London Ambulance Service
NHS Trust

NHS

Annual Report
2003/04

Vision

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.

Values

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.

Respect and courtesy – We will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy.

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.

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.

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.

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.

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

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

Cover: Emergency care practitioners attend patients with minor injuries and illnesses, and determine the best care to meet their needs

London Ambulance Service NHS Trust

Contents

Sigurd Reinton, Chairman of the London Ambulance Service

Chairman's Views

What have been the highlights for the Trust during 2003/04?

Our Service Improvement Programme, now in its third year, has delivered a number of highly visible and welcome changes. Technology which transfers information about 999 calls to vehicles and guides crews to scenes has now been introduced across the entire fleet of ambulances and fast response cars, as have 12-lead ECG heart-monitoring machines. All A&E and Patient Transport Service staff have received new uniforms, and we have begun replacing the old ambulances with new models.

We had two very good external inspections in the year. The Commission for Health Improvement (CHI) carried out a clinical governance review and the Greater London Authority and the Association of London Government jointly did the local authority scrutiny. Both highlighted areas for further improvement, but were pleasingly complimentary about the great strides the Trust has made in recent years.

This was the year we introduced emergency care practitioners – specially-trained paramedics who attend selected patients instead of an ambulance. The first schemes have gone live in Wandsworth, Croydon and Havering, and are being followed by Bromley and Hillingdon later this year.

Our staff have remained focused on caring for patients, and have worked hard to make a reality of our aim to be a world-class service. I want to thank them – and our supporters outside the Service – for that.

Alongside the successes, have there been any disappointments?

My biggest disappointment is not having been able to get widespread cardio-pulmonary resuscitation (CPR) training for Londoners established on a solid and properly funded basis - yet. Cardiac arrest survival depends on bystanders recognising the signs of a heart attack and knowing what to do in the first few minutes after a person has collapsed. We need to get as many Londoners as possible trained to know what to do in this situation.

What improvements have patients seen during the year?

Our patients have seen faster responses to their 999 calls. Moreover, thanks to improved training and the introduction of new equipment, the response will have been a better and more effective one for patients. For example, patients who suffer a sudden cardiac arrest in London are now expected to walk out of hospital alive and well in 6.4 per cent of cases. We still have a way to go to match the survival rates achieved in, say, Seattle but just a few years ago it was less than two per cent.

How much is funding continuing to be an issue for the Trust?

Funding has increased significantly in recent years but remains an issue. An independent consultants' report last year suggested we need a further 460 frontline staff to meet all our targets and provide a safe service. We want to fill that gap in the remaining two years of our Service Improvement Programme but that will require funding.

In what ways have changes in the wider NHS affected the Trust in the past year?

The new GP contract relieves GPs of the obligation to provide service outside normal office hours. Some GPs are willing to work evenings, nights and weekends to provide the out-of-hours service but they will expect to be properly paid for this. That will raise costs and has led primary care trusts to question whether many of the calls to GP out-of-hours services could safely be dealt with by our emergency care practitioners. Meanwhile, the pressure on acute hospitals to cut A&E waiting times has led them to look to the London Ambulance Service to find alternatives (to transport to A&E) for patients who don't need to go to hospital. As a result, we are coming under pressure to expand our emergency care practitioner scheme faster and further than we originally envisaged.

How do you see the Trust adapting to these changes in the future?

The new GP contract and the renewed emphasis on reduced A&E waiting times have made our partners in the NHS realise the central role the ambulance service can play in a much more integrated emergency and urgent care system. I expect the London Ambulance Service to continue to deliver the traditional 999 service but increasingly also the NHS' initial response to a wide range of patients who have what they see as a medical emergency, but who do not have an immediately life-threatening condition. These changes will test our ability to work differently; they will be much more patient-led than in the past and will involve much closer working with other agencies.

Sigurd Reinton
Chairman

Peter Bradley, Chief Executive and Chief Ambulance Officer

Chief Executive's Views

Last year has been quoted as the most successful in the Trust's history. What made it so?

It was a really good year for us, and all our staff deserve credit for their contribution to our success. Once again, our response times have improved, meaning we are getting to our patients more quickly than ever before.

Last year, we reached 500 more patients with life-threatening injuries or illnesses each week within the Government's eight minute target time. More people who suffer a cardiac arrest outside of hospital are surviving, and heart attack patients are receiving better and faster treatment as a result of new technology and enhanced training. Our staff survey results continue to get better and staff turnover is the lowest it has been for many years. To cap an excellent year we had a very good review from the Commission for Health Improvement and have recently regained our two star status in the NHS Performance Ratings.

How do you plan to sustain that success?

There is still more we want to do and must do to improve the quality of care we provide to our patients, and improve the working lives of our staff.

The environment in which we deliver our service is changing, and the only way we can meet the challenges ahead is to work differently, alongside a range of other organisations. Cultural changes will be as important as operational ones, and a few years from now could see us looking, feeling and behaving very differently as an organisation.

We still have eighteen months left to complete our Service Improvement Programme, but over the next year we will start to consult with staff, patients, members of the public and other parts of the NHS in London to find out their views on where we take the Trust in the future.

How is the Trust involving patients in developing new services?

The only reason we exist is to care for patients so it is logical that we involve them in plans to develop our service, and improve access to it. This is a huge challenge for us - and the rest of the NHS - and we will be working with our Patients Forum and other organisations to involve patients and the public in as much of our work as possible. Over the last year patients have contributed to a number of our clinical audits; they played a role in our cardiac awareness campaign; and Patients Forum members are increasingly being invited to sit on a number of committees throughout the Trust.

What are your priorities for the coming year?

I have three main priorities for this year and, in fact, for every year. Firstly, we must ensure that patient care (not just fast response times) is our main focus and that we all strive to continue improving the quality of care we deliver. We need to seek further ways of measuring improvements in patient care so we, and others, can know we are travelling in the right direction. Secondly, I want us to carry on improving the working lives of our staff and encourage greater understanding and integration across the various areas and departments in the Trust. Thirdly, we must all look at our everyday attitudes and behaviours towards colleagues and the public, seeking at all times to respect diversity, respect each other and live the London Ambulance Service values.

How are you engaging staff in making the Trust a world-class service?

Last year we spoke face to face with more staff than ever before from across the organisation, and we aim to build on that again this year. Communicating with staff, listening to their views and concerns, and involving them in developing our plans for the future, is crucial to our success. If we can ensure that good two-way communication becomes a natural part of how we operate at all levels, and in all areas of the Service, then I believe we will be a long way towards developing a strong and healthy organisation fit to meet the challenges and changes of the future.

How do you see your new role as National Ambulance Advisor benefiting the Trust and the ambulance service as a whole?

I hope that the ambulance review I am undertaking as part of my role will result in changes for the better in many areas - how calls are categorised, consistent recording of response times across the country and changes to performance standards, especially for lower priority calls. I also hope that the review will make important recommendations about the funding, delivery and national standards for ambulance education and training.

Peter Bradley
Chief Executive & Chief Ambulance Officer

Organisation

We provide the emergency ambulance service for the entire Greater London area and patient transport services for about half the hospitals in the capital.

The London Ambulance Service is the only London-wide NHS Trust, a status attained in April 1996.

The South West London Strategic Health Authority has responsibility for monitoring our performance while representatives of the primary care trusts (PCTs) in London are responsible for agreeing our funding. While all 32 PCTs fund our A&E service, individual hospital trusts purchase our patient transport services.

The Board

Our Trust Board comprises a non-executive chairman, five executive directors (including the Chief Executive), five non-executive directors and an associate director.

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, Colin Douglas, and Sarah Waller. The Trust Chairman, Sigurd Reinton, chairs the Service Development Committee, and he and the non-executive directors make up 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 Trust 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 Health and Safety Executive. He has previously worked at the Audit Commission, Transport for London and Sport England, as well as for a range of London local government and public service organisations. He has a reputation for and commitment to minority ethnic concerns.

Toby Harris was appointed a working peer in 1998. A former leader of Haringey Council and chair of the Association of London Government, he was a member of the Greater London Assembly from May 2000 to June 2004. He is a member of the Metropolitan Police Authority and was Chairman until June this year. He was also Director of the Association of Community Health Councils for England and Wales from 1987 to 1998.

Barry MacDonald is the Director of Resources and Corporate Development at the Human Fertilisation and Embryology Authority. He has previously been Finance Director of the 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 the 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.

Associate director

Dr Beryl Magrath, who took up her post in December 2003, worked as a consultant anaesthetist for 26 years. She was a founder of South Bromley HospisCare in 1984 and subsequently became its medical director in 1986. She was the medical director of Bromley Hospitals from 1992 to 2000, where she was also director of day surgery from 1996 to 2000. She is a trustee of Harris HospisCare.

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. Before joining us, he was 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 the 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 **Mark Jones**, who has spent most of his career within the NHS, joined us in February 2000 from a similar post at Wiltshire and Swindon Healthcare NHS Trust.

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.

Medical Director **Fionna Moore** was appointed in December 1997 and was made an executive director in September 2000. Dr Moore has 16 years' experience as an A&E consultant, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She also chairs our Paramedic Steering Group.

Directors

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

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

Deputy Chief Ambulance Officer (East) **Martin Flaherty** joined us in 1979, having gained a BSc in Biochemistry/Biology from the University of London. His career has included time spent as an operational technician and paramedic, followed by 15 years as a manager in a variety of positions. Martin was appointed to his current role in September 2000.

Deputy Chief Ambulance Officer (West) **Philip Selwood** joined us in January 1998 after serving 32 years with the Metropolitan Police Service, latterly as a chief super-intendent. He is the Trust's representative at London Resilience and Civil Contingencies Committee meetings at the Cabinet Office.

Senior managers

Head of A&E Development **Kathy Jones** joined us from the South West Thames Health Authority in November 1992. She had previously worked in 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 Board meets on Tuesdays from 10am in the conference room at the Trust's headquarters.

The remaining meetings of 2004 will be held on 28 September (plus AGM at 2pm) and 30 November. This will be followed by meetings in 2005 which are to be held on 24 January (Monday), 29 March, 31 May, 26 July, 27 September (plus AGM at 2pm) and 29 November 2005.

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

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

During the year progress on the Service Improvement Programme continued apace, and we completed many more of the 290 initiatives.

The programme, which began in 2001 and continues until March 2006, is designed to improve the quality of patient care we provide and the quality of working life for all our staff.

Much of the content was developed as a direct result of feedback from staff at our annual round of Chief Executive consultation meetings and issues raised at these events continue to be fed into the programme.

A key achievement has been the signing of a partnership agreement with the trade unions demonstrating that we are working closer than ever, and more effectively, with staff representatives.

Initiatives sit within three categories – patients, people and performance – and range from the modernisation of our ambulance fleet to developing greater support for our staff.

Underpinning the Service Improvement Programme is our organisation development strategy which outlines how the Trust must change to ensure improvements are long lasting for patients and staff. It emphasises the need for better communication and greater staff involvement; and learning and development is encouraged, as is closer working across the Trust. These changes will lead to the development of an organisation that looks, feels and behaves differently.

New ambulances, new uniforms and the introduction of a new management structure for the A&E service were among the Improvement Programme achievements of 2003/04.

Others included the extension of our new emergency care practitioner scheme and the completion of training for all staff in the use of 12-lead ECG (heart-monitoring) machines.

Mobile data terminals, together with satellite navigation, were installed in all our frontline vehicles and we piloted a scheme to ensure ambulances are clean and fully-equipped for the beginning of each shift.

A strategic review of our Patient Transport Service resulted in a commitment to develop the service and to integrate it more with the rest of the organisation.

Since the launch of the Improvement Programme, 150 initiatives have been completed and many more are currently underway.

Over the coming year, we intend to build on many of the projects already launched. The emergency care practitioner scheme will be extended and a new level of service to deal more appropriately with lower-priority calls will be expanded.

We will roll out new patient and public involvement initiatives and strive to make progress in recruiting more black and minority ethnic staff. One of the biggest challenges will be the introduction of the

What the Service Improvement Programme achieved in 2003/04

Patients

- Piloted and rolled out the emergency care practitioner scheme to two primary care trust areas
- Introduced a new drugs management scheme to all stations
- Introduced 130 new ambulances with enhanced patient care features
- Received a positive review by the Commission for Health Improvement
- Completed training of all frontline staff in the use of 12-lead ECG heart-monitor machines

People

- Implemented a new A&E management structure
- Provided improved uniforms to A&E and Patient Transport Service staff
- Piloted a performance development review scheme
- a new annual leave agreement, and the next phase of the Partnership Agreement with trades unions
- Launched a free 24-hour confidential telephone helpline for staff to resolve work or home-related problems

Performance

- Installed mobile data terminals and satellite navigation in our A&E ambulances, and changed the way we dispatch ambulances in Central Ambulance Control accordingly
- Piloted a 'make-ready' scheme to ensure that ambulances are clean and ready for use at the beginning of each shift, and appointed an external contractor to carry out this work
- Completed a strategic review of our patient transport service

Patient care is at the heart of the Service Improvement Programme

new NHS pay and conditions system – Agenda for Change.

Our achievement of the Government target of reaching 75 per cent of our most seriously-ill and injured patients within eight minutes must be maintained and we will work towards meeting the remaining targets concerning lower-priority calls. The introduction of a 'make-ready' scheme to ensure that clean and fully equipped ambulances are readily available, will contribute to achieving our performance goals.

What we plan to achieve in 2004/05

Patients

- Implement emergency care practitioner schemes in a significant number of primary care trusts
- Introduce a new non-urgent care service
- Finalise the patient and public involvement strategy
- Implement our Commission for Health Improvement action plan
- Implement a new Emergency Bed Service structure

People

- Implement a new emergency medical technician course so that it reflects new national clinical guidelines
- Implement personal performance development reviews across the Trust
- Make significant progress in the recruitment of black and minority ethnic staff
- Implement Agenda for Change – the new national pay scheme, aimed at harmonising the pay and terms and conditions of service for staff across the NHS

Performance

- Continue achieving the Government's target of responding to 75 per cent of Category A (immediately life-threatening) calls within eight minutes
- Make progress towards meeting the Government's other targets for Category B and urgent calls
- Introduce the 'make-ready' scheme to 10 ambulance station complexes


NHS

Patients

Emergency care practitioners attend minor injuries units as part of their training

Patients

We are committed to improving the quality of our services so that we can provide the best possible care to our patients.

Last year's review by the Commission for Health Improvement (CHI) - now the Healthcare Commission - highlighted that we provide a strongly patient-centred service; one which is valued by patients who praised the professionalism and care given by our staff.

CHI's review recognised the range of services provided by the Trust to ensure that patients receive the most appropriate care to meet their needs. Many of these services focus on patients with non-serious illnesses and injuries.

Providing appropriate care

Emergency care practitioner scheme

Our new emergency care practitioner scheme went live during the year. Emergency care practitioners are specially-trained paramedics who respond by car to calls concerning patients with non life-threatening but complex conditions, to assess the patient and decide on an appropriate course of action.

Options include conveying the patient to a hospital, minor injuries unit or walk-in centre, or arranging care with the other local health professionals involved in the scheme.

In preparation for their role, trainee practitioners attend a healthcare practice course involving a number of relevant modules leading to a diploma qualification run by St George's Hospital Medical School and Kingston University.

The scheme is being introduced gradually across London starting in Wandsworth in September 2003, followed by Croydon in December. It now also operates in Havering and will be extended to Hounslow and Bromley in the coming year.

'No send'

In 2002, we became the first ambulance service in the UK to offer people who dial 999 with non-serious illnesses and injuries advice about how they can access the most appropriate form of care. Based in Central Ambulance Control our clinical telephone advisors - specially-trained paramedics and emergency medical technicians - dealt with up to 400 calls a month during 2003/04.

Last year, we became the first ambulance trust in England to allow our clinical telephone advice staff to refuse to send an ambulance to people who do not require a 999 ambulance response.

From December 2003, some callers with minor injuries or illnesses were informed that they would not be sent an ambulance

Our Patient Transport Service staff provide a helpful and reassuring service to their patients

and instead we were able to offer advice on more appropriate ways of accessing treatment from the NHS.

Our 'no send' policy was introduced on a six-month pilot basis, and is now subject to ongoing evaluation.

Non-urgent care service

Towards the end of the year, we finalised plans for a new service to manage the care of all 'non-urgent' patients.

The first phase of the service was introduced in June 2004, and is operated by specially-trained staff with the skills to care for non-critical patients.

They deal with all non-urgent patient transfers which are arranged by healthcare professionals, and a small proportion of our urgent patient transfers that are requested by GPs. The service will also attend some patients who have dialled 999 with a non-serious illness or injury.

Previously, this type of work was undertaken by A&E ambulance crews and was fitted in around their responses to more serious calls. This could at times lead to delays. The new service will help us improve our care to these high-priority patients.

Cardiac care

The care and treatment of cardiac patients, with the aim of improving their long-term survival rates, remains one of our top priorities.

During the year, we completed a training programme for all our emergency medical technicians and paramedics to acquire and interpret a 12-lead electrocardiograph (12-lead ECG) which is a trace of electrical activity occurring in the heart. In addition to this, all our ambulances are now fitted with Life Pak 12™ defibrillators which monitor essential vital signs and deliver life-saving electric shock treatment to cardiac arrest patients.

Together, these measures mean that we can alert hospitals to the arrival of a confirmed heart attack patient so that life-saving 'clot-busting' drugs can be administered more quickly.

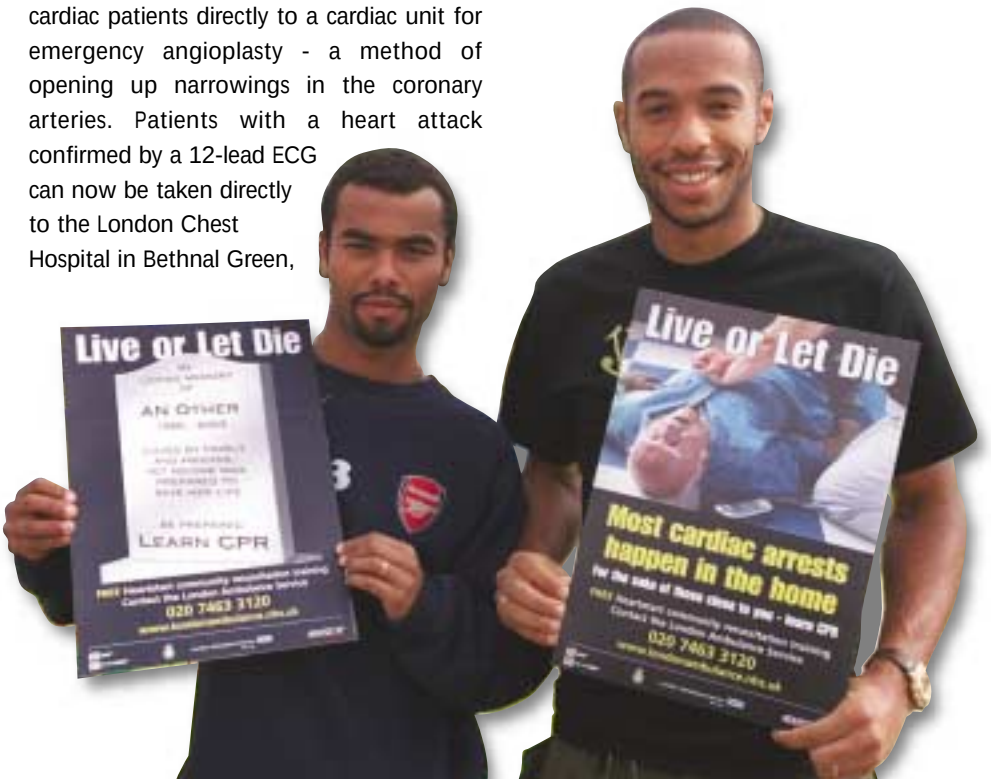
We also expanded our scheme to admit cardiac patients directly to a cardiac unit for emergency angioplasty - a method of opening up narrowings in the coronary arteries. Patients with a heart attack confirmed by a 12-lead ECG can now be taken directly to the London Chest Hospital in Bethnal Green, the Hammersmith Hospital NHS Trust and the Harefield Hospital in Middlesex for treatment. In April 2004, the Heart Hospital and St Mary's Hospital, both in central London, also became part of the scheme.

Our Community Resuscitation Training Team provides paid-for consultancy and training to private and public sector organisations which in turn supports the delivery of free cardio-pulmonary resuscitation (CPR) training to community groups.

There was a strong growth in commercial clients during the year including HM Treasury, Westminster City Council, Heathrow Terminal 5, KPMG, Unilever and HMP Belmarsh as well as 13 primary care trusts.

We continued to deliver free community training on our British Heart Foundation approved Heartstart courses. Attendance on these courses was boosted by the launch of our Live or Let Die campaign which aimed to increase public awareness of CPR and the need for fast action when someone has had a heart attack or if their heart has stopped.

The campaign was launched in October by celebrity Paul O'Grady and endorsed by Arsenal Football Club. Radio adverts and posters encouraged the public to book places on our free CPR training courses and as a result, we trained more than 3,000 members of the public by the end of the year.



Arsenal footballers Ashley Cole and Thierry Henry endorsed our 'Live or Let Die' public awareness campaign

Did you know?

The four Emergency Bed Service core services - GP referrals, adult and paediatric intensive care, general paediatric beds and cubicles, and neonatal intensive care - transferred 11,659 patients during the year.

Our neonatal transfer service ambulances provide the best possible care for premature and seriously-ill babies

Older people and fallers

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

During the year, we adopted a strategy and action plan with 36 recommendations for improving the care of older people which draws on a number of individual projects and the knowledge and experience of members of staff already actively involved in improving care for older people in their area.

During the year we also took forward a major Department of Health-funded research project developing and testing a decision-making tool to allow ambulance crews to safely leave elderly people who have fallen at home.

Protection of children and vulnerable adults

New operational procedures enabling our ambulance staff to report suspected abuse of children and vulnerable adults were introduced during the year.

The procedures give ambulance crews a clear course of action when they are concerned that someone has been abused.

Cases of suspected child abuse are followed up with social services and, where available, information about what action has been taken is fed back to crews. This allows us to meet the recommendations of the Victoria Climbié inquiry and build links with colleagues in social care.

Staff are currently making approximately 50 referrals a month.

The procedures have been adopted by all UK ambulance services through the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.

Emergency Bed Service

We have been responsible for the Emergency Bed Service (EBS) since 1999.

The core areas of work for EBS are GP referrals, where it works with GPs to arrange the referral of seriously-ill patients to hospitals in and around London; the national intensive care bed register, where it monitors the availability of critical care units across England for general, paediatric and neuroscience patients; and the paediatric service, where it locates paediatric beds and cubicles in and around London.

EBS also provides a coordinating service for the British Red Cross, St Joseph's Hospice and for district nurses in three areas of London, and works with Medic Alert, who provide bracelets to patients with potential medical emergencies.

A new development within EBS during

We are committed to, and actively involved in, improving the care of older people

2003/04 was the introduction of a neonatal transfer service which operates in London, Kent, Surrey and Sussex. Here, suitable intensive care cots are found for premature and seriously-ill babies and arrangements made for the babies to be transferred by teams of paramedics, nurses and doctors using state-of-the-art ambulances, designed to provide the best possible care for these patients. The London base for the neonatal transfer service is the Royal London Hospital and this service now handles around 70 requests per month.

A development project is now underway aiming to further integrate the EBS into the work of the Trust and to extend and improve its range of services.

During the year, research and preparatory work took place to develop a more coherent service for GPs and other healthcare professionals by providing them with a single contact point for bed location at, and patient transport to, hospital.

Risk data sharing project

In March 2004, a six-month pilot scheme was launched in the boroughs of Camden, Islington and Westminster aimed at improving the care of people with serious mental health illnesses who are at high risk of harming themselves or others.

The risk data sharing project is based in Central Ambulance Control where specially-trained mental health professionals are managing a database holding key information on individuals with serious mental illnesses. Staff based in all the partner organisations can request information from them about individual patients.

The pilot is being externally evaluated in the coming year and a decision will then be made on whether extend it across the rest of London.

Drugs

Between May and October we implemented a new drugs management scheme which ensures that our ambulance staff always carry a full set of drugs.

As well as reducing the clinical risks associated with staff carrying out-of-date or inconsistent ranges of drugs, the scheme helps us monitor drugs usage and it has led to considerable cost savings.

During the year, we introduced three new drugs for administration by our paramedics: Benzylpenicillin, an antibiotic for use in the most serious form of meningococcal disease; Glucose 10%, a fluid for treating hypoglycaemia; and Sodium Chloride 0.9%, a fluid replacement.

Patient and public involvement

Developing patient and public involvement (PPI) throughout all areas of the Trust is one of our biggest challenges. It is not something the organisation has been used to doing on a regular basis, but it presents a huge opportunity for us to communicate with all the many communities in London and find out what they want and require from their ambulance service.

Completing the Commission for Health Improvement (CHI) questionnaire as part of our review demonstrated that patients and the public are involved in many areas of our work including clinical audit, publicity campaigns, surveys, ambulance station open days, school visits and public events. However, it is clear that there is much more to do in this area and the CHI review confirmed this as a priority.

During the year, our PPI Committee was formed. Its purpose is to make sure that patient and public involvement is developed at corporate and local level so that regular engagement with our communites becomes an integral part of our work.

Membership of the committee includes representatives of the newly-formed Patients Forum – an independent body created by the Government under the umbrella of the Commission for Patient and Public Involvement in Health. The Forum is represented with observer status on the Trust Board.

We are developing a good working relationship with the Patients Forum (www.patientsforumlas.org.uk) and we share the joint aim of ensuring that PPI becomes an accepted way of how we 'do business'.

The PPI Committee has begun work on a strategy which will result in local patient and public involvement activities being designed and introduced throughout the Trust during the next two years.

Patient Advice and Liaison Service

Our Patient Advice and Liaison Service (PALS) provides information, advice and support to patients, the public and health and social care professionals. A comprehensive PALS was set up in June 2003 and between June 2003 and the end of March 2004, it received a total of 2,844 enquiries, of which 543 were letters of thanks.

Via PALS, emerging patterns of patient concerns are reported to our clinical governance committee for appropriate action.

PALS also works alongside health and social care partner organisations and uses concerns raised by patients to help improve the 'patient journey' through the NHS.

A particular strength in PALS' first year of operation has been working with other organisations to find solutions for patients who ring 999 frequently as they often have needs that can be better met by social or housing services, or other health care providers.

In the coming year, the service will be seeking to evaluate its performance against Department of Health core standards for PALS.

We introduced three new drugs for administration by our paramedics during the year

Complaints

Our Professional Standards Unit deals with all complaints and investigations. During the year, the unit received a total of 534 external complaints compared with 499 in the previous year.

Of these, 273 were written and 256 (73 per cent) of these were resolved in 20 days. Whilst below the Department of Health target of 80 per cent, it was an improvement on the previous year, when only 53 per cent of our written complaints had been resolved in 20 days.

A total of 506 of our complaints were resolved locally. Five requests were received for referral to independent review, one went to panel, one is still being considered and three were turned down requiring no further action.

During the year, we used complaints as a form of feedback to improve our service in several areas. For example, we are now prioritising calls where a healthcare professional has requested our attendance at a complicated birth; and case conferences are now a regular feature of our complaints handling process.

We are working towards compliance with the new Department of Health complaints procedure due for implementation in the coming year.

Clinical audit and research

Our projects are aimed at reforming emergency care and often involve working with hospitals, other ambulance services and universities. All research projects comply with Department of Health guidelines on research governance.

During the year, our research projects looked at using a protocol for the identification of stroke patients and transporting them directly to a specialist hospital, and considering different ways of treating patients with chronic obstructive pulmonary disease.

Patient report forms completed by ambulance crews are audited by team leaders

Our staff published five research papers and we won two out of three research awards at AMBEX 2003 - the ambulance service's annual national conference. One of the winning papers focused on the impact of road humps on patient care, the other on our cycle response unit in central London.

Our clinical audit and research unit continued to work on our clinical audit programme, and projects completed during the year included two key snapshot audits examining the accuracy of the Medical Priority Dispatch System in detecting cardiac arrest and the care of chronic obstructive pulmonary disease patients.

We are involved in a number collaborative audits, and are currently one of the pilot sites for a national clinical performance indicators audit. We contribute data to three national audits - around coronary heart disease, cardiac arrest and paediatric resuscitation. Our clinical effectiveness manager is chair of the South East Ambulance Clinical Audit Group, with whom we are also working on a hypoglycaemia re-audit.

The clinical audit and research unit has continued its programme of monthly research seminars and surgeries aimed at promoting evidence-based practice among staff. The team also publishes a quarterly newsletter disseminating our research findings across a wide audience, and has developed clinical audit handbooks for all frontline staff who wish to undertake this work.

Did you know?

The Helicopter Emergency Medical Service (HEMS) is based at the Royal London Hospital. HEMS flew a doctor and a paramedic to 993 of the most serious incidents in the capital, clocking up a total of 468 hours' flying time. A medical team attended a further 463 incidents by car.


NDON
NHS
BULANCE
NHS

People

Well-trained, enthusiastic and proud staff are key to our success

People

Our focus is to ensure our staff are given the leadership, support and development opportunities so that we can sustain improvement in our service.

We are in the process of restructuring our A&E service so that there is more focus on service delivery at local level.

Ambulance operations managers have been appointed to oversee the development and delivery of the ambulance service locally, and work with other parts of the NHS to extend care options for patients.

The ambulance operations managers head up new local management teams whose aim is to offer better leadership and support to our frontline crews.

Good progress has been made, and at the end of March 2004, 94 out of 100 posts in the local management teams were filled. The focus now is on developing the effectiveness of these teams through a tailored programme of learning and development.

Agenda for Change

Agenda for Change is the new national pay scheme, aimed at harmonising the pay and terms and conditions of service for staff across the NHS.

In December 2003, we appointed an Agenda for Change project manager and by March 2004, working in close partnership with the trade unions, we had established a project board to steer us towards full implementation.

We are in the process of establishing joint panels which will evaluate all jobs within the Trust and allocate them to one of eight pay bands. The band for emergency medical technicians has not yet been confirmed and we and two other ambulance services are working with the Department of Heath and the trade unions to resolve this.

Subject to agreement with the trade unions, introduction of the new pay bands and pay scales will start in December 2004, although all new terms and rates of pay will be retrospectively applied from October 2004. Full implementation of new pay scales, including arrears, is planned for April 2005.

Performance development reviews

We aim for every member of staff to have a performance development review by October 2005.

A requirement for Agenda for Change, this will take the form of an annual review at which staff and their line manager discuss performance over the past year, and personal development that is required. The outcome of this will be a personal development plan – a written plan, agreed by both the member of staff and their manager, outlining the individual's development goals for the coming year.

By the end of March 2004, six pilot sites had been established across London, covering a range of different types of departments and functions. They will test the process for how meaningful discussions can take place to agree clear objectives and development plans for each member of staff.

Pay and modernisation

Our first partnership agreement, signed in 2002, set out the commitment of managers and trade unions to work together to improve patient care and the working lives of staff.

During the year, the initial programme of work outlined in the agreement neared completion, and our second partnership conference took place in September 2003 which was attended by around 100 managers and trade union representatives.

Another key achievement was the appointment, in December 2003, of nine lifelong learning advisers. These trade union members have been trained to offer support and advice to staff on opportunities for learning new skills outside the workplace in an initiative jointly funded by UNISON and the Trust.

Staff safety

Following the introduction of stab-proof vests last year, frontline staff were issued with mobile phones that they can use if they are in immediate danger. The phones, which are preset with speed-dial numbers, were purchased as an interim step ahead of all ambulance services switching to digital radios in 2005/06.

A full-time ergonomics and back care advisor was appointed and a manual handling group established to provide advice on the design of vehicles, equipment and small manual handling transfer aids. Thirty staff were trained as manual handling assessors during the year and there was a 20 per cent reduction in reported manual handling incidents.

There were 344 reports of physical violence against staff in 2003/04, a reduction of 38 per cent from last year. Reports of verbal abuse remained constant at 1,765 incidents.

A further 450 staff attended our personal safety training course during the year, and operational managers received training in how to support staff who experience violence while on duty.

To help us learn from past events, operational managers were trained in how to grade accidents and incidents and identify those requiring a full investigation. There was a 50 per cent reduction in the level of absence due to accidents on duty.

Occupational health service

Our occupational health service is provided by King's College Hospital NHS Trust. As part of this, a counselling service is available to staff at eight sites across London. We are looking at extending our occupational health service and, during the year, we established a new nurse clinic in Bromley and a new consultant clinic in Caterham, Surrey. In the coming year we will be offering 'well person' medicals to staff on a voluntary basis.

Supporting staff

We continued to offer several initiatives aimed at providing better employment opportunities and conditions for staff. These include a scheme enabling staff to choose to exchange part of their salary for childcare vouchers and continued promotion of the Government's Starter Home Initiative. More than 30 staff have used the latter of these schemes, to date.

In May 2003, we launched a 24-hour free confidential telephone helpline service giving staff access to professional advisors who can help them resolve personal or work related problems. The service is run by an independent company, Focus EAP.

We also launched a 24-hour internal telephone support network, known as LINC, allowing staff to share any worries of concerns they may be having with specially trained members of our staff. And an initial review of our maternity leave and pay policy took place following a survey of 70 staff who had taken maternity leave within the last five years.

Equality and diversity

We are committed to promoting equality and diversity and to eliminating discrimination within the workplace.

During the year we produced a race equality and diversity implementation plan that details progress towards objectives set out in our Race Equality Scheme and includes measures to tackle potential disadvantage affecting other groups.

Work currently underway includes ensuring that we measure the impact of our policies and functions on different groups within the community. We are also continuing to review our data collection and monitoring systems to enable improved use of management information in both employment and service planning.

Did you know?

Our procurement department placed 21,500 orders last year, amounting to £28,122,650, the majority of which were placed online.

We worked with the Three Boroughs Refugee Team to build links between ambulance staff and refugee communities

During the year, we improved our staff training on equality and diversity issues by including a session on our corporate induction programme and by developing a number of 'diversity champions' in our training centres.

New policy guidelines on helping staff with specific learning difficulties - in particular, dyslexia - have been introduced. The British Dyslexia Association has since praised this document and has asked to use it in putting together their own guide.

We also created a database of black and minority ethnic community groups within London that is now being used as part of our public and patient involvement programme.

Our community resuscitation training team worked with staff at Deptford ambulance station and with Three Boroughs Refugee Health team - hosted by Lambeth Primary Care Trust - to help deliver resuscitation training to refugee communities in Southwark. The team also employed a bi-lingual trainer to develop and deliver resuscitation training to South Asian communities.

We are continuing to work with the charity EnRé to provide pre-recruitment training to help unemployed people apply for roles within the ambulance service.

Work being planned for 2004/05 includes the publication of a revised equality and diversity statement and policy and a revision of our harassment guidelines. We will also be conducting research around the experiences and expectations of specific minority groups within London, including mental health service users, when using our ambulance service.

Improving working lives

Improving Working Lives is a national NHS initiative aimed at encouraging high standards across a range of areas including human resources strategy and management, equality and diversity, personal development, staff involvement and flexible working.

Following our successful accreditation at Practice standard during 2002/03, we are now working towards the more exacting standard of Practice Plus. A group made up of staff from across the Trust, trade union representatives and human resources leads, is leading on work to achieve this target.

New uniforms

New uniforms were introduced for more than 2,500 A&E and Patient Transport Service staff by the end of April 2004, following a comprehensive review and extensive user trials.

Brand new elements of the uniform include fleeces, belts and hats, while the existing elements – trousers, high-visibility jackets and tabards and shirts - have been completely redesigned.

All staff wear the same style and colour of uniform, which is corporately marked with the NHS logo.

In the coming year Central Ambulance Control and resource centre staff are to trial a variation of the A&E and Patient Transport Service clothing, prior to being issued with new uniform.

Recruitment and training

During the year, we recruited 215 frontline A&E staff, and 37 staff into our control room. Staff turnover remained low at five per cent.

We trained 201 trainee emergency medical technicians and 80 paramedics. Fifty-six members of staff also passed our training supervisor course in 2003/04, qualifying them to mentor trainee emergency medical technicians during their probationary year.

A new trainee emergency medical technician course was piloted that reflects the introduction of the Joint Royal Colleges Ambulance Liaison Committee guidelines and increased patient-assessment and diagnostic skills, which will be implemented in the coming year.

We were pleased to introduce our first-ever modular paramedic course in October 2003, aimed at staff whose personal circumstances make it difficult for them to study full-time.

This year, our bursary scheme enabled around 60 members of frontline staff to attend external courses aimed at further improving the care of our patients. These included courses in pre-hospital trauma life support, paediatric advanced life support, major incident medical management and support, and immediate medical care.

In October 2003, we changed the title 'qualified ambulance technician' to 'emergency medical technician' to better describe the professional role of these frontline staff and to bring us in line with ambulance services in countries such as the US.

National clinical guidelines

Joint Royal Colleges Ambulance Liaison Committee clinical practice guidelines are a set of nationally agreed patient care guidelines which are being adopted by all ambulance services to ensure uniformly high standards of practice across the country.

By April 2004, we had trained 1,500 of our frontline staff in the use of the guidelines, providing a two-day training package followed by a day working under supervision for less experienced staff. All staff undergoing training were issued with a full set of guidelines, and an aide memoire. A leaflet explaining the switch to guidelines was also distributed to staff at A&E hospitals across the capital.

We have continued to contribute to the national development of the guidelines. During the year, four of our protocols – procedures for the recognition of children and vulnerable adults, the management of sickle cell patients, cocaine ingestion and obstetric emergencies - were adopted nationally and are to be used by all UK ambulance services in the future.

A London Ambulance Service training officer teaches cardio-pulmonary resuscitation to students at the University of Hertfordshire

Higher education scheme

We have been working closely with the University of Hertfordshire since 1996 to develop a range of paramedic science courses from certificate level up to BSc (Hons).

A team of our training officers is based at the university from where it delivers all the vocational aspects of courses – including all clinical and driver training – and arranges clinical placements for students at our ambulance stations. We also employ the majority of students once they have graduated – 16 out of 19 in 2003.

Each year, we arrange for around 70 of our paramedics and emergency medical technicians to join the university, paying their fees and allowing them study leave so that they can study part-time on the paramedic science programme.

During 2003/04:

- 40 members of staff gained a certificate of higher education in Paramedic Science
- 15 members of staff gained a diploma in Paramedic Science
- 12 member of staff graduated with a BSc or BSc(Hons) degree in Paramedic Science

An exciting new development during 2003/04 was the launch of a new Foundation Degree in Health and Medical Sciences (paramedic pathway) in conjunction with Kingston University and the St George's Hospital Medical School. Twelve students joined the course in February 2004, and they will be working part-time for the Trust in their second year.

Consulting staff

The Chief Executive's annual staff consultation meetings took place between October 2003 and January 2004 at 48 different venues across London and were attended by around 1,500 staff.

For the first time, the Chief Executive held meetings specifically for Patient Transport Service staff.

The aim of the meetings is to give staff the opportunity to ask the Chief Executive about the issues that affect them. The key issues raised by staff are fed into the Service Improvement Programme in the following year.

In 2003, issues raised included concerns that too high a proportion of 999 calls are classified as Category A by our priority dispatch system; there is a lack of clarity around pay levels after Agenda for Change comes into effect; the inappropriate use of the 999 service by the public and some

healthcare professionals; and the amount of training and education opportunities available to our staff.

All staff feedback is recorded and each ambulance station receives a summary of the issues raised locally.

Staff survey

The results of our 2003 staff survey, which was completed by 1,500 members of staff, showed a continued rise in satisfaction levels, although in some areas levels of satisfaction are below the NHS average. The results of the 2003 survey are fed into the Improvement Programme in the current year.

As many as 81 per cent of our staff said they enjoyed the work they do, while 88 per cent agreed that the Trust is a good employer and 87 per cent were willing to change the way they do their jobs to provide a better service.

However, only 33 per cent of staff felt happy with their pay, compared with 42 per cent across the NHS, and 41 per cent of staff felt they received adequate training, compared with 50 per cent across the NHS. Thirty eight per cent of staff rated their manager's people-management skills, compared with 51 per cent across the NHS.

Recognising achievements

We have continued to recognise the contribution that individuals make to the Trust. During the year, 16 ceremonies were organised for newly-qualified operational staff. Two retirement ceremonies and two long service ceremonies also took place.

Several high-profile awards were also received by our staff during the year.

One of our Patient Transport Service crews based at Queen Mary's Hospital, Roehampton won an NHS Excellence award from the South West London Strategic Health Authority, having been nominated by their patients.

Three members of staff were commended by the Ambulance Service Association: our cycle response unit co-ordinator, for creating the first ever bicycle response unit in central London and an ambulance crew from Waterloo ambulance station, for preventing a man from committing suicide.

A crew from St John's Wood ambulance station won the prestigious NHS Champions award, presented by the Evening Standard and the King's Fund, for treating a firefighter on the seventh floor of a burning building.

Did you know?

Our Schools and Events team, along with frontline staff, educated 49,500 children between pre-school age and 18 years-old last year about the ambulance service and what to do in a medical emergency. It also visited 79 external events, including charity and hospital functions as well as 49 internal events, including retirement, long service and graduation ceremonies.

Richard Webb-Stevens and Walter Oryem from St John's Wood were named NHS champions

Performance

We are required to respond to 75 per cent of Category A (immediately life-threatening) calls in eight minutes

Performance

Last year was the most successful in the Trust's history, which means that patients are getting cared for better and more quickly than ever before.

The Commission for Health Improvement's (CHI) clinical governance report on the Trust was published in March and acknowledged the consistent progress that we have made in improving patient care across the capital.

CHI stated that the rest of the NHS could learn from our approach to emergency preparedness and from our policy that enables staff to report suspected abuse of children and vulnerable adults.

The report identified areas of notable practice including our 24-hour restocking system for drugs, our clinical audit processes and the use of clinical telephone advice in our control room. The work of the cycle response unit in central London and our public awareness campaigns were also positively received.

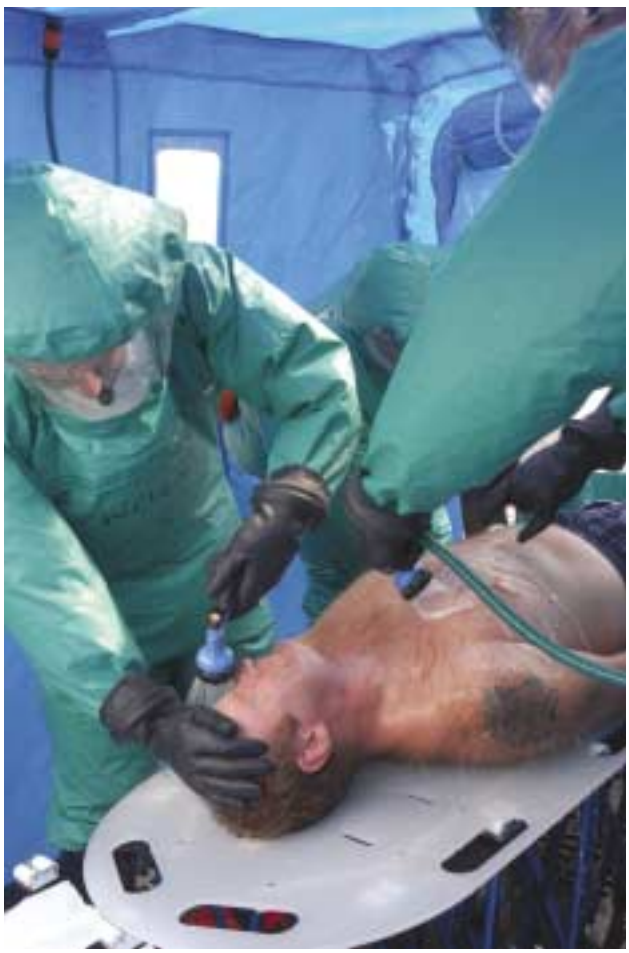
On the other hand, CHI highlighted that we need to make more effort to involve patients and the public in our work, and that our risk management systems need to be further developed and communicated to frontline staff.

We need to rebuild the role of our team leaders to give more clinical focus to their work; ensure the consistent use of national clinical guidelines by staff; and make sure our ambulances are cleaned and restocked regularly.

We have worked with key stakeholders to develop our action plan in response to CHI's findings. This has been approved by CHI (now the Healthcare Commission) and our progress against it will be monitored by the South West London Strategic Health Authority.

We were pleased to be awarded two stars in the NHS Performance Ratings, announced in July 2004 – an increase of one star on the previous year's.

Areas in which we did particularly well included meeting the Government's eight minute performance target, managing our finances and improving the working lives of our staff. Our focus on child protection issues, the introduction of 12-lead ECGs on all ambulances and participation in clinical audits all contributed to the two-star rating.



Specially-trained staff decontaminate patients who are injured in chemical incidents

Did you know?

Our vehicles covered 12 million miles last year, using 4.6 million litres of fuel. We operate 13 vehicle workshops in various parts of London in which 63 maintenance fitters are employed.

Meeting targets

In line with Government guidelines, all calls that are received by ambulance services via the 999 system are categorised as either Category A (immediately life-threatening), Category B (serious), or Category C (non-serious injury or illness).

The national response time targets are that 75 per cent of Category A calls should be reached within eight minutes and 95 per cent of Category B calls should be reached within 14 minutes.

Ambulance services also deal with 'doctors' urgent' calls where the ambulance must arrive within a definite time period to collect the patient for admission to hospital. These calls fall outside the 999 service and the national response time target is that 95 per cent should be reached not more than 15 minutes late.

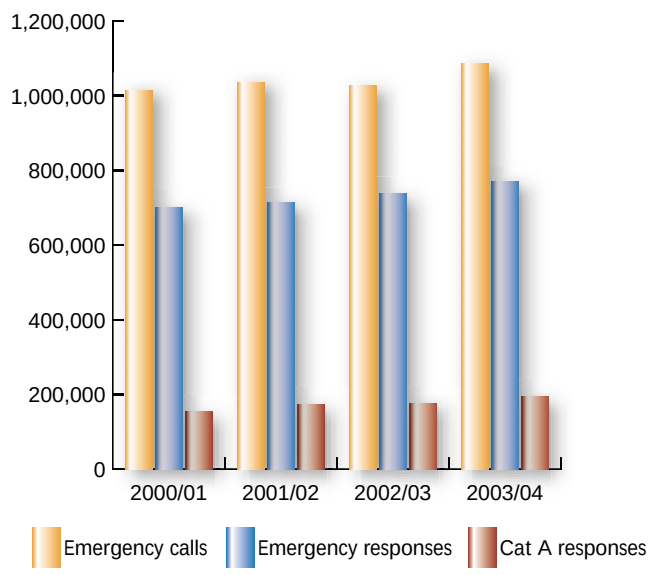
For the period 2003/04 we responded to:

- 76 per cent of Category A calls in eight minutes (69 per cent in 2002/03).
- 77 per cent of Category B calls in 14 minutes (79 per cent in in 2002/03).
- 50 per cent of urgent calls where we were not more than 15 minutes late (47 per cent in 2002/03).

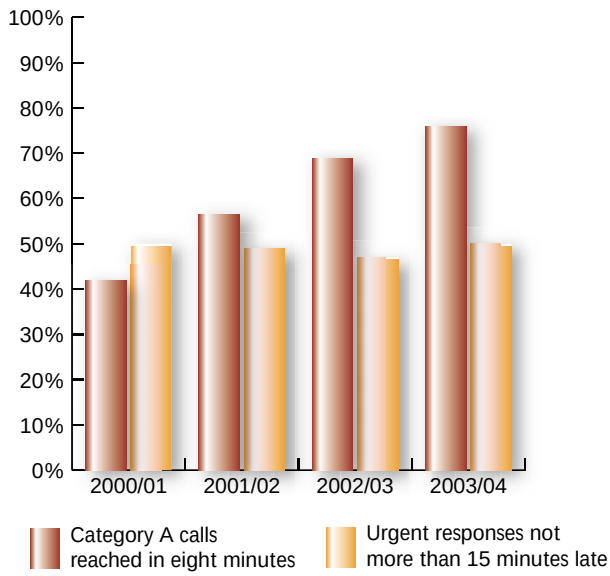
We are introducing a new non-urgent care service to help us improve our performance with urgent calls and we aim to achieve the Government's 95 per cent target by March 2006.

- During the period 2003/04, our Central Ambulance Control received a total of 1,088,559 emergency calls (1,030,581 in 2002/03).
- We undertook a total of 770,038 emergency responses (738,276 in 2002/03). Of these, 195,362 were Category A responses, up from 176,753 in the previous year.
- For the same period, we made 54,417 urgent patient journeys (58,265 in 2002/03).
- Special/planned patient journeys are arranged by healthcare professionals and include pre-booked hospital and hospice transfers. During the year, we undertook 660,410 such journeys (682,682 in 2002/03).

Perfomance



Emergency demand



Performance

Improving our A&E performance

New ambulances

Delivery of the first batch of our new all-yellow A&E ambulances began in August 2003 and was complete by December. In total, 130 ambulances were received as a direct replacement for our oldest vehicles.

We are committed to replacing the remainder of our 265 ambulances with the new style ambulances at a rate of 65 per year for the next four years.

Mobile data terminals

By March 2004, all 395 of our ambulances, 59 fast response cars and 10 duty station officers' vehicles had been fitted with mobile data terminals and satellite navigation, and new supporting software had been introduced in Central Ambulance Control.

The new technology allows us to dispatch our emergency vehicles more quickly and helps ensure that our staff are more informed about the calls they are attending.

Mobile phone technology

In February, we became the first emergency service in the UK to adopt leading-edge technology to help us narrow down the location of people dialling 999 from mobile phones.

The new technology helps reduce the frustration of both callers and emergency medical dispatchers in working out where the ambulance is needed.

Our emergency medical dispatchers now work with an additional mapping screen which shows the 'cell' from which a mobile phone call is being made.

Estates

In April 2003, approval was given to a new estates strategy aimed at providing a better response to patients. We are currently working with a number of primary care trusts and a health authority to help provide new satellite facilities.

During the year, the ambulance stations at New Malden, Hayes and Deptford were refurbished and an extension was built to our main training centre in Fulham, providing two additional classrooms.

Mobile data terminals allow information about 999 calls to be transferred electronically to vehicles, while satellite navigation guides ambulance staff to the scene using an electronic voice and mapping system

Patient Transport Service

Our Patient Transport Service (PTS) provides high-quality non-emergency transport for those patients who would otherwise have difficulty getting to and from hospital appointments.

Following a strategic review in 2002/03, it was decided that the PTS should continue to be a core part of the Trust and since then we have been involved in a range of benchmarking activities aimed at improving the quality of this service.

During 2003/04, we joined the National Patient Advisory Group PTS Modernisation Group, a national group for NHS organisations involved in commissioning or providing a patient transport service, and we also visited a number of other ambulance services to review processes, share experiences and identify innovative and good working practice.

Financially, it was a successful year for PTS. Despite increasing competition, we retained more than 30 contracts, and contributed £864,000 towards central costs. Another key performance indicator during the year was a 50 per cent reduction in the number of complaints received by the service, now at a level of one per 20,000 patient journeys.

All PTS managers and support staff undertook a basic life support and emergency aid course during the last 12 months, and we purchased 35 FR-2 defibrillators to administer life-saving treatment to heart attack patients. We now have 23 work-based trainers who deliver a range of courses to our staff, including customer care and child protection.

PTS staff received new uniforms during the year and are set to benefit from other

Service Improvement Programme initiatives in the coming 12 months, including defibrillators on vehicles and improved IT support. Twenty new PTS stretcher ambulances, featuring the same trolley bed as used on the new A&E ambulance, are also to be introduced.

Looking ahead to 2005, the responsibility for commissioning will pass from individual health care trusts to primary care trusts. We have been working on forging links with our future commissioners, a process which will continue over the coming months.

Emergency preparedness

During the year, we revised our major incident plan to include, among other things, new sections on catastrophic and chemical/biological/radiological/nuclear (CBRN) incident planning and post traumatic stress syndrome. The updated version of the plan, approved in June 2004, is fully compliant with the Department of Health's 'Handling Major Incidents: An Operational Doctrine'.

We attended two major incidents during the year, the first in July 2003, when around 4,000 people were trapped in trains beneath Camden underground station, and four patients were conveyed to hospital. The second, a similar incident at Oxford Street underground station in October, left five people needing hospital treatment.

We participated in several training exercises, including a mock chemical attack at Bank underground station in September 2003. Around 70 frontline staff took part in this exercise, clinically decontaminating 20 casualties, and conveying them to University College London Hospital.

In October, we also took part in a 'live' exercise at the City Airport in Docklands with the London Fire Brigade and the Metropolitan Police. Here we tested our major incident plan and how we work together with other agencies during a major incident.

Supporting planned events

We provided medical aid at a number of planned events during the year with the support of the voluntary organisations St John Ambulance and the British Red Cross.

These included the 2003 May Day demonstrations, where approximately 30 casualties were treated for minor injuries and the Notting Hill Carnival in August 2003, where some 600 people were treated, around 100 of whom were taken to hospital.

Planning began in July for dealing with New Year's Eve - the busiest night of our year which tests to the full our ability to deal with a high volume of 999 calls and reach the most seriously-ill and injured patients first. Between midnight and 5 am on New Year's Day, we received 880 emergency calls and we managed to reach 76 per cent of the Category A (immediately life-threatening) incidents in eight minutes.

Did you know?

Our Cycle Response Unit pedalled over 4,800 miles and attended nearly 1,000 incidents during its operational period of April to November. Use of the environmentally friendly unit led to a fuel cost saving of £2,000 last year.

Exercises test our major incident plan and how we work with other agencies

2003/04 FINANCIAL SUMMARY STATEMENTS

Financial Review

The Trust fulfilled all three of its statutory financial duties in 2003/04:

1. On income and expenditure the Trust reported a surplus of £89,000 for the year, and therefore did better than the break even target set for it by the Department of Health for 2003/2004. 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 £257,000.

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

3. A return on assets (the capital cost absorption duty) of 4.1% was achieved. This was better than the target of 3.5%.

The financial year 2003/04 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 and its emergency preparedness capability.

In the capital programme £6.8m was spent on a range of projects, including special incident vehicles, additional tender vehicles and other vehicles, new technology projects, replacement defibrillators, and projects to improve the estate. Overall the Trust underspent by £74,000 against its capital resource limit, which it is permitted to do.

The Trust was able to pay 79% of its invoices within 30 days which was lower than the previous year's figure of 80%, which was below the target set for it by the Department of Health.

The Audit Commission was the Trust's external auditors for the year-ending 31st March 2004. The Trust paid the Audit Commission £196,000 for audit services relating to the statutory audit. The Audit Commission did not provide any other services for the Trust.

There were no important events occurring after the year end that had a material effect on the 2003/04 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 below.

This report is made solely to the Board of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 54 of the Statement of Responsibilities of Auditors and of Audited Bodies, prepared by the Audit Commission.

Respective responsibilities of directors and auditors

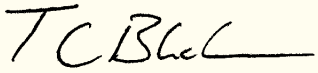
The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statements with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications 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 2004 on which I have issued an unqualified opinion.



Terry Blackman 17 August 2004

Audit Commission
4th Floor, Millbank Tower
Millbank, London
SW1P 4QP

Income and Expenditure £000s

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Surplus/Deficit(-) in year	-163	485	-909	101	46	94	89
Cumulative Surplus/Deficit(-)	-163	322	-587	-486	-440	-346	-257
Cumulative deficit permitted (0.5%)	-529	-540	-571	-618	-678	-804	-843

The surplus in 2003/04 meant that the cumulative position improved for the fourth year running, and remained well within the limit of 0.5% of turnover permitted by the Department of Health.

Related party transactions

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

During the year none of the Board Members or members of the key management staff or parties related to them have 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:

- Richmond & Twickenham Primary Care Trust
- NHS Litigation Authority
- NHS Supplies Authority
- NHS Pension Agency
- 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.

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 14 July 2004

Statement of director's 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:

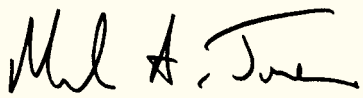
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

The directors 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 requirement outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Chief Executive 14 July 2004



Director of Finance 14 July 2004

Statement on internal control

Scope of Responsibility

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 policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum. The Assurance Framework provides evidence of the assessment of the effectiveness of the system of internal control and assurances that actions are or will be taken to address issues arising.

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 accountability arrangements that surround this role are supported by the management systems provided in the Trust's Risk Management Framework which is our risk Management Strategy. The framework explains the London Ambulance Service NHS Trust position on risk and defines the management and ownership of risk. The summary of the Risk Strategy was placed on the Trust's website so that external stakeholders may learn how our risk management system works.

This year's statement of internal control has been prepared in a new style. It is the starting point for the next year's statement of internal control and a more developed supporting assurance framework.

The purpose of the system of internal control

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

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

The system of internal control was in place in the London Ambulance Service NHS Trust at 31 March 2004 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The leadership for risk management within the Trust is delegated by the Trust Board through the Chief Executive who is a member of the Audit Committee, Risk Management Committee and the Clinical Governance Committee and is chair of the Risk Management Group. The Director of Finance and Business Planning has overall responsibility for financial risk and any other corporate risks not covered by other directors. He attends the Audit Committee and chairs the Controls Assurance Steering Group. Individual executive directors are responsible for, and manage, the corporate risks within their particular spheres of activity.

The Trust has conducted a risk management training needs analysis and produced a list of statutory, mandatory and desirable training for staff. Guidance has been produced on how often it should be attended and by whom. Each course has measurable objectives in line with the model used by the Trust for the National Pre-Hospital Clinical Guidelines. With the development of evaluation for these training courses and lessons learned from the integrated incident reporting system, the Trust will identify good practice and disseminate it using established mechanisms such as Patient Care News produced by the Medical Director and by presentations at the Trust's Patient Care Conference.

The risk and control framework

The risk management framework provides a definition of risk and sets out the authority and accountability structure to manage the different types of risk. A key part of the framework is the risk management process which specifies the way risk (or change in risk) is identified, evaluated and controlled. An appendix to the risk management framework lists the sources used to undertake a systematic identification of risks including; monitoring of incidents, claims, inquests and complaints and risk assessments on all new major project plans.

Once identified, risks are allocated to an appropriate person or working group in the Trust. The Risk Management group discusses the recommendation, including the evaluation of the risk's priority and possible action. We categorise risk using a risk prompt and scoring matrix, where evidence based impact and likelihood are considered, which defines the priority level of the identified risk. The Risk Management Group decides whether to include the proposed risk on the risk register. A risk is entered onto the risk register with an appropriate action plan to address gaps in control. Risks on the risk register are reviewed for progress and re-grading on a six monthly basis, in some cases the risk may change due to action being completed or a change in circumstance, in this case the risk will be redefined and re-evaluated.

The framework and the risk scoring matrix provide the basis for embedding risk management in the organisation. The embedding of the risk scoring matrix is illustrated by our incident reporting system where staff report clinical and non-clinical incidents. Incidents are graded and according to the result of the grading afforded an appropriate level of investigation so that actions can be implemented to prevent their re-occurrence.

The Clinical Risk Group has been an active forum for embedding risk management in the organisation. For example the need for greater infection control awareness prompted the establishment of an Infection Control Steering Group which is taking forward a comprehensive infection control programme.

In addition to the risk management framework and our risk register, the assurance framework enables us to examine how well we are managing risks that are threatening the achievement of strategic objectives from our service plan. This has enabled gaps to be identified for appropriate action. The table on the back inside cover of this report provides an example of how the London Ambulance Service NHS Trust's assurance framework operates. This approach is the beginning of an ongoing process and it will be supplemented with further objectives as they are reviewed and developed in strategic plans.

We are beginning to routinely use complaints to help identify risks to our service and determine appropriate action to preventing them in the future. Public and patient involvement needs developing further however, so that patients are involved in the management of risks which impact on them. External assurance highlighted the need to ensure that specific risks to patients are identified and acted upon. In order to achieve this, the Trust will develop systems for more systematic involvement of patients in risk management.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Executive managers within the Trust who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the Trust achieving its principal objectives have been reviewed. My review is also informed by the Commission for Health Improvement (CHI) clinical governance review of the Trust, comments made by external auditors, progress against the Service Improvement Programme and the Trust's business planning process.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the:

- Board
- Audit Committee
- Internal Audit
- Risk Management Committee
- Risk Management Group
- Clinical Risk Group
- Clinical Steering Committee
- Infection Control Group
- Corporate Health and Safety Group
- Clinical Governance Committee
- Vehicle and Equipment Working Groups

A plan will be developed to address weaknesses and ensure continuous improvement of the system.

The process used to maintain and review the effectiveness of the system of internal control

The Board is informed of the effectiveness of the system of internal control through its sub-committees, the Audit, Risk and Clinical Governance Committees. The Audit Committee will advise the Board about how well the Trust is operating the Risk Management System (known as the 'Core Standard' in Controls Assurance). To carry out this responsibility it will receive reports from the Chief Executive and from both internal and external audit when they look at risk management systems and processes.

The Clinical Governance Committee has responsibility for ensuring the provision of high quality clinical care within the Trust. This is achieved through monitoring and making appropriate recommendations on performance in the areas of clinical governance reviewed by CHI. The Risk Management Committee has delegated responsibility for taking a general overview of all risk management activities within the Trust and to pick up any specific risk management issues which are not covered by the specialist Audit and Clinical Governance Committees. This committee also receives a report on the management of all identified high priority risks that were identified in the trust-wide risk assessment in February 2001. It is the intention of the Trust to conduct another trust-wide risk assessment in the coming year to ensure the risk register is representative of all areas of the Trust.

This structure is supported by executive managers. The Director of Finance and Business Planning has overall responsibility for financial risk, and for any corporate risks not covered by other directors. The Medical Director has overall responsibility for clinical risk and clinical governance, chairs the Clinical Risk Group and is a member of the Clinical Governance Committee. The Director of Technology is responsible for all risks arising out of the provision, use, operation and maintenance of the Trust's vehicle fleet, its estate and all of its technology and communication systems.

To supplement this mechanism, information is provided to the Board through minutes and annual reports on risk management and clinical governance in order for the Board to be confident that sufficient progress has been made. The Clinical Governance Annual Report includes reports from the Patient Advice and Liaison Service (PALS) which reports to the Clinical Governance Committee via the Patient and Public Involvement Group.

Identified strengths and weaknesses have been highlighted from various sources including CHI, Service Improvement Programme outcomes, risk pooling scheme for Trusts and Internal Audit. This informs relevant action to ensure the system of internal control is effective.

Chief Executive 14 July 2004

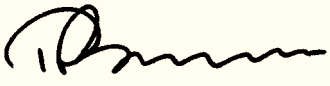
(on behalf of the Board)

Income and expenditure account for the year ended 31 March 2004

	2003/04 £000	2002/03 £000
Income from activities:		
Continuing operations	**165,103**	152,645
Other operating income	**3,405**	8,105
Operating expenses:		
Continuing operations	**(165,661)**	(156,945)
OPERATING SURPLUS		
Continuing operations	**2,847**	3,805
Cost of fundamental reorganisation/restructuring	**0**	0
Profit on disposal of fixed assets	**111**	258
SURPLUS BEFORE INTEREST	**2,958**	4,063
Interest receivable	**237**	335
Interest payable	**0**	(19)
Other finance costs - unwinding of discount	**(150)**	(104)
Other finance costs - change in discount rate on provisions	**25**	0
SURPLUS FOR THE FINANCIAL YEAR	**3,070**	4,275
Public Dividend Capital dividends payable	**(2,981)**	(4,181)
RETAINED SURPLUS FOR THE YEAR	**89**	94

Balance sheet as at 31 March 2004

	31 March 2004 £000	31 March 2003 £000
Fixed Assets		
Intangible assets	**565**	520
Tangible assets	**91,663**	83,876
	92,228	84,396
Current Assets		
Stocks and work in progress	**1,610**	1,603
Debtors: Amounts falling due:		
after one year	**0**	0
within one year	**16,585**	16,289
Cash at bank and in hand	**911**	2,120
	19,106	20,012
CREDITORS : Amounts falling due within one year	**(13,967)**	(16,820)
NET CURRENT ASSETS/(LIABILITIES)	**5,139**	3,192
TOTAL ASSETS LESS CURRENT LIABILITIES	**97,367**	87,588
CREDITORS: Amounts falling due after more than one year	**0**	(40)
PROVISIONS FOR LIABILITIES AND CHARGES	**(12,220)**	(12,650)
TOTAL ASSETS EMPLOYED	**85,147**	74,898
FINANCED BY:		
CAPITAL AND RESERVES		
Public dividend capital	**52,838**	49,207
Revaluation reserve	**28,024**	23,348
Donated Asset Reserve	**893**	0
Other reserves	**10**	10
Income and expenditure reserve	**3,382**	2,333
TOTAL CAPITAL AND RESERVES	**85,147**	74,898



Chief Executive 14 July 2004

Cash flow statement for the year ended 31 March 2004

	2003/04 £000	2002/03 £000
Operating Activities		
Net cash inflow from operating activities	**6,415**	10,998
Returns on Investments and Servicing of Finance :		
Interest received	**237**	335
Interest paid	**0**	0
Interest element of finance leases	**0**	(19)
Net cash inflow/ (outflow) from returns on investments and servicing of finance	**237**	316
Capital Expenditure		
Payments to acquire tangible fixed assets	**(7,295)**	(8,123)
Receipts from sale of tangible fixed assets	**188**	1,276
Payments to acquire intangible fixed assets	**(195)**	(327)
Net cash (outflow) from capital expenditure	**(7,302)**	(7,174)
DIVIDENDS PAID	**(2,981)**	(4,181)
Net cash inflow/(outflow) before financing	**(3,631)**	(41)
Financing		
Public dividend capital received	**3,631**	239
Public dividend capital repaid (not previously accrued)	**0**	0
Public dividend capital repaid (accrued in prior period)	**0**	(198)
Capital element of finance leases	**0**	(128)
Net cash outflow from financing	**3,631**	(87)
Increase/(Decrease) in cash	**0**	(128)

Statement of total recognised gains and losses for the year ended 31 March 2004

	2003/04 £000	2002/03 £000
Surplus for the financial year before dividend payments	**3,070**	4,275
Unrealised surplus on fixed asset revaluations/indexation	**5,636**	11,175
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed asset	**1,051**	0
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	**(158)**	0
Total recognised gains and losses for the financial year	**9,599**	15,450
Prior Period Adjustment	**0**	(2,175)
Total gains and losses recognised in the financial year	**9,599**	13,275

Salary and pension entitlements of senior managers

Name and Title	Age	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Golden hello/compensation for loss of office £000	Real increase in pension at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2004 (bands of £5000) £000	Benefits in kind (Rounded to the nearest £100) £
2003/04							
Sigurd Reinton, Chairman	62	£20,001-£25,000	£0-£5,000	0	**	**	0
Beryl Magrath, Associate Non-Executive Director	63	£0-£5,000	£0-£5,000	0	**	**	0
Suzanne Burn, Non-Executive Director	56	£5,001-£10,000	£0-£5,000	0	**	**	0
Sarah Waller, Non-Executive Director	57	£5,001-£10,000	£0-£5,000	0	**	**	0
Colin Douglas, Non-Executive Director	40	£5,001-£10,000	£0-£5,000	0	**	**	0
Toby Harris, Non-Executive Director	50	£5,001-£10,000	£0-£5,000	0	**	**	0
Barry MacDonald, Non-Executive Director	56	£5,001-£10,000	£0-£5,000	0	**	**	0
Ian Tighe, Director of Technology	50	£85,001-£90,000	£0-£5,000	0	£0-£2,500	£30,001-£35,000	4,300
Wendy Foers, Director of Human Resources	49	£85,001-£90,000	£0-£5,000	0	£0-£2,500	£20,001-£25,000	0
Fionna Moore, Medical Director	53	£60,001-£65,000	£0-£5,000	0	£5,001-£7,500	£15,001-£20,000	0
Mark Jones, Director of Finance & Business	43	£85,001-£90,000	£0-£5,000	0	£0-£2,500	£20,001-£25,000	0
Peter Bradley, Chief Executive	46	£125,001-£130,000	£0-£5,000	0	£0-£2,500	£5,001-£10,000	2,900
2002/03							
Sigurd Reinton, Chairman	61	£15,001-£20,000	£0-£5,000	0	**	**	0
Suzanne Burn, 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
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
Ian Tighe, Director of Technology	*	£80,001-£85,000	£0-£5,000	0	*	*	3,700
Wendy Foers, Director of Human Resources	48	£80,001-£85,000	£0-£5,000	0	£0-£2,500	£20,001-£25,000	0
Fionna Moore, Medical Director	52	£45,001-£50,000	£0-£5,000	0	£0-£2,500	£15,001-£20,000	0
Mark Jones, Director of Finance & Business	42	£75,001-£80,000	£0-£5,000	0	£0-£2,500	£15,001-£20,000	0
Peter Bradley, Chief Executive	45	£110,001-£115,000	£0-£5,000	0	£0-£2,500	£5,001-£10,000	1,500

* Consent to disclose age and pension entitlements withheld.
** As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.
Beryl Magrath was appointed as a non-executive director on 1st December 2003.

Management costs

	2003/04 £000	2002/03 £000
Management costs	**9,466**	8,473
Income	**167,920**	160,622

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.

	2003/04 Number	2003/04 £000	2002/03 £000
Total bills paid in the year	**64,476**	**50,879**	44,882
Total bills paid within target	**50,918**	**40,801**	36,846
Percentage of bills paid within target	**78.97%**	**80.19%**	82.10%

External financing

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

	2003/04 £000	2002/03 £000
External financing limit set by the NHS Executive	**3,631**	41
External financing requirement	**3,631**	41
Undershoot	**0**	0

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

Example of the assurance framework

Principal Objective	1
Principal Risk	Risk of not being able to identify that essential staff training has been provided due to incomplete and inaccessible training records (19). FM
Key Controls	Archivist appointed and action plan for archiving being produced, paper copies will be stored for 10 years as per HR Department; All H&S training records (except operational induction) are kept by HR Development. Long term aim to integrate all training records so that they are held centrally; Development of portfolios is included on most training courses. Template provided to training; Management training record; Tutor/student signatures for each session; Workshop - staff training; Records kept; Staff attendance record; Daily staffing; Late records; Sickness/absence records; Team brief; Records; Training records; Learner outcomes; Achievement records; Personal issue of instructions and guidance; Station record; LA401 (Personal Issue of documents)
Independent Assurance	State registration "Paramedics"; CHI (Jan-04); CNST; IHCD Accreditation
Management Assurance	Records Management - controls assurance self-assessment (yearly) OSU Audit on LA401s (Personal Issue of documents) (Sep-02)

As the Framework covers all of our organisation's main activities it is a key tool in examining the system of internal control that is in place to manage our risks. By identifying and examining the review and assurance mechanisms which relate to the effectiveness of the system of internal control it also helps contribute to the evidence in support of the statement of internal control.

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 કોઇ 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 ਐਂਬੁਲੈਂਸ 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

Photography:
Justine Desmond: *cover, p14, p19*
Andrew McArthur: *p7, p8-9, p10-11 middle, p15, p16-17, p18, p24-25, p28*
Evening Standard: *p23*
Media Resources Unit, London Ambulance Service NHS Trust: *p12, p13, p20, p26*

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