

One of our key developments during the year was the official launch of our six-strong cycle response unit in central London in July 2002. This followed a trial conducted in 2000 by Qualified Ambulance Technician Tom Lynch which showed that in central London's congested and pedestrianised streets, a single bike could arrive at 88 per cent of the calls to which it was dispatched before the ambulance sent at the same time.

Fitted with blue lights and sirens, and carrying defibrillators and other life-saving equipment, the bikes enable paramedics and qualified ambulance technicians to deliver medical treatment before the ambulance arrives. And, if not required, the ambulance can be cancelled, making it immediately available to respond to another 999 call.

Between April and November 2002, the cycle response unit responded to 100 per cent of Category A calls in eight minutes and had an average response time of six minutes. For half of the incidents to which both a cycle and an ambulance were sent, the ambulance was either not required or cancelled. The unit will now operate in central London between April and November every year.

QAT Tom Lynch meets HM The Queen

Equipment exchange scheme

A new equipment exchange scheme has been introduced to enable faulty equipment to be replaced within 24 hours, seven days a week. Ten equipment support personnel were recruited to run the scheme and new dedicated vehicles were bought for their use. The scheme, which involves equipment support personnel calling at stations once a day, has improved greatly on the previous arrangements where four days were needed to replace faulty equipment.

Drugs management scheme

A new drugs management scheme was piloted during the year, aimed at removing the risk of administering out-of-date drugs and reducing costs. The scheme involves paramedics signing drugs packs out at the beginning of their shift and signing them in again at the end, a system which is already in use in many other UK ambulance services.

A trial in June 2002 involving 200 staff highlighted the benefits of the exchange system compared with the method of personal issue. Prior to this, drugs had been issued to paramedics on request and stored in their personal paramedic bag, making control and accountability difficult and meaning that drugs had to be stored on station, presenting a security risk.

In the new scheme, the distinctive yellow drugs bags will be packed by an external provider and a projected saving of £200,000 per annum is expected when it goes live in autumn 2003.

Fire strike

Responding to the unique demands of the Fire Brigades Union strikes was a key challenge for us during the year. Prior to the announcement of the first fire strike in November 2002 we had made contingency plans with other key agencies.

Operational briefings took place and staff were issued with guidance outlining the role of the military, arrangements for handling 999 calls and the significant health and safety issues that had to be considered during the strike. A key message was that staff should not place themselves in any danger by undertaking rescue duties that they had not been trained for, nor were equipped to deal with.

During the strikes our frontline staff played a key role in incidents where people were trapped in vehicles and burning buildings. In addition, CAC had a permanent presence in the Joint Operation Control Centre at Chelsea Barracks.

Bain report

In 2002, the Bain report was published on the future of the fire service. We welcomed the recommendation that firefighters should be trained in the use of defibrillators and we already actively support the Department of Health Defibrillators in Public Places initiative. The proposal to combine emergency services control rooms was not seen as a workable option in London. One reason is the specialist nature of our call centre, where emergency medical dispatchers are trained to use specialist AMPDS software and give life-saving medical advice over the phone.

Staff demonstrate clinical decontamination

Emergency preparedness

We have continued to work closely with a wide range of other agencies as part of the London Resilience Team.

In November 2002, a National Audit Office report suggested that a mass casualty incident or a hazardous substances incident on a large scale in London would seriously challenge the capabilities of both us and other NHS organisations. Following the report, the Department of Health asked all NHS trusts to audit and review their arrangements against a set of criteria. We were able to report that we are 'well prepared' in a number of areas and 'prepared' in all other respects.

Our progress during the year included doubling to 150 the number of frontline staff trained to deal with decontaminating casualties of chemical and biological incidents. We issued new personal safety equipment to staff and prepared new decontamination units. In addition, six specialist tactical support officers were put on call 24 hours a day, trained to give advice in decontamination procedures.

In January 2003, we gained experience in testing our emergency preparedness in collaboration with the other emergency services, the Department of Health and other parts of the NHS when, following the discovery of ricin at an address in London, our decontamination units were placed on 24-hour standby while the situation was investigated.

Iraq war

In the lead up to the Iraq war we represented ambulance services nationally at Cabinet Office planning meetings. We also entered into mutual aid arrangements with Surrey, Beds and Herts and Essex ambulance services in the transport of military patients from Gatwick, Stansted and Luton airports. Nine members of staff were called up for military operations in the Gulf.

Emergency planning

Our emergency planning unit ensures that we are prepared for any eventuality, from civil disorders at demonstrations to train derailments and large-scale fires.

During the year, we refined our 'triage' system – the way in which patients are prioritised for treatment by medical staff – at major incidents. Responsibility for contingency planning was devolved, leading to increased awareness and responsibility at a local level. Our arrangements for dealing with 'capacity issues' – formerly known as 'winter pressures' – were also changed so that we are better prepared and briefed.

We planned for and oversaw the involvement of St John Ambulance and the British Red Cross at the funeral of Her Majesty Queen Elizabeth, the Queen Mother in April 2002 and at the Golden Jubilee celebrations in June 2002.

At the Potters Bar train derailment in May last year we supported Beds and Herts Ambulance Service by supplying nine out of the 12 ambulances that attended the incident.

Patient Transport Service (PTS)

Our Patient Transport Service (PTS) provides non-emergency transport to and from hospital appointments for patients who are not able to use public transport. PTS is provided on a contractual basis, in competition with other organisations from both the public and private sectors.

It was a very successful year for PTS, with increased quality standards and a contribution to central costs of £500,000 more than budgeted for. This is compared to a loss of £96,000 in 2001/02. We ended the year with a total of 31 main contracts. Activity to secure new business continued with six tenders submitted during the year, compared to seven in 2001/02.

Highlights of the year included winning the South West London & St George's Mental Health NHS Trust contract. In a new venture for PTS, this five-year contract includes the transport of mail, pathology laboratory samples and meals. A new 24-hour service was also provided to the Chelsea & Westminster and Kingston Hospital Trusts. PTS staff employed on these contracts were given extra clinical and driver training to meet the demands of this new service. A new contract was secured at Whipps Cross University Hospital, safeguarding the jobs of 20 staff previously employed by Essex Ambulance Service. On a less positive note, we lost an interim contract with the Royal Free Hospital.

A major strategic review of PTS took place in which external consultants were employed to identify areas PTS needed to strengthen and to describe options and recommendations for the future direction of PTS. An independent review of PTS also took place during the year as the result of a letter of complaint. This has led to improvements in the way PTS complaints are handled and the development of new London-wide PTS performance standards.

INNOVATION AND FLEXIBILITY

"In resource centres, we are receptive to change, performing an integral role in the modernisation of the Service, benefiting crew staff and improving patient care".

Richard Mexter Resource Co-ordinator

PARTNERSHIPS

New NHS structure in London

At the beginning of the year, the NHS was restructured and 32 new Primary Care Trusts (PCTs) now control health care locally in London, with performance standards monitored by five Strategic Health Authorities (SHAs).

PCTs are responsible for improving the health of the local community, developing primary and community health services and commissioning hospital care and A&E ambulance services for their local population. Above them, the role of the SHAs is to develop strategies for the local health services and ensure high-quality performance. They manage the NHS locally and are a key link between the Department of Health and the NHS.

The South West London Health Authority has responsibility for managing our performance while representatives of the PCTs in London are responsible for agreeing our funding. While individual hospital trusts purchase Patient Transport Services, all 32 PCTs in London fund our A&E service and in April 2002, we reached a new service agreement with them, clearly defining the service we provide. During the year we also forged links with PCTs and SHAs at senior level and as the reorganisation of our A&E sector management goes ahead during the current year, we plan to develop these contacts.

Reorganisation of A&E sector management

In March 2003 plans were finalised to reorganise our local management structures in response to the changes in the structure of the wider NHS and to deliver more support for our staff.

During the current year, the structure of our station complex management teams will change. They will be given the support to develop closer links both with the newly formed Primary Care Trusts and Strategic Health Authorities, as well as community groups, local authorities and other emergency services.

The new local teams will comprise an ambulance operations manager, three duty station officers and a training officer and it is anticipated that between 7am and 11pm, up to 25 managers will be on duty across the Service, providing both station-based and on-the-ground operational support for staff.
A number of new responsibilities will be assigned to the new ambulance operations managers, reflecting their increasingly important role in the community.

Emergency care practitioner scheme

A pilot scheme to develop a new role of emergency care practitioner was launched with Wandsworth Primary Care Trust in January 2003. The aim of the scheme is to train new practitioners who will work more closely with other parts of the health and social care system to serve patients with minor illnesses and injuries.

A team of eight paramedics are undertaking a course at Kingston University in conjunction with St George's Medical School. They will be responding primarily to patients who have come through the 999 system but whose condition has been categorised as neither serious nor immediately life-threatening. The patients will be reached by car and fully assessed by an emergency care practitioner, who will identify an appropriate form of treatment or referral to another agency and ensure they know how to access this. It is expected that GPs will also use the emergency care practitioners to carry out an assessment of their patients at home and then feed back their findings.

Emergency services collaboratives

We have continued to participate in the emergency services collaborative schemes in London, which were set up as part of the NHS Modernisation Plan and are aimed at improving emergency care for both patients and staff by reducing waits and delays. Participation by ambulance services in this scheme is seen as vital with the groups working towards a target of 100 per cent of patients being discharged, transferred or admitted within four hours from arrival at A&E.

INTEGRITY

"As a team leader, it is important to be open, honest and genuine at all times in order to provide staff with the support they need".

Lorraine Bint Team Leader
(currently seconded to HEMS)

NHS Nu-Care centre

Between June 2002 and March 2003, four members of staff were seconded on a full-time basis to Harrow PCT to work in the NHS Nu-Care centre at Northwick Park Hospital. Three paramedics and one ambulance technician worked within the A&E department alongside GPs, A&E nurses, nurse practitioners and NHS Direct staff. They received comprehensive training in the treatment of minor injuries, wound dressing and patient assessment skills, as well as gaining valuable experience of working alongside other healthcare practitioners.

Mental health risk data sharing project

Plans took shape during the year for a new project aimed at reducing the frequency of incidents in which emergency services and healthcare workers are injured by patients with a severe mental illness.

LEADERSHIP

"We are all able to bring about positive change through leading by example. For me, it is about creating an environment in which I can motivate others, helping them to develop and improve".

Caroline Lynch Station Officer

The mental health risk data sharing project will involve sharing risk-related information across agencies through a 24-hour call centre service staffed by community psychiatric nurses, who will provide up-to-date information to us and other parts of the NHS, as well as the police, probation service and social services. Basic risk information will be available within a few minutes in response to a request from any agency.

We will host the call centre and the pilot stage of the project will be offered to agencies in the London boroughs of Camden, Islington and Westminster for six months.

Protection of children and vulnerable adults

The report published in January 2003 following the public inquiry into the death of Victoria Climbié, looked at how health services, local authorities and the police carry out their functions and work together in cases of child abuse. We identified 13 recommendations from the report which required us to change our operational procedures. We have been working with specialists in the protection of children and vulnerable adults and are developing a new procedure for crews to report concerns about the welfare of patients they have attended. During the coming months all operational staff will receive training about these issues and in the use of the new protocol.

Older people and fallers

The National Service Framework for Older People states that, by 2005, it should be possible to refer older people and fallers to appropriate support organisations as part of an integrated falls service, and, that people who should be referred include those who have called for an ambulance.

During the year, our frontline staff continued to work with a number of older peoples' groups in London. We are developing a strategy to bring this work together and address:

- tackling age discrimination
- promoting active aging, and
- improving access to appropriate services.

During the year, we were very pleased to be awarded an £87,000 grant from the Department of Health to conduct a research project looking at developing an assessment tool around the non-conveyance of older fallers.

HEMS

The Helicopter Emergency Medical Service (HEMS) is the capital's air ambulance and is based at the Royal London Hospital in Whitechapel. It flies during daylight hours and is dispatched by a paramedic, based in Central Ambulance Control, to emergency calls which will often involve serious traumatic injuries.

As well as a doctor from the Royal London Hospital, it carries one of our paramedics, working as part of a pool of staff seconded from their normal operational roles. To extend the hours of this service, a car works several nights a week from the time the helicopter is non-operational, until midnight. It is hoped to increase this service by working closely with British Association of Immediate Care (BASICS) doctors in London.

Emergency Bed Service

The Emergency Bed Service (EBS), which we have managed since 1999, provides four main services – GP referrals, a neonatal intensive care service, a national intensive care bed register, and a paediatric beds and cubicles service. During the year, demand for the neonatal intensive care service increased by 24 per cent although there was a 21 per cent fall in demand across the four main services. A total of 14,053 cases were dealt with – a reasonably quiet year due in part to low levels of flu during the winter.

The other EBS services include hospice referrals, out-of-hours district nursing contracts, taking emergency calls for the British Red Cross and the Medic Alert Foundation, and providing information on mental health services. During the year 17,000 of these calls were dealt with, which is comparable with the previous 12 months.

In August 2002, a service development manager was appointed to EBS. In partnership with Kent, Surrey and Sussex ambulance services, EBS is co-ordinating a new neonatal transfer service which started in January 2003. A London-based scheme is due to be launched in the autumn of 2003, for which three specially designed and equipped Special Care Baby Units have been purchased.

In the current year, a strategic review of EBS has been completed and its recommendations are now being taken forward.

Crew staff work with firefighters at the scene of an accident

Paramedic science degree

We are working towards achieving the Joint Royal Colleges Ambulance Liaison Committee recommendation of 30 per cent of paramedic graduates in UK ambulance services by 2010.

We continue to work in partnership with the University of Hertfordshire which offers a paramedic science degree programme. Three LAS training officers are currently seconded to the paramedic science programme to deliver the vocational aspects of full-time courses, including all clinical and driver training to nationally recognised standards. We also offer full-time students clinical placements with the Service, where they gain the opportunity to put their skills into practice.

Our own qualified ambulance technicians and paramedics are also given the opportunity to join the part-time degree programme. We support staff accepted on the course by paying their tuition fees and allowing them 70 hours' study leave per semester. During 2002/03:

- 21 members of staff achieved a certificate of higher education
- 12 members of staff achieved a diploma, and
- Seven members of staff graduated with a BSc or BSc(Hons) degree.

2002/03 FINANCIAL SUMMARY STATEMENTS

Financial Review

The Trust fulfilled all three of its statutory financial duties in 2002/03:

1. On income and expenditure the Trust reported a surplus of £94,000 for the year, and therefore did better than the break-even target set for it by the Department of Health for 2002/03. However, the Trust's statutory duty to break even is calculated on a cumulative basis, and the table below shows that the cumulative position was a deficit of £346,000.

2. The Trust achieved its EFL (external financing limit) for the year.

3. A return on assets (the capital cost absorption duty) of 6.4% was achieved. This was better than the target of 6.0%.

The financial year 2002/03 was one of growth overall, as the Trust used extra funding from Health Authorities to implement the Service Improvement Programme and improve accident and emergency response time performance. Other operating income has increased compared to the previous year. This is predominantly due to extra income received from health authorities to cover future liabilities of the Trust.

In the capital programme £7.9m was spent on a range of projects, including mobile data terminals, additional

Income and Expenditure £000s

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Surplus/Deficit(-) in year	-163	485	-909	101	46	94
Cumulative Surplus/Deficit(-)	-163	322	-587	-486	-440	-346
Cumulative deficit permitted (0.5%)	-529	-540	-571	-618	-678	-804

The surplus in 2002/03 meant that the cumulative position improved for the third year running, and remained well within the limit of 0.5% of turnover permitted by the Department of Health.

rapid response cars and other vehicles, new technology projects, replacement defibrillators, and projects to improve the estate. Overall the Trust underspent by £116,000 against its Capital Resource Limit, which it is permitted to do.

The Trust was able to pay 80% of its invoices within 30 days which was lower than the previous year's figure of 85%, and meant that the Trust failed to achieve the target set for it by the Department of Health.

There were no important events occurring after the year end that had a material effect on the 2002/03 accounts. The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

Independent auditors' report to the directors of London Ambulance Service NHS Trust on the summary financial statements

I have examined the summary financial statements set out herein and the summary directors' statement.

Respective responsibilities of directors and auditors

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 statements 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 statements.

Basis of opinion

I conducted my work in accordance with Bulletin 1999/6 'The auditor's statement on the summary financial statements' issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In my opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2003 on which I have issued an unqualified opinion.

Nick Ward 29 July 2003
Audit Commission, 16 South Park, Sevenoaks TN13 1AN

Related party transactions

London Ambulance Service NHS Trust is a body corporate established by order of the Secretary of State for Health. Non-Executive Director Colin Douglas is also a Director of the Audit Commission. During the year details of related party transactions undertaken by the Trust with the Audit Commission were as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due From Related Party
	£	£	£	£
Audit Commission	116,852	0	0	0

During the year no other Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the London Ambulance Service NHS Trust.
The Department of Health is regarded as a related party. During the year the Trust has 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:

Walthamstow, Leyton and Leytonstone PCT, the NHS Litigation Authority, the NHS Supplies Authority, the NHS Pension Agency and other Primary Care Trusts.

The Trust received an administration fee of £2,500 from the London Ambulance Service Charitable Funds, certain of the Trustees for which are also members of the NHS Trust Board.

Directors' statements

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

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officers Memorandum issued by the Department of Health.

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.

Chief Executive 23 July 2003

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Services Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing those accounts, the directors are required to:

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

The directors confirm that they have complied with the above requirements in preparing the accounts.

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

By order of the Board

Chief Executive 23 July 2003

Director of Finance 23 July 2003

Statement of directors' responsibilities in respect of internal control

The Board is accountable for internal control. As Accountable Officer, and Chief Executive Officer of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and for reviewing its effectiveness. The system of internal control is designed to manage rather than eliminate the risk of failure to achieve these objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing risk management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically. The system of internal control is underpinned by compliance with the requirements of the core Controls Assurance standards:

- Governance
- Financial Management
- Risk Management

As Accountable Officer, I also have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control has taken account of the work of the executive management team within the organisation who have responsibility for the development and maintenance of the internal control framework, and of the internal auditors. I have also taken account of comments made by external auditors and other review bodies in their reports.

The assurance framework is still being finalised and will be fully embedded during 2003/04 to provide the necessary evidence of an effective system of internal control.

The actions taken so far include:

- The organisation has undertaken a self-assessment exercise against the core Controls Assurance standards (Governance, Financial Management and Risk Management). An action plan is being developed and implemented to meet any gaps
- The organisation has in place arrangements to monitor, as part of its risk identification and management processes, compliance with other key standards, including relevant Controls Assurance standards covering areas of potentially significant organisational risk
- The organisation has begun to compare its performance with other ambulance services in specific controls assurance standards, in governance, and in risk management
- The organisation has implemented its Integrated Risk Management System to record and report incidents, claims and risks
- The organisation has in place an overarching Risk Management Committee to monitor all risk management activities within the Trust and keep the Trust Board informed on issues not covered by existing committees.

In addition to the actions outlined above, in the coming year it is planned to:

- Further embed the new incident reporting procedure containing guidance on grading, investigation and root cause analysis. This is planned in the first quarter of the year
- Implement and monitor risk management training in the first quarter
- Fully develop our assurance framework by making arrangements to obtain and evaluate assurance on the effectiveness of key controls across all areas where the Trust faces significant risk in achieving its strategic objectives. This is planned for the fourth quarter.

By order of the Board

Chief Executive 23 July 2003

Income and Expenditure account for the year ended 31 March 2003

	2002/03 £000	2001/02 £000
Income from activities:		
Continuing operations	**152,645**	132,050
Other operating income	**8,105**	3,725
Operating expenses:		
Continuing operations	**(156,945)**	(131,924)
OPERATING SURPLUS		
Continuing operations	**3,805**	3,851
Exceptional Gain: on write-out of clinical negligence provisions	**0**	190
Exceptional Loss: on write-out of clinical negligence debtors	**0**	(190)
Profit on disposal of fixed assets	**258**	18
SURPLUS BEFORE INTEREST	**4,063**	3,869
Interest receivable	**335**	416
Interest payable	**(19)**	(27)
Other finance costs – unwinding of discount	**(104)**	0
SURPLUS FOR THE FINANCIAL YEAR	**4,275**	4,258
Public Dividend Capital dividends payable	**(4,181)**	(4,212)
RETAINED SURPLUS FOR THE YEAR	**94**	46

Balance Sheet as at 31 March 2003

	31 March 2003 £000	31 March 2002 £000
Fixed Assets		
Intangible assets	**520**	1,831
Tangible assets	**83,876**	68,688
	84,396	70,519
Current Assets		
Stocks and work in progress	**1,603**	1,430
Debtors: Amounts falling due:		
after one year	–	–
within one year	**16,289**	6,441
Cash at bank and in hand	**2,120**	890
	20,012	8,761
CREDITORS : Amounts falling due within one year	**(16,820)**	(9,465)
NET CURRENT ASSETS/(LIABILITIES)	**3,192**	(704)
TOTAL ASSETS LESS CURRENT LIABILITIES	**87,588**	69,815
CREDITORS: Amounts falling due after more than one year	**(40)**	(44)
PROVISIONS FOR LIABILITIES AND CHARGES	**(12,650)**	(4,205)
TOTAL ASSETS EMPLOYED	**74,898**	65,566
FINANCED BY:		
CAPITAL AND RESERVES		
Public dividend capital	**49,207**	48,969
Revaluation reserve	**23,348**	13,559
Other reserves	**10**	10
Income and expenditure reserve	**2,333**	3,028
TOTAL CAPITAL AND RESERVES	**74,898**	65,566

Chief Executive 23 July 2003

Cash Flow statement for the year ended 31 March 2003

	2002/03 £000	2001/02 £000
Operating Activities		
Net cash inflow from operating activities	**10,998**	10,562
Returns on Investments and Servicing of Finance		
Interest received	**335**	416
Interest paid	**0**	(1)
Interest element of finance leases	**(19)**	(26)
Net cash inflow/ (outflow) from returns on investments and servicing of finance	**316**	389
Capital Expenditure		
Payments to acquire tangible fixed assets	**(8,123)**	(2,439)
Receipts from sale of tangible fixed assets	**1,276**	24
Payments to acquire intangible fixed assets	**(327)**	(15)
Net cash (outflow) from capital expenditure	**(7,174)**	(2,430)
DIVIDENDS PAID	**(4,181)**	(4,212)
Net cash inflow/(outflow) before financing	**(41)**	4,309
Financing		
Public dividend capital received	**239**	0
Public dividend capital repaid (not previously accrued)	**0**	(3,948)
Public dividend capital repaid (accrued in prior period)	**(198)**	(132)
Capital element of finance leases	**(128)**	(126)
Net cash outflow from financing	**(87)**	(4,206)
Increase/(Decrease) in cash	**(128)**	103

Statement of total recognised gains and losses for the year ended 31 March 2003

	2002/03 £000	2001/02 £000
Surplus for the financial year before dividend payments	**4,275**	4,258
Unrealised surplus on fixed asset revaluations/indexation	**11,175**	4,041
Total recognised gains and losses for the financial year	**15,450**	8,299
Prior Period Adjustment	**(2,175)**	(2,175)
Total gains and losses recognised in the financial year	**13,275**	6,124

Salary and pension entitlements of senior managers

Name and Title	Age	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Golden hello/compen-sation for loss of office	Benefits in kind	Real increase in pension at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2002 (bands of £5000)
		£000	£000	£000	£000	£000	£000
Suzanne Burn, Non-Executive Director	55	£5,001-£10,000	£0-£5,000	0	0		**
Colin Douglas, Non-Executive Director	39	£5,001-£10,000	£0-£5,000	0	0		**
Toby Harris, Non-Executive Director	49	£5,001-£10,000	£0-£5,000	0	0		**
Barry MacDonald, Non-Executive Director	55	£5,001-£10,000	£0-£5,000	0	0		**
Sarah Waller, Non-Executive Director	56	£5,001-£10,000	£0-£5,000	0	0		**
Sigurd Reinton, Chairman	61	£15,001-£20,000	£0-£5,000	0	0		**
Fionna Moore, Medical Director	52	£45,001-£50,000	£0-£5,000	0	0	£0-£2,500	£15,001-£20,000
Mark Jones, Director of Finance and Business Planning	42	£75,001-£80,000	£0-£5,000	0	0	£0-£2,500	£15,001-£20,000
Wendy Foers, Director of Human Resources	48	£80,001-£85,000	£0-£5,000	0	0	£0-£2,500	£20,001-£25,000
Ian Tighe, Director of Technology	*	£80,001-£85,000	£0-£5,000	0	4	*	*
Peter Bradley, Chief Executive	45	£110,001-£115,000	£0-£5,000	0	2	£0-£2,500	£5,001-£10,000

* Consent to disclose age and pension entitlements withheld.
** Non-executive directors do not receive any pensionable remuneration.
The figures shown under the heading 'benefit in kind' refer to the provision of lease cars.

NHS managers' pay for 2002/03

The pay increases awarded to senior managers for the year 2002/03 were restricted to 3.6% in compliance with the guidance issued by the Department of Health dated 11th April 2002.

Management costs

	2002/03 £000	2001/02 £000
Management costs	**8,473**	7,312
Income	**160,622**	135,577

Better payment practice code – measure of compliance

The NHS Executive requires that NHS trusts pay their non NHS creditors in accordance with the CBI prompt payment code and Government accounting rules. The target is to pay non NHS creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

	2002/03 Number	2002/03 £000	2001/02 £000
Total bills paid in the year	**50,306**	**44,882**	35,384
Total bills paid within target	**40,357**	**36,846**	30,704
Percentage of bills paid within target	**80.22%**	**82.10%**	86.78%

External financing

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

	2002/03 £000	2001/02 £000
External financing limit set by the NHS Executive	**41**	(4,258)
External financing requirement	**41**	(4,309)
Undershoot	**0**	51

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

Where to contact us

London Ambulance Service NHS Trust HQ
220 Waterloo Road
London
SE1 8SD

London Ambulance Service Training HQ
150 Seagrave Road
London
SW6 1RX

Press and Public Affairs
LAS HQ
220 Waterloo Road
London
SE1 8SD

The Press & Public Affairs Department would like to thank everyone who agreed to be featured in this Annual Report.

Website

www.londonambulance.nhs.uk
This Annual Report and further details about the London Ambulance Service and our Improvement Programme can be found on our website.

আমাদের সম্পর্কে আপনি কি ভাবেন আমরা তা জানতে চাই। সার্ভিসের কোন দিক অথবা এই রিপোর্ট সম্পর্কে আপনার যদি কোন মন্তব্য বা প্রশ্ন থাকে, অথবা লণ্ডন অ্যাম্বুলেন্স সার্ভিস সম্পর্কে যদি অতিরিক্ত তথ্য জানতে চান, তবে অনুগ্রহ করে এই ঠিকানায় লিখুন:

તમે શું વિચારો છો તે અમે જાણવા માગીએ છીએ. જો તમે અમારી સેવાના કોઈ પણ પાસા બારામાં અથવા આ રિપોર્ટ વિષે ટીકાઓ કે પૂછપરછ કરવા માંગતા હો અથવા લંડન એમ્બ્યૂલન્સ સેવા વિષે વધુ માહિતી મેળવવા ઇચ્છતાં હો તો મહેરબાની કરી લખો:–

ਅਸੀਂ ਜਾਣਨਾ ਚਾਹੁੰਦੇ ਹਾਂ ਕਿ ਤੁਸੀਂ ਕੀਹ ਸੋਚਦੇ ਹੋ। ਜੇਕਰ ਸਾਡੀ ਸੇਵਾ ਜਾਂ ਇਸ ਰਿਪੋਰਟ ਦੇ ਬਾਰੇ ਤੁਸੀਂ ਕੋਈ ਟਿੱਪਣੀ ਜਾਂ ਪੁੱਛ-ਗਿੱਛ ਕਰਨੀ ਹੋਵੇ, ਜਾਂ ਤੁਸੀਂ ਲੰਡਨ ਐਂਬੂਲੈਂਸ ਬਾਰੇ ਵਧੇਰੇ ਜਾਣਕਾਰੀ ਲੈਣਾ ਚਾਹੋ, ਤਾਂ ਮਿਹਰਬਾਨੀ ਕਰਕੇ ਇਨ੍ਹਾਂ ਨੂੰ ਲਿਖੋ:

Θέλουμε να ξέρουμε τι σκέπτεστε. Εάν έχετε σχόλια ή ερωτήσεις πάνω σε οποιοδήποτε θέμα της υπηρεσίας μας ή σχετικά με αυτή την έκθεση, ή εάν θέλετε περισσότερες πληροφορίες για την Υπηρεσία Πρώτων Βοηθειών Λονδίνου, γράψετε μας στη διεύθυνση:

Waxaanu dooneynaa inaanu ogaano sida ay kula tahay. Haddii aad qabtid faallo ama su'aal ee ku saabsan nooc kasta ee adeegyadeena ama warbixintani, ama haddii aad u baahan tahay akhbaar dheeraad ah ee ku saabsan Adeegyada Ambulaanska London, fadlan waxaad u soo qortaa:

我們想知道你的意見。如果你對我們的服務或這份報告書的任何方面有意見或疑問，或想獲得更多有關倫敦救護車服務的資料，請致函：

ہم جاننا چاہتے ہیں کہ آپ کا کیا خیال ہے۔ اگر آپ ہماری سروس کے کسی پہلو یا اِس رپورٹ کے بارے میں کچھ کہنا یا پوچھنا چاہتے ہوں یا لندن ایمبولنس سروس کے بارے میں مزید معلومات حاصل کرنا چاہتے ہوں تو برائے مہربانی اس پتے پر خط لکھئے:

Peter Bradley
Chief Executive
London Ambualnce Service NHS Trust HQ
220 Waterloo Road
London SE1 8SD

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220 Waterloo Road
London SE1 8SD

Tel: **020 7921 5100**
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