London Ambulance Service
NHS Trust

2008/09

Annual Report

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Jeśli pragnęliby Państwo ten dokument w swoim języku, proszę zadzwonić pod numer telefonu 020 7887 6678.

Patient Experiences

Our patient experiences team is your first point of contact if you have any comments, feedback or complaints about the service you have received from us.

To contact the team:

Patient Experiences
London Ambulance Service NHS Trust
St Andrews House
St Andrews Way
London
E3 3PA

patientexperiences@londonambulance.nhs.uk

020 7887 6678

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NHS Trust

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Who we are

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

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

The vast majority of our patients, however, have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. We offer a range of care to them, and recognise that many have complex problems or long-term medical conditions. Often these patients will receive better care somewhere other than at hospital.

We run a patient transport service which provides pre-arranged transportation for patients to and from their hospital appointments. In addition, we manage the Emergency Bed Service, a bed-finding system for NHS healthcare professionals who need to make arrangements for their seriously-ill patients.

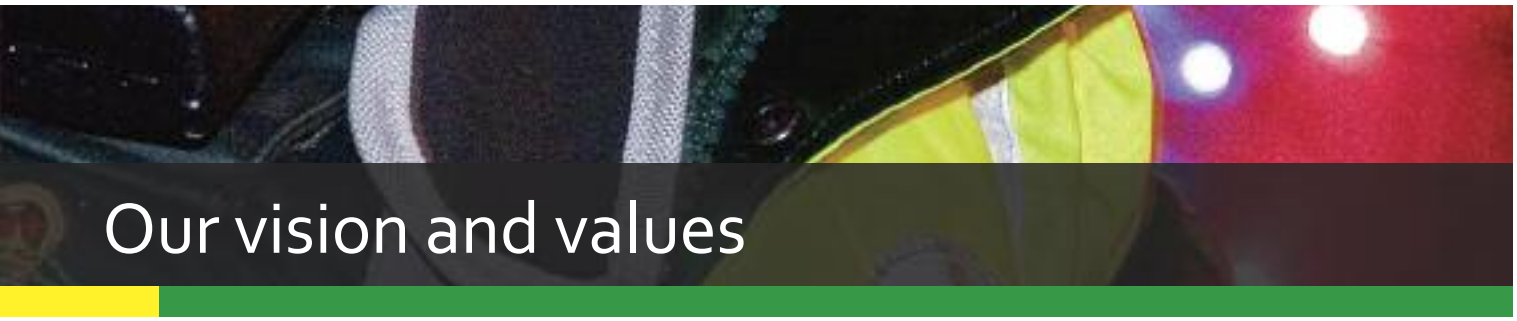
We are led by a Trust Board which comprises a non-executive chairman, six non-executive directors and five executive directors, including the Chief Executive.

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

We have more than 4,500 staff, who work in a wide range of roles across London. We provide an emergency healthcare service for over seven and a half million people living in the capital, as well as visitors and commuters to the city. This covers about 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

In 2008/09 we handled more than 1.4 million emergency 999 calls from across London and attended almost one million patients.

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



Our vision and values

"Our vision and values are at the very heart of everything we do."

Our vision is to meet the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job that they do.

Our values underpin everything we do – how we deliver our services and how we work with each other.

We believe in treating people with respect and courtesy and in valuing diversity.

We encourage communication and teamwork, and expect our staff to act with integrity.

We welcome innovation and new ideas, and want all our staff to provide the highest levels of care.

It is also important that each and every one of us accepts responsibility for our actions, and provides leadership and direction, always leading by example.

Chairman's views

After 10 years as Chairman, Sigurd Reinton shares his views for the final time.

As you prepare to step down as Chairman, what are your thoughts on how the Trust has changed during your 10 years here?

In 1999 the Trust was seen by the media, many Londoners, and ministers as failing. We were in financial deficit and not meeting our targets. Crews were working with out-of-date equipment, morale was low and relations between management and staff were poor.

Today, we couldn't look more different. The most visible change is the introduction of new ambulances, fast response cars, bikes, electronic information screens in our vehicles, satellite navigation equipment and new uniforms. Less visibly, there have been big improvements in clinical practice, stronger clinical leadership, better management and the introduction of partnership working. In recent years the Healthcare Commission has found us to be the best performing ambulance service in the country.

What stands out as the Trust's greatest achievement during this time?

Patient care has improved dramatically. For example, the survival rate to discharge from hospital for cardiac arrest patients has more than doubled in the last five years. We can now diagnose different types of heart attacks and take these patients direct to specialist units, leading to much better outcomes, and we are moving in the same direction with strokes. We can focus the care we provide to patients with specific needs and have introduced better pain management to make patients more comfortable. We routinely check blood glucose in all patients (which can help pick up early onset of diabetes), and are conducting clinical trials of improved resuscitation protocols.

What do you see as your legacy for patients in London?

Helping to change the way we deal with 999 calls to reflect the fact that while the vast majority are not about life-threatening conditions, nearly all are from someone with what they see as an urgent health problem. Historically, our emphasis was on trauma and other life-threatening conditions, and we could have taken the view that calling 999 about anything else is inappropriate.

Instead, we have accepted that 999 is, in effect, a portal into the NHS system and that it is up to us to differentiate our response so it matches the nature and urgency of each case. Thus we are responding ever faster to the most immediately life-threatening cases and often take these patients straight to specialist units for definitive treatment, bypassing accident and emergency departments. Where we know from the outset that the problem is not life-threatening, we will increasingly send an experienced clinician in a car, or carry out a telephone consultation to assess the patient, before deciding what is the best way to help. Then we can offer a much wider range of solutions, from the traditional blue-light ambulance transport to hospital, to referral to a wide range of local services or simple advice on self-help.

Is there anything you regret not doing before leaving?

Not qualifying to take calls in the control room or to work on an ambulance. I admire the work our people do with patients – whether on the phone or face-to-face – and thought that maybe I could find the time to learn those skills. Whenever I was doing ride-outs with crews, I felt helpless just standing there or at best carrying some bags. In the end, I could not find the time. I do regret that.

The Trust is applying for foundation trust status. What impact will achieving this have on the future of the organisation?

Not as much as many people seem to expect. We will always be focused on our main mission of excellent patient care, but there are things required of us as a foundation trust which we can turn to advantage – such as the engagement with Londoners and our partner organisations through the membership scheme. We will not suddenly turn into a profit-maximising corporation but will be able to make a surplus and plough it back into improved services.

What is your message to the new chairman of the Trust?

You are inheriting a great responsibility. Take care of the London Ambulance Service for me.

Sigurd Reinton CBE

Chief Executive's views

Chief Executive Peter Bradley talks about a challenging but positive year for the Service.

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

In a nutshell, I would say more care than ever before, more quickly than ever before. We reached over 47,000 more patients with life-threatening conditions within the Government's eight minute target than the year before.

However, one of the less visible aspects of the care we provide happens over the telephone. Over the last year our staff answered 999 calls faster than ever before, often within one to two seconds of the call being received. They provided more clinical telephone advice than ever before and our new clinical support team gave high quality support and advice to frontline staff with some of the difficult situations they have to deal with out on the road.

You have said that winter 2008/09 was the toughest you had seen for 10 years. How did the Trust get through this period?

We got through it like we always do during difficult times; everyone pulls together and helps each other. A sense of humour also helps. We worked more closely with hospitals and were able to agree diverts to other hospitals at busy times. The snow was the heaviest we had seen in London for many years. Our staff made real efforts to get into work, but those who relied on public transport had the greatest issues. We arranged collection points for them and overnight accommodation in some cases, but we need to make sure these arrangements are in place in advance in the future.

How did the Trust achieve the much tougher new Government performance target for reaching life-threatening calls?

Through a lot of hard work, determination and commitment across the whole of the organisation. We introduced new technology, dramatically improved 999 call answering, found increasing numbers of alternative treatment options for patients through our clinical telephone advice service and face–to-face assessment of our patients, and staff worked hard and long hours to help get us there.

How do you intend to improve the response to patients with potentially serious illnesses or injuries, which is still well below target?

We are the busiest and most heavily utilised ambulance service in the UK and probably the world. Working with the primary care trusts who buy our services, and following an independent review of our resourcing requirements, we have secured significant additional funding for 2009/10 and this will allow us to recruit an additional 400 frontline staff. This will mean for the first time we will be able to hit the target for this group of patients. More importantly, this will reduce the time our patients have to wait for an ambulance.

More than 300 frontline staff were recruited last year, with plans for a further 400 in 2009/10. What impact will these staff have?

Firstly, they will assist us in further reducing waiting times for patients during periods of high demand. We will have more ambulances on duty across London every day of the week. Secondly, the additional staff will allow us to release far more staff for clinical training. We have not been able to do this to anywhere near the level we, or our staff, have wanted to over recent years.

What are the priorities for this year?

We have a number of priorities during 2009/10, and I believe it will be the start of one of the most exciting periods in our history. We will for the first time have sufficient staff and vehicles in place to be able to meet our response time targets, while at the same time we will start to release existing staff for long overdue training and development. We will progress our application to become a foundation trust, roll out the new digital radio system, bring in a fleet of new ambulances and equipment, and we will continue to work with the rest of the NHS in London to improve clinical care for patients suffering major trauma, stroke and with an urgent care need.

Peter Bradley CBE

Our future plans

We are developing our services so that we can provide care that is better tailored to the different needs of our patients – whether they have life-threatening injuries or illnesses, less serious but complex conditions, or minor medical conditions for which they still need advice or treatment.

We are looking at how we can extend the care we offer by building on our strengths of being a healthcare organisation that is mobile and that operates across the whole of London 24 hours a day.

Our strategic plan, which will take us to 2013, outlines how we will achieve this.

Increasingly we are taking patients with life-threatening conditions to specialist units for treatment. For example, when we diagnose that patients are having a heart attack we will now bypass their local hospital and take them to one of eight heart attack centres in London. Here they receive specialist treatment which increases their chance of survival and reduces the time they need to recover. In the future we will also be taking stroke patients and those who suffer major trauma to specialist units.

As recently as 2000, we took all our patients to hospital for treatment. For many however this is not the best place for them to receive care. Increasingly we are treating more patients at home and are providing more clinical advice over the telephone. Our staff are referring more people to their GP or social services, or taking them somewhere other than hospital for treatment, such as minor injuries units. By 2013 we anticipate taking 200,000 fewer patients to hospital each year.

Our progress over the last year towards achieving our strategic plan is detailed in this section.

Improving access to our service

We are introducing new ways of working so that people can access us as quickly and easily as possible.

In 2008/09 we:

- signed a contract to provide a new system for answering 999 calls and sending resources to patients
- improved our current call-handling telephone systems in the interim, and increased the number of call-taking positions
- upgraded the technology and systems used by our Patient Transport Service
- took forward plans for introducing a text-based system to enable patients with speech or hearing impairments to contact us more easily
- continued to experience high usage of our translation service for callers whose first language is not English.

Improving our response to patients

We are providing better care and reaching more patients more quickly than ever before, and are working hard to develop the resources, skills and equipment to allow us to do this.

In 2008/09 we:

- introduced six more ambulance community responder volunteer schemes. Volunteers are trained in cardio-pulmonary resuscitation and the use of defibrillators (the machine used to re-start a person's heart when it has stopped beating), so they can treat patients in their local area before the ambulance crew arrive
- received the first of a new batch of high-specification ambulances
- increased our motorcycle response scheme by 12 vehicles to reach patients more quickly in built-up areas
- started sending vehicles to standby at locations where our data tells us the next 999 call is likely to come from, rather than basing crews at an ambulance station.

Developing our people

To ensure we can tailor care to meet individual patient's needs, we need to increase the size of our workforce, and ensure staff have the right skills and confidence to deal with a wide range of clinical conditions.

In 2008/09 we:

- recruited nearly 340 people onto our three-year in-house paramedic training programme, as well as 86 into A&E support and 87 to the role of emergency medical dispatcher
- began a pioneering new initiative at Barnehurst and Chase Farm stations to develop exemplary ambulance stations through the improvement of clinical leadership, the way frontline services are delivered, and how staff work together
- began the development of a programme to identify and develop our most talented staff
- developed a range of training modules to help operational staff diagnose certain types of heart attack and identify mental health issues
- delivered equality and diversity training to more than 150 staff and finalised plans to introduce psychometric testing for all new applicants
- agreed a new partnership agreement with the unions to enable constructive engagement with the Trust's management.

A 999 call is taken in our control room at headquarters

Computer-generated images of how the 2012 Games might look

Planning for the London 2012 Games

The Games will be the biggest planned event we have ever dealt with and we need to ensure we can maintain our normal service during this period.

In 2008/09 we:

- undertook study tours to Beijing during the 2008 summer Olympic Games and Vancouver for the test events leading up to the 2010 Winter Games
- attended the annual British Paralympic Conference to understand the requirements of Paralympians
- began to look for a location for an additional ambulance station for the Games, and worked to identify extra control room capacity to handle 999 calls
- identified our requirements for information technology
- undertook further modelling work to identify and understand the expected demand during the Games and areas where our staff will need to learn extra skills
- developed operational and contingency plans for the construction phase of the Olympic Park
- continued to work with partners involved in Olympic preparations and act as the UK coordinator for ambulance services involved in the 2012 Games.

Improving our governance arrangements

By improving our internal processes we are able to help our frontline staff to provide better patient care.

In 2008/09 we:

- began a pilot of a new automated staff administration system for paying overtime, staff expenses and managing annual leave
- identified a site in west London for a new workshop to support our plans to modernise the management of our fleet
- started using black box data recorders in our cars to support accident investigation if these vehicles are involved in a collision
- implemented new software to support the information and data collection we do for stakeholders (like the Care Quality Commission)
- started a pilot to computerise stock management, and began to introduce a new system to improve vehicle maintenance and accident reporting.

Our patients

In 2008/09 we attended 973,908 patients in London – three per cent more than in the previous 12 months and our highest number ever.

In this section:

Our cardiac care for patients, including the experiences of cardiac arrest survivor Tynisha Johnson-Ballantyne and heart attack sufferer Paul Le Vesconte.

How we are dealing with non life-threatening calls by giving advice over the telephone and increasing treatment for patients at home.

What we have learnt from our patients this year and the work we have done to engage with them.

Dealing with life-threatening calls

We continue to improve the care we provide to our patients with life-threatening injuries or illnesses. One area we are particularly proud of is our care for patients who have suffered a cardiac arrest or a heart attack.

Cardiac arrest *case study*

Five-month-old Tynisha Johnson-Ballantyne was with her mother, Yvonne (both pictured above), in Boots on Islington High Street when she suffered a cardiac arrest. Her heart suddenly stopped beating.

An ambulance was called while store staff started to give Tynisha cardio-pulmonary resuscitation (CPR) to keep blood and oxygen moving around her body.

As Tynisha was initially given CPR, her chances of survival increased to almost 39 per cent. During 2008/09, our community resuscitation team trained almost 11,000 people in CPR and basic life support. This will help to ensure that more and more Londoners have a better chance of surviving a cardiac arrest.

After arriving on scene, our staff re-started Tynisha's heart by giving her an electric shock with a defibrillator – a life-saving machine carried on all our emergency vehicles. During the past year we have installed 79 defibrillators in public places, taking the total to 488. Our community defibrillation team also trained or re-trained more than 1,180 people in 2008/09.

Tynisha was taken to University College Hospital for further treatment. She suffers from an enlarged heart, and was discharged from Great Ormond Street Hospital two weeks later with a pacemaker.

Our latest figures show we treated 458 patients in 2007/08 after they suffered a cardiac arrest*. Twelve per cent of these patients were discharged alive from hospital. This figure is down on the previous year, but is still almost double the survival rate of five years ago.

* This figure only includes patients whose cardiac arrest was witnessed and whose heart responded to an electric shock from a defibrillator.

Heart attack *case study*

Fifty-five year-old Paul Le Vesconte's wife dialled 999 one Sunday in summer 2008 when her husband was having chest pains. The couple were unaware at the time, but Paul (pictured above (left) with medical staff who saved his life) was having a heart attack. Their call was just one of the 100,000 plus received by the Trust last year from patients reporting chest pain.

Within minutes a blue-light response was at Paul's home. Our staff administered drugs to ease Paul's pain and used ambulance equipment to diagnose that he had a blockage in his heart. He was having a common, yet serious, type of heart attack.

Rather than take Paul to his nearest A&E in Bromley, our crew took him to King's College Hospital, one of eight specialist heart attack centres in London.

By taking patients like Paul direct to a cardiac catheter laboratory they receive specialised treatment, increasing their chances of recovery. We started to take heart attack patients to specialist centres in 2008, and were the first ambulance service to do so. Our latest research shows that in 2007/08, 1,280 patients, or 86 per cent of those diagnosed by our staff with a STEMI (a common type of heart attack), bypassed their local A&E and went straight to a heart attack centre.

At the specialist centre, Paul underwent primary angioplasty, a pioneering technique whereby a catheter is passed into the arteries in the heart and a balloon is inserted and inflated to release the blockage in the artery. It offers a much better chance of survival than the standard treatment, thrombolysis, which involves administering clot-busting drugs.

Paul was recovering back at home three days after his ordeal.

Care for stroke patients

Stroke, or brain attack, is the second-highest cause of death and the most common cause of adult disability in London.

Over three-quarters of strokes suffered by Londoners are caused by a blockage of blood flow to the brain These are known as ischaemic strokes. The other type – when blood vessels burst – are known as haemorrhagic. The treatment a patient needs in both cases is different.

We are working closely with other healthcare agencies to help to improve the care of patients suffering a stroke in the capital. We will soon take patients direct to a hyper-acute stroke unit where the correct life-saving treatment can be given straight away.

In February, we were also involved in a Department of Health campaign to highlight the FAST (Face, Arm, Speech, Time to call 999) test. This test allows people to recognise the symptoms of stroke, meaning they can react immediately and dial 999.

The Department of Health publicity poster for the FAST (Face, Arm, Speech, Time to call 999) test

Getting to patients faster

We receive an average of 865 life-threatening calls every day, and these patients need help as quickly as possible.

Since early 2008 we have been training volunteers in local communities in basic life-saving skills so they can attend and treat these patients while an ambulance is on the way.

Currently we have community responders in Biggin Hill, Bounds Green, Collier Row, Coulsdon, Enfield, Feltham and Purley. Six of these schemes were set up in the last year and we are planning to expand this to even more parts of London during 2009/10.

We have invested in other resources to help us respond more quickly. Our use of fast response cars, motorcycles and bicycles means we can navigate London's busy roads, narrow streets and pedestrian areas much better than in an ambulance.

We have expanded our fleet of bicycles to 60 this year, with the scheme extended to include Chelsea, Hammersmith, the Isle of Dogs and Heathrow's Terminal 5.

We have also invested in 12 new motorcycles, taking the total to 22, while we also have 200 cars operating across London.

From top: A community responder with the kit these volunteers carry; our cycle response unit at work in Heathrow Airport; our motorcycle response unit reaches patients quickly in busy areas; one of our fast response cars

Dealing with non life-threatening calls

For most of our patients it is not a case of life or death – and many now do not even need to leave their own home to be treated.

Advice over the telephone and providing urgent care

When patients with less serious injuries or conditions first make a 999 call to our control room, our call-takers assess their needs through a series of questions.

Calls that do not need an immediate ambulance response are then passed to our clinical telephone advice team. The team establishes what the best course of treatment is for the patient – it could involve being cared for at home, or being referred to the local pharmacy, GP or walk-in centre.

This team dealt with 64,027 calls during 2008/09 compared to 58,210 the previous year. An average of 40 per cent of these calls are dealt with without the need to send any vehicle to the patient.

The other 60 per cent of callers are given an assessment at home. We will send one of our emergency care practitioners, A&E support staff or a patient transport service crew to the patient.

These staff are able to treat the patient at home, or offer advice on the most appropriate way forward such as referral to a GP or walk-in centre at another time. This saves us approximately 16,000 ambulance journeys a year as just 54,000 of these calls are taken to hospital.

Treating patients at home

Our emergency care practitioners are paramedics who have been given extra training so they have the enhanced skills to assess and provide treatment if patients do not need or want to go to hospital.

The calls these staff respond to are specially selected and are generally our less urgent 999 calls that are complex enough to need a face-to-face assessment rather than telephone advice, but do not necessarily require a trip to hospital.

Our team of 65 emergency care practitioners can provide medication plans, make referrals or, if necessary, transport patients to a GP surgery or a minor injury unit. During 2008/09 they attended around 16,800 incidents, up from 14,000 in the previous year.

Our clinical support desk

Staffed by experienced paramedics, our recently-introduced clinical support desk provides advice and guidance to frontline staff with patient-related clinical problems.

Common reasons for calling include enquiries about unusual medical conditions, issues linked to patient consent, and drug and patient protocol questions.

Providing pre-arranged patient transport

As well as our 999 service, we offer pre-arranged transport for patients to and from their hospital appointments. In the last year 331,113 of these journeys took place.

We delivered patients to hospital on time in 90 per cent of the journeys (up from 89 per cent the year before) and departed hospital on time in 92 per cent of cases (89 per cent in 2007/08). And complaints remained low at less than one per 10,000 journeys.

Whereas our 999 service is available to all Londoners, our Patient Transport Service operates on a contract basis. During the year we won eight new contracts including those with Lambeth Primary Care Trust, Whipps Cross Hospital and Barnet, Enfield and Haringey Mental Health Trust. We lost one contract with Royal National Orthopaedic Hospital in Stanmore. Our total number of contracts at the end of the year stood at 28.

We have continued to improve the experience for our patients by helping staff to attain further qualifications in road passenger transport.

Our bed-finding service
During the year we began to record information about hospital capacity, meaning we can better manage where we take our patients, because we know where there will be free hospital beds on arrival.

This builds on our national intensive care bed register for critical care beds in three quarters of England. We help with antenatal transfers too and act as a co-ordinator for the Neo-natal Transfer Service in London, Kent, Surrey and Sussex, which transports sick babies between hospitals.

We manage around 10,000 referrals a year for NHS professionals as we help them to find beds and arrange transport for their acutely-ill patients.

Focusing our care

Every patient we attend is different and we continue to review the way we deliver care to our patient groups.

Frequent callers
At any one time we have over 100 callers London-wide who make repeated 999 emergency calls. These frequent callers have a significant impact on our service, but sometimes need support in accessing alternative care. For this reason, we are working with these patients and relevant health and social care professionals to find more appropriate help for them.

Patients with alcohol-related illnesses and injuries
We now deal with nearly 60,000 emergency calls a year for patients who are ill or injured because of alcohol. Since the introduction of new licensing laws in 2005 these calls have gone up by nearly 24 per cent.

Dealing with these calls – which now amount to more than six per cent of our workload – puts a strain on our service and potentially diverts our resources away from people with life-threatening conditions. Friday and Saturday nights are the busiest for alcohol-related calls, so to help cope with demand we run an alternative response vehicle – the 'booze bus' – to go specifically to patients who are drunk, thus saving our other ambulances for more serious calls. In previous years the booze bus only worked during December, but in 2009 it was announced that the vehicle would continue permanently.

In the run-up to Christmas our treatment tent at Liverpool Street station dealt with more than 155 drunk patients in the City over nine shifts during the party season. A pilot took place in Camden to deal with alcohol-related calls by using an alternative response vehicle and aiming to treat patients without taking them to hospital. The initiative was funded by the primary care trust and was run in partnership with the local authority, police and other agencies.

Vulnerable children and adults
We have done a lot of work to improve the reporting of incidents involving children and vulnerable adults and to develop communications with other agencies. At a local level, we have safeguarding leads, who are responsible for liaising with the local authority, primary care trust and safeguarding board. Our responsibility is to ensure concerns are passed to the relevant agency to take appropriate action.

In 2008/09 we made 702 child protection referrals, up from 659 the previous year. In addition there were 2,982 vulnerable adult referrals compared to 2,720 in 2007/08. We also have a safeguarding group to develop strategic policy and practice. Last year the group led pan-London clarification of our role in sudden unexpected death in infants, children and adolescents, which we hope will influence national ambulance practice.

A member of staff treats a drunk patient collapsed on a tube station platform

Individual care plans for patients
Since 2000, patients or their supervising clinician have been able to contact us and ask for a specific treatment to be carried out, or for them to be taken to a preferred place of care. This is beneficial for patients such as those awaiting organ transplants where they have special machines to assist organ functions that need to be handled in a specific way. Another example is children who have complex seizure patterns and who require drugs that are not in normal ambulance practice.

We have been recognised by the Department of Health for our system for recording clinical care plans for patients who are at the end of their lives. These patients' addresses are flagged so that we can pre-alert crews and make them aware of the patient's care plan.

Under these agreements, our staff can legally administer a named drug for a named patient if that drug is in the house; they can stop resuscitation if there is sufficient evidence of an end of life care plan, and it is acceptable in many circumstances to hold the patient's hand and allow them to quietly die. Our crews can contact our clinical support desk for help in these situations; the desk has access to all the correspondence and records that led to the formulation of the care plan.

We currently have 1,624 care plans for patients in London.

Learning from and engaging with patients

Learning from our patients, either by evaluating care or inviting feedback, allows us to continually develop and improve for the future.

Clinical audit and research
We examine a random sample of five per cent of patient records completed by our staff to check that the right care was given and best practice was followed. By doing this we can give constructive feedback to staff, and develop our practices for the future.

We routinely audit cases involving cardiac arrests, acute coronary syndrome and difficulty in breathing. We have also taken part in a national audit which benchmarked us against other ambulance services in England for the care we provide to patients with asthma, or those who have had a stroke or cardiac arrest.

Last year, we undertook a clinical audit of the care provided to obstetric patients who are transported to the Royal London, Homerton and St George's hospitals. Obstetrics is the surgical speciality dealing with the care of women and their children during pregnancy and childbirth. The audit examined the quality of care provided to routine and emergency obstetric patients from the initial 999 call to admission at hospital. The findings of the audit will be used to inform future practices aimed at improving patient care.

We are at the forefront of developing best practice for dealing with specific illnesses and injuries. This year we gained funding from The Stroke Association for a two-year research project to evaluate the best way for us to assess patients suspected of having a stroke. We hope the project will help us identify more stroke cases.

We are nearing completion of the Smart CPR project, which is looking at new ways to help patients whose hearts have stopped beating. For this project, we are collaborating with New York's Emergency Medical Service to see whether there is an improved rate of survival.

Patient experiences
All patient-related complaints, queries and concerns about our Trust are now managed through the patient experiences department.

The changes follow calls from the Government for a new, simpler process for handling complaints. We were chosen by the Department of Health to take part in an early adopter programme for the 'Making Experiences Count' initiative.

Last year, our patient experiences team received 5,604 enquiries which was a 19 per cent increase on the previous year. Enquiries vary from requests for medical records (1,013), issues about ambulance delays, the clinical care provided, and staff attitude. We also received 362 complaints, down from 539 the previous year.

We use feedback as a learning opportunity and publish examples of changes made arising from service user feedback on our website.

One of our A&E support staff listens to a patient describe her symptoms

We are proud of the 'thank-yous' our staff receive. During the year, these expressions of appreciation totalled 859, compared to 783 in the previous year.

We aim to be as open and transparent about our work as possible and publish documents, minutes from meetings and reports on our website. Enquiries are still made through the Freedom of Information Act and in 2008/09 our team handled 154 of these, compared to 119 in the previous year. As with the year before, the majority of the requests did not require the use of the Act to access the information.

Our work in the community

Our staff regularly go out in the community to educate people about the work that we do.

Ten members of staff involved in public education attended a development programme last year which was designed with the help of South Bank University.

Our staff took part in a range of activities including knife and gun crime awareness events, talks to groups of older people, and school visits including one to a school for blind and partially-sighted children where the aim was to reduce their fear of ambulances and sirens. Dozens of staff have also been involved in the multi-agency Junior Citizens Scheme, teaching thousands of primary school children about first aid and giving advice on how to make a 999 call.

In the Barnehurst and Chase Farm areas we have appointed community involvement officers to work closely with community groups, partner organisations, patients and the public. These staff look at how we manage frequent callers and our list of addresses where previous experience suggests our staff may be at risk of physical or verbal abuse.

We launched a new website at www.londonambulance.nhs.uk with the aim of raising awareness of the opportunities to work for us, the work that we do and what people should do in a life-threatening emergency. Around two million commuters saw our 'use us wisely' message displayed on posters at London Underground stations. The posters were designed to remind people about the other healthcare options available to them instead of calling 999. The posters also appeared in local and regional newspapers.

The homepage of our new website: www.londonambulance.nhs.uk

A staff member talks to young people about the importance of safe driving

Patients have their say

We learn from our patients by finding out what they think. Our Patients' Forum, although not a statutory body anymore, continues as an independent charity and we remain closely involved with it. We have also started to develop relationships with Local Involvement Networks (LINks), which have replaced the Patients' Forum and have been set up in each borough. The role of the LINks is to find out what people want, monitor local health and social care services and use their power to hold local authorities and other service providers to account.

Our annual patient care conference in summer 2008 focused on the future of healthcare in London. One of the breakout sessions was led by a group of year 11 students from schools in Barking and Dagenham who had carried out a work experience project for the Trust, finding out about young people's views of us.

We were a pilot site for a new national survey, commissioned by the Department of Health and conducted by Picker Europe, looking at the experiences of patients receiving a Category C response (when illness or injury is reported to be neither serious nor life-threatening) from the ambulance service. The full national survey was carried out late in 2008 and 97 per cent of respondents said that they had received a good, very good or excellent level of care from us. Trust staff attending the calls were also found to be reassuring. Ninety-seven per cent of patients said that they felt reassured and 99 per cent had trust and confidence in the staff who attended them. Patients felt they were treated with dignity and respect (97 per cent) and 98 per cent felt staff explained their care and treatment in a way they could understand.

Our people

Demand on our service is increasing every year and it is vitally important we meet the challenge with a skilled, motivated workforce that has first-class patient care as its top priority.

In this section:

News on our largest ever recruitment campaign and the experiences of one of our new members of staff, Joanne Wood.

Hear from peer support worker Jackie Bishop and how our staff support schemes are going from strength to strength.

Details on our latest awards for members of staff and the processes we have in place to recognise the work they do.

This year saw the start of our largest ever recruitment campaign. A new role of student paramedic was created and 340 people were successfully appointed to the three-year training programme.

Recruitment *case study*

Our recruits have come from all walks of life. Previous careers include a charity worker, law student and a Royal Marine.

One new member of staff was 27-year-old Joanne Wood (pictured above), who previously worked on a farm. She joined us in late 2008 and was posted for classroom-based learning at our new training centre at Elephant and Castle. Joanne and her colleagues took part in nine weeks' studying on courses which have been designed and delivered in-house. She then completed a three-week driving course before her first placement in north east London. She put into practice all the skills learnt in the classroom under the supervision of experienced staff, who act as mentors. After 150 hours' work experience, it is back to the classroom for the next stage of learning.

With more than 400 further recruits planned for 2009/10, we are well on track with our long-term workforce plan which aims to see frontline numbers increase by a fifth to more than 3,000 by 2010.

This year we also appointed 86 new A&E support staff, the skill level we introduced in the recognition that some of our patients do not need to be treated by staff with paramedic or emergency medical technician skills. This role frees up accident and emergency crews to attend to patients with serious or life-threatening illnesses or injuries.

A further 87 people were appointed to work in our control room as emergency medical dispatchers – the people who answer 999 calls and help send ambulances. These staff, along with our other new starters, brought our total workforce to 4,634 compared to 4,127 last year. Staff turnover also decreased slightly to 6.82 per cent. Trust-wide sickness absence stood at a little over five per cent on average for the year.

Staff training

To support the student paramedic course we have begun an ambitious programme to train our fully-qualified staff to act as mentors to the trainees and oversee student paramedic placements. So far, more than 500 staff have completed module one of this training.

As well as our in-house student paramedic course, we have 316 staff at three universities in the South East.

At the University of Herfordshire, 49 of our staff are enrolled on a part-time paramedic science degree programme. It runs over five years and we offer sponsorship in the form of payment of academic fees and study leave allowance. So far, 194 of our staff have gained a certificate award for completing the first year of this course, with a further 370 graduating at diploma level (by completing three years of this course) or degree level (by completing all five years).

We run a full-time four-year paramedic science BSc (Hons) degree in partnership with the University of Hertfordshire. We support 112 students on this programme, where they spend the third year of their studies on a fixed-term contract working with us.

We also have 155 students on our foundation degree programmes based at the University of Hertfordshire, University of Greenwich and St George's University of London. These students spend half of year two and year three working for us.

As well as our training for frontline staff, there is an extensive programme of learning for non-operational and non-clinical staff. This includes short courses, career counselling and leadership development.

Equality and diversity

We are committed to promoting equality and valuing diversity in all that we do. We are working to make sure our staff better reflect the community they serve and that the services we provide more effectively meet the needs of our patients.

We carry out annual equality reporting on employment and training, service delivery and how we engage with our workforce.

We have two staff diversity networks; Glass (Gay and Lesbian Ambulance Service Society) and Label (London Ambulance Black and Ethnic Liaison). These bodies encourage two-way communication between all groups, enabling greater consultation and informed input into policy development and review.

We have maintained our 'Two Ticks – positive about disabled people' accreditation, and we are a member of Stonewall's Diversity Champions Programme and the Employers' Forum on Disability. We have recently joined the

Staff support *case study*

Our LINC peer support scheme has gone from strength to strength and this year celebrated its fifth anniversary.

LINC, which stands for listening, informal, non-judgemental, confidential, now has 80 members of staff trained to provide support to colleagues. Duty Station Officer Jackie Bishop (pictured above) has been a LINC worker since the scheme began and is also one of six senior LINC workers who take it in turns to provide a 24-hour on-call service.

The volunteers support colleagues following attendance at traumatic calls, through personal and relationship issues, and with practical issues by pointing them in the direction of expert advice.

Some LINC workers have taken extra training to deliver support to groups of staff following particularly traumatic incidents.

The scheme was this year commended by the Health Professions Council.

Other support schemes include occupational health and counselling services for all staff. We have also introduced the first in a series of stress management workshops for staff this year.

In the run-up to the London 2012 Games, we are offering interest-free loans to help staff to buy a bicycle. Other benefits offered to staff include interest-free season ticket loans, an option for flexible working and childcare vouchers.

Employers' Forum on Belief and the Employers' Forum on Age. Membership of these forums helps us to promote equality throughout the Trust.

To ensure we are prepared for the requirements of the forthcoming Equality Act, a new Equality and Diversity Strategy is being drawn up, supported by a steering group.

Rewarding staff

Outstanding members of staff were praised at our awards night in summer 2008.

There were eight categories of awards, with all 11 winners nominated by their colleagues for the work they do.

During the evening some former patients were reunited with the staff who treated them.

Our recognition process for staff who have reached long-service milestones saw 268 staff during the year celebrating periods of service from 10 years up, including one person who had completed 45 years with us.

Ambulance Operations Manager Steve Colhoun was named NHS Champion 2008 for the support he gave to his staff when Paramedic Ron Pile was tragically killed in a motorcycle accident.

And Emergency Medical Technician Frank Samaras reached the finals of the Daily Mirror Pride of Britain awards, narrowly missing out on the Emergency Services person of the year award in a vote cast by viewers of GMTV. Frank showed outstanding bravery when he left the safety of his ambulance to confront a violent attacker and protect two members of the public.

Our charitable work

Staff came together last August to support 7 July bombing survivor Gill Hicks on her 200-mile walk from Leeds to London. About 20 staff took turns to accompany Gill on the four-week WalkTalk event.

Our staff also raised money for charities by running the Flora London Marathon and taking part in other events.

Finding out what staff think

This year's NHS staff survey rated us above average for ambulance trusts for our good communication between managers and staff and the number of staff having yearly appraisals.

As a result of some less positive findings however, a number of staff action groups will be set up for 2009/10. For example, the survey showed a 10 per cent rise in those not receiving the training identified in their personal development plan – up to 53 per cent from 43 per cent.

A total of 842 staff were randomly pre-selected to complete the Healthcare Commission NHS staff survey, with 40 per cent returning their questionnaires.

Keeping staff safe

The results of the staff survey showed an increase from 16 per cent to 21 per cent in the number of staff reporting physical violence from patients or patients' relatives.

We continue to press for prosecutions against people who assault our crews. In one case, a man who punched an emergency medical technician was found guilty and given a 12-month conditional discharge and ordered to pay costs.

We provide our staff with personal safety training, which teaches them how to display non-aggressive body language and the safest way to approach patients in potentially violent situations.

By the end of March 2009, we held a list of 1,750 patient addresses where previous experience suggests that there may be a risk to our staff of physical or verbal abuse. This high risk register helps to protect staff from being sent into potentially dangerous situations. When we receive a call to a flagged address, we immediately notify the police. We will not enter the property until they are in attendance.

7 July bombing survivor Gill Hicks with Trust staff and supporters during her charity walk from Leeds to London

Our performance

We reached 25 per cent more patients with life-threatening injuries or illnesses within eight minutes compared to the previous year. Those 47,172 patients would fill half of Wembley Stadium.

In this section:

How we are reaching more patients more quickly than ever before.

How we achieved this performance for our patients despite the challenge of unprecedented demand, new targets for reaching patients and the worst winter weather for many years.

How our work was also recognised by the Healthcare Commission who gave us a favourable rating in the annual health check.

2008/09 was our busiest ever year, with overall demand up by three per cent. The cold weather was one cause, coupled with the flu and winter vomiting virus.

Snow patrol *case study*

During the first few days of February, London experienced its heaviest snowfall in 18 years. Slips, trips and falls led to nearly 5,000 calls a day, compared to 3,800 on a normal day.

Buses, trains and tubes did not run and ambulance staff had to make a considerable effort to get to work. The control room, based in central London, was most affected as many staff rely on public transport to travel to work.

Emergency Medical Dispatcher Patricia Smith travelled in by car as the snow fell. Working in the control room her role is to send out emergency vehicles to incidents in the south west of London.

By mid-morning, Patricia found that about half of the vehicles she would normally have available to dispatch were unavailable. The remaining ambulances used 'snow socks'; the specially designed tyre covers allow our vehicles to drive safely in dangerous, slippery conditions.

However, while it was almost impossible to reach patients as quickly as normal, we maintained our service to the people of London. Patricia's colleagues who were taking 999 calls began advising people with less serious conditions to consider making their own way to hospital or a minor injuries unit. NHS Direct also helped by dealing with some of our lower priority calls.

It was a difficult period for everyone involved, but we are proud of the effort and commitment staff demonstrated.

Managing demand

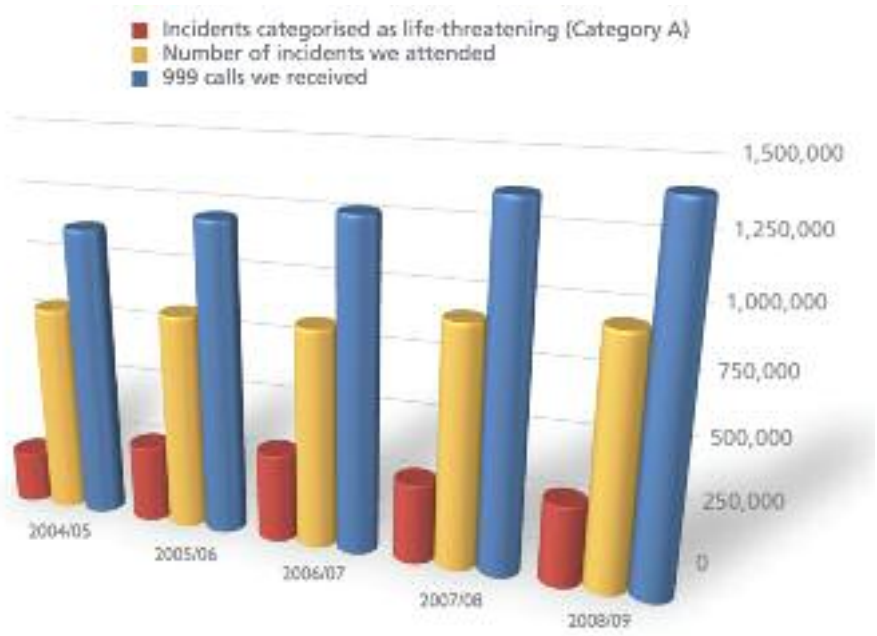
The three per cent increase in overall demand for 2008/09 underplays the months of November and December when we experienced our busiest ever weeks.

During one week in December ambulance staff responded to 20,939 emergency incidents across the capital – an increase of nearly eight per cent on the average of the previous four weeks.

The pressure was compounded by a high number of calls initially treated as being immediately life-threatening, and delays at hospitals while staff waited to hand over patients.

As a result of these issues, we raised our pressure level from 'severe' to 'critical' for the remainder of December and early January – the first time that it has reached this level since the capacity levels were introduced.

Emergency demand



* Note: Incident numbers for 2006/07 do not include 'urgent incidents'. These were first introduced in 2007/08

The levels trigger a range of pre-determined measures to help us cope with periods of additional pressure and ensure we do everything possible to protect patients across London in times of excessive demand. We escalated to 'critical' again in early February when it snowed heavily, and operated no lower than 'severe pressure' throughout the rest of the year.

The party season in the build-up to Christmas generated a high number of alcohol-related calls. On New Year's Eve extra staff were on duty to help manage the 1,761 calls received between midnight and 4am.

We used extra resources, such as an alternative response vehicle and staff on foot with medical equipment, and worked with St John Ambulance to provide 13 temporary treatment centres.

Changes to how response times are recorded

An added challenge came from new national standards measuring our response times which began in April 2008. The 'clock' now starts as soon as a call is connected to the control room, rather than after key details about the patient are recorded.

The changes mean that our measured response time is now closer to that experienced by our patients. Our recorded response times now start approximately two minutes earlier than they did, while our response time target of eight minutes remains unchanged – so patients are getting a better service from us.

New technology has played a part in reducing patient waiting times. We now use existing call data to predict where the next emergency call is likely to come from, meaning we can place ambulance crews closer to incoming 999 calls. Instead of our crews waiting for emergency calls at ambulance stations, they are now able to provide cover from standby points within the community. This system is used in other areas of the country and is a proven way of reducing the waiting time for patients.

Our system that allows us to automatically dispatch our ambulances continues to reduce the number of patients waiting for an emergency crew. The system won two top regional prizes last year at the NHS Innovator London Awards and the Health and Social Care awards in the Innovative Information and Communications Technology category.

Meeting our targets

Each time a 999 call is received into our Emergency Operations Centre, our staff assign the call into one of three categories depending on its urgency.

To do this our call-handlers use information about the nature of a patient's illness or injury, sophisticated software and their own skills and experience.

The most serious calls are classed as Category A, where it is assessed that there is an immediate threat to life. Serious incidents are prioritised as Category B calls, while those which are neither serious nor life-threatening fall into Category C. Each call then receives a response proportionate with its categorisation.

The Government-set performance targets require us to reach patients within nationally-agreed timescales, depending on the categorisation of the call.

For 2008/09, the targets were to reach:

- 75 per cent of Category A calls within eight minutes
- 95 per cent of Category A calls within 19 minutes
- 90 per cent of Category B calls within 19 minutes (this target was agreed with our commissioners for one financial year only and was previously 95 per cent within 19 minutes).

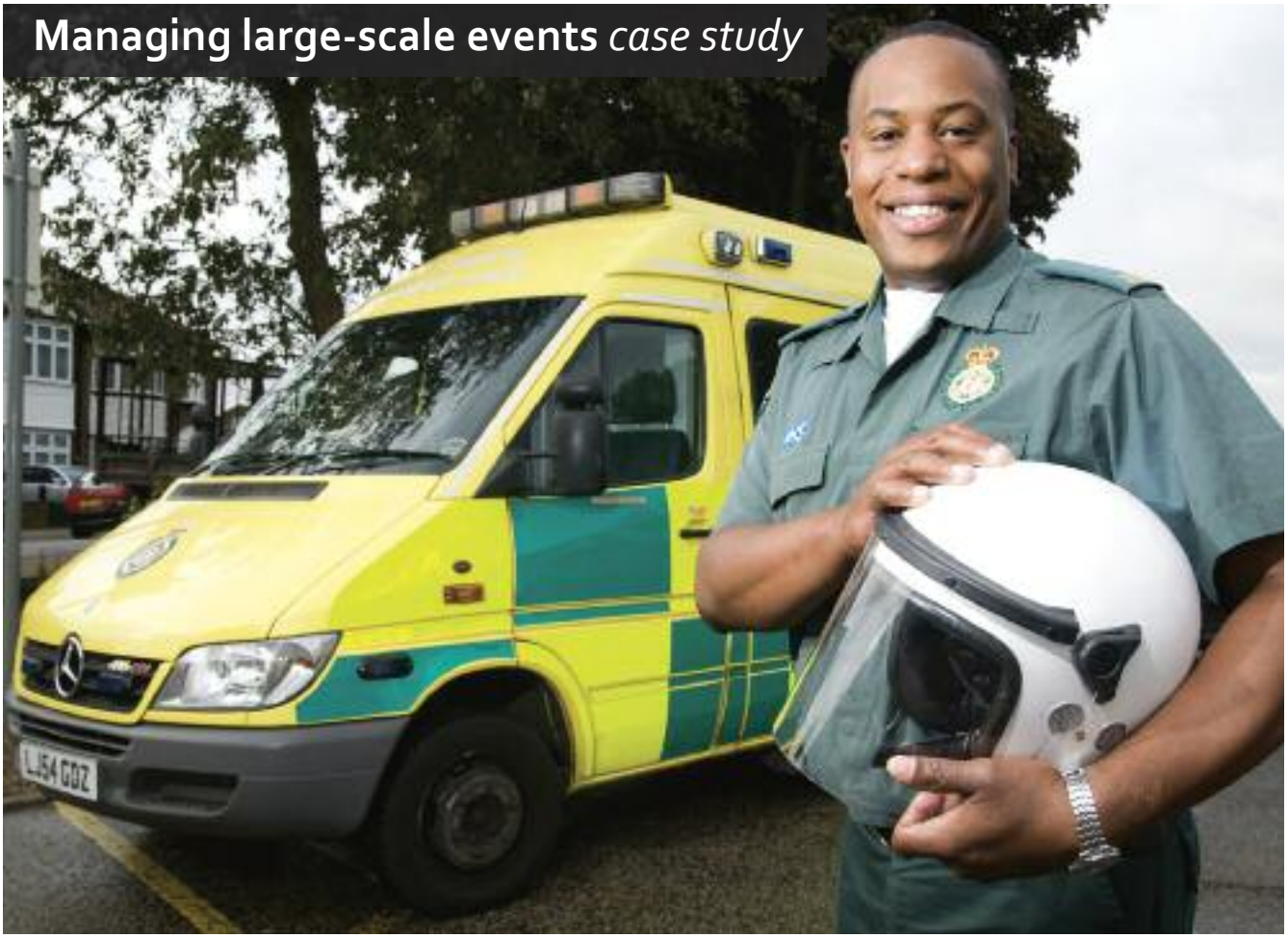
However, for the first time this year, the new call connect performance standards effectively meant that our target time was roughly two minutes shorter than previously.

The figures below show how we performed against these new targets. We have also included comparisons to the year before.

In 2008/09 we responded to:

- 75.5 per cent of Category A calls within eight minutes. This is equivalent to 83.6 per cent if measured against the previous system (under which we achieved 79 per cent in 2007/08).

Managing large-scale events *case study*



One of the most challenging weeks in recent years occurred at the start of this spring when thousands of demonstrators descended on London ahead of the G20 summit, a high-profile meeting of world leaders.

Six months of extensive planning within the Service, and close work with the police, St John Ambulance and other ambulance services, meant we were well-prepared for the event.

A&E support worker Lyndon Allen (pictured above) was just one of an additional 547 members of staff brought in over the four-day period. Lyndon worked to make sure staff and emergency vehicles were well stocked with safety and medical equipment.

Staff in our incident control room at headquarters monitored the events ensuring that Londoners dialling 999 were not adversely affected by the disturbances in the city. In all we treated 40 patients connected with the event.

Other large-scale events managed during the year included the London Marathon, New Year's Eve celebrations, the Notting Hill Carnival and the Wimbledon tennis championships.

- 99 per cent of Category A calls within 19 minutes, an increase on our performance in 2007/08 of one percentage point.
- 84.5 per cent of Category B calls within 19 minutes. This is equivalent to 86.3 per cent if measured against the previous system (under which we achieved 85 per cent in 2007/08).

During 2008/09 we also:

- received a total of 1,423,496 emergency calls, compared to 1,389,660 in 2007/08
- attended a total of 973,908 emergency incidents, compared to 945,776 in 2007/08. Of these, 319,677 were classed as Category A, compared to 315,744 in the 12 months before
- sent 1,352,996 emergency vehicles to these incidents, compared to 1,279,441 the previous year
- undertook 289,192 special/planned patient journeys, compared to 279,457 in the year before. These journeys are pre-booked through us by healthcare professionals and include hospital and hospice transfers.

Maintaining good governance

The annual health check by the Healthcare Commission in October 2008 judged us as 'good' for our use of resources and our services. This meant we maintained the standards we had set the year before, despite an increase in demand.

Preparing for the unexpected

Our staff need to be prepared for anything in the capital. This year alone saw a five-day vigil at an unexploded World War Two bomb, a plane crash into a housing estate in Farnborough and, most recently, a fire at Northwick Park Hospital which led to the evacuation of 170 patients.

To help us prepare for these events, we take part in major incident tests with agencies such as the fire brigade, police and local authorities. At Coppermills Water Treatment Works in Waltham Forest staff tested responses by using the scenario of chlorine gas being accidentally released.

We also hosted the first national ambulance seminar on emergency preparedness to share information on lessons learnt from a range of serious and major incidents such as the 2005 London bombings.

We have expanded our specialist team that treats patients in hazardous circumstances. Eighteen members of our hazardous area response team also completed an intensive three-week training scheme in urban search and rescue. They now work closely with the London Fire Brigade at incidents where access to patients is difficult, such as on building sites, river banks, in deep tunnels or up on a roof.

Our responsibility for the environment

We are very aware of our impact on the environment and have a responsibility to make the service we provide as green as possible.

We have been taking steps to offset our environmental impact, such as:

- promoting a reduce, reuse, and recycle policy throughout the Service
- replacing our ambulances with new, fuel-efficient vehicles that have lower CO^2 emissions
- increasing the use of telephone advice which has reduced ambulance journeys by 21,000 in 2008/09
- looking at vehicle specification based on CO^2 emissions rather than engine size
- introducing a staff 'bicycle loan' scheme
- having battery management systems and LED lighting for new vehicles which use less fuel than older models
- recycling cans, paper, cardboard and plastic at 90 per cent of our sites, with all sites expected to do so by the end of 2009
- sending used printer cartridges to be refurbished
- introducing collection points for used batteries and glass
- shredding all confidential waste on site before it is recycled
- recycling almost one fifth of our waste with plans to increase this over the coming months.

Our staff at work during the G20 demonstrations

The Trust Board

The Board

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

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. The non-executive directors are appointed by the same method but independently through the Appointments Commission. All executive appointments are permanent and subject to normal terms and conditions of employment.

All of our non-executive directors make up both the Service Development Committee and Remuneration Committee. The Audit Committee comprises Roy Griffins, Brian Huckett, Caroline Silver and Sarah Waller and meets on four occasions during the financial year. It considers all matters of probity, monitoring and advising on appropriate standards for risk management, internal control and financial propriety. The committee reviews matters connected with the audit and approves the Trust's accounts.

Beryl Magrath chairs our Clinical Governance Committee, whose membership also includes Sarah Waller and until recently Ingrid Prescod. Our Charitable Funds Committee is chaired by Caroline Silver.

Non-executive directors

Sigurd Reinton CBE was first appointed as Chairman in October 1999 after having held the same post with Mayday Healthcare NHS Trust for two years. He has been chair of our remuneration committee, and was made an honorary CBE in the 2008 New Year Honours list. Sigurd is a director of NATS Holdings, the provider of air traffic control services in UK and North Atlantic airspace and for the main UK airports. He is a former director of international management consultancy McKinsey & Co. Sigurd stepped down as our Chairman at the end of June 2009, having served three terms, the maximum allowed.

Richard Hunt CBE took up the position of Chairman in July 2009. He has specialised in logistics for over 20 years and until recently was international president of the Chartered Institute of Logistics and Transport. He was appointed CBE for services to logistics and transport in the 2004 New Year honours.

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

Dr Beryl Magrath MBE took up her post as non-executive director in 2005, and is chair of our clinical governance committee. She is a former consultant anaesthetist and previously worked at Bromley Hospitals NHS Trust in Kent. She was a founder of South Bromley HospisCare in 1984 and was medical director of Bromley Hospitals NHS Trust between 1992 and 2000. Beryl is now a trustee of Harris HospisCare and serves as a school governor for a Bromley primary school.

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

Caroline Silver took up her post as a non-executive director with us in March 2006 and is chair of our audit committee and the charitable funds committee. A chartered accountant, she has recently been appointed vice-chairman, EMEA Investment Banking at US investment bank Merrill Lynch. Previously she was vice-chairman of the Investment Banking Division at US investment bank, Morgan Stanley. In her 13 years at Morgan Stanley, she specialised in advising on international mergers, acquisitions and financings, particularly in the financial services and healthcare sectors. Previously, she worked at Price Waterhouse (now PwC) and at Morgan Grenfell (now Deutsche Bank).

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

Dr Ingrid Prescod took up her post as a non-executive director in April 2006. She left the Trust in April 2009 due to other commitments. At the time of publication a replacement has yet to be appointed.

Executive directors

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

Deputy Chief Executive Martin Flaherty OBE joined the Service in 1979. His career has included time spent as a paramedic, followed by 20 years as a manager in a variety of positions. He became an executive director in April 2005 and was responsible for coordinating the emergency medical response to the 7 July bombings that year. He was the recipient of an OBE in the 2006 New Year Honours. Martin took up the newly-created role of Deputy Chief Executive in May 2009 following four years as Director of Operations.

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

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

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

Meetings

The Trust Board meets every two months on Tuesdays from 10am in the conference room at our headquarters.

The remaining meetings of 2009 will be held on 29 September and 24 November.

We comply with the code of practice on openness in the NHS and our Trust Board meetings are always open to the public, with time set aside for their questions at the beginning and end of the meetings.

Directors

Director of Information Management and Technology Peter Suter was appointed in November 2004, after serving as Head of Information Technology at Sussex Police for 10 years. Before that, he had worked for Siemens-Nixdorf, GEC in South Africa, and BT. He is joint chair of the Trust's Information Governance Group and currently chair of the National Ambulance Service IM&T Directors Group. Peter holds a BSc in Information Technology from the Open University.

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

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

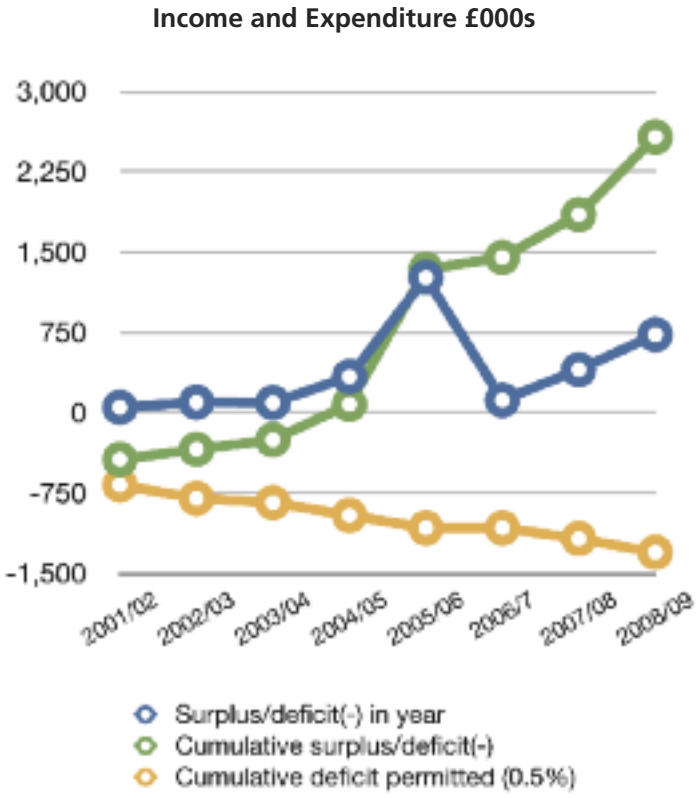
Director of Corporate Services Sandra Adams took up this newly-created post in July 2009. Sandra joined us from Moorfields Eye Hospital NHS Foundation Trust, where she had project managed its application to become one of the first NHS foundation trusts in the country. Previously she worked on the London Patient Choice Project which aimed to improve patient satisfaction and waiting times, as well as in operational posts in acute and community services, and as a commissioner in posts in South East and South West London.

Director of Communications David Jervis joined us in 1995, after serving as Head of the Press Bureau at the Metropolitan Police. The decision was taken to disestablish David's role and he left the Trust in December 2008.

2008/09 financial summary statements

Financial review

We fulfilled three of our statutory financial duties in 2008/09:



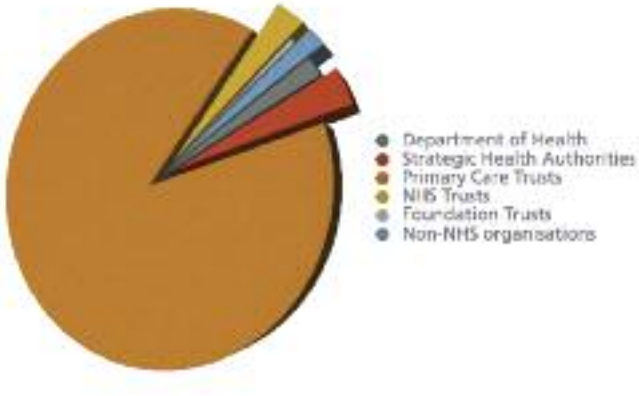
Our surplus in 2008/09 meant that our cumulative position improved for the eighth year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

1. On income and expenditure we reported a surplus of £725,000 for the year, and therefore did better than the break-even target set by the Department of Health for 2008/09.
2. We achieved its external financing limit (EFL) for the year.
3. A return on assets (the capital cost absorption duty) of 4.2 per cent was achieved. This was not within the permitted range of three per cent to four per cent. The variance from 3.5 per cent is due to the fall in value of land and buildings attributable to the current economic downturn.
4. In the capital programme £14.6m was spent on a range of projects, including ambulances, new technology projects, and projects to improve the estate. Overall we underspent by £1,247,000 against our capital resource limit, which we are permitted to do.

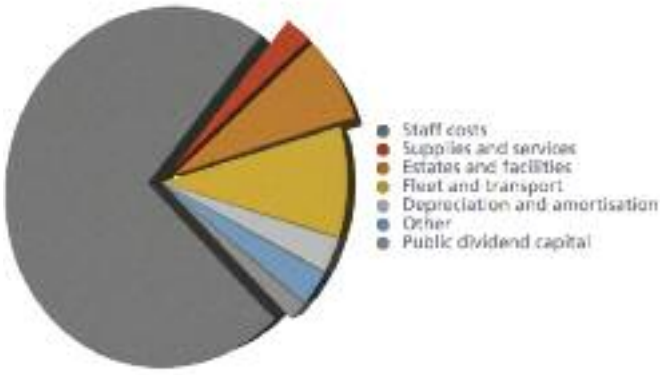
We were able to pay 85 and 89 per cent of our non-NHS and NHS trade invoices respectively within 30 days, which was below the 95 per cent target set for us by the Department of Health.

Summary

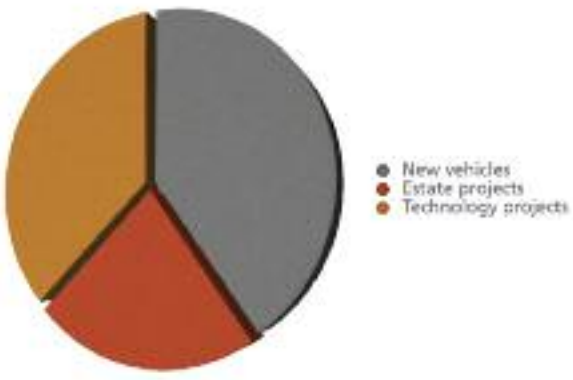
Income



Revenue expenditure



Capital expenditure



Balance sheet

The largest item on the balance sheet is £114 million of fixed assets (£123 million in 2007/08) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. We fund the investment in capital assets through our capital programme. In 2008/09 we invested £14.6 million (£10.8 million in 2007/08). The most significant addition was related to the project to replace the emergency operational control computer system. The financing for capital projects is through internally generated funds i.e. retained surpluses.

We have a net working capital of £3 million (£15 million in 2007/08) and long term creditors and provisions of £11.9 million (£18.6 million in 2007/08). We had £2.5 million cash in the bank as at 31 March 2009 (£9 million in 2007/08).

Our assets are ultimately owned by the public and the taxpayers' equity section of the balance sheet shows the component elements. Public dividend capital is £57.5 million (£56.5 million in 2007/08) of the equity - this represents the Department of Health's investment in the Trust and annual dividends are payable on this sum. A further £32.8 million (£50.6 million in 2007/08) is held in a revaluation reserve representing the accumulated increase in value of our estate.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 1.11 to the full annual accounts. The remuneration report sets out information on the pension benefits of directors.

Financial plan 2009/10

We have formally submitted a plan for 2009/10 that takes into account planned contracted income levels and the expenditure budgets that have been set for the new financial year. The plan is set to deliver a surplus of £1.9 million.

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

Financial risk

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

International Financial Reporting Standards

The Treasury has announced that public sector bodies will be required to prepare their accounts under International Financial Reporting Statements (IFRSs) from 2009/10. This will be the first year of accounting under IFRSs but 2008/09 results will have to be reworked to act as prior year comparators in the 2009/10 accounts. We have carried out a preliminary impact assessment of the effects of IFRSs on the Trust and have used this to identify resources, training needs, system and procedural changes as well as prepare a detailed conversion plan. We are well placed to prepare our 2009/10 accounts under IFRSs.

Other information

The Audit Commission was the Trust's external auditors for the year-ending 31 March 2009. We paid the Audit Commission £166,000 for audit services relating to the statutory audit. In addition, the Audit Commission was paid £1,000 for work performed on the National Fraud Initiative. All issues relating to financial audit and financial governance are overseen by our Audit Committee.

There were no important events occurring after the year end that had a material effect on the 2008/09 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 our Financial Controller who can be contacted at the address given at the end of this Annual Report.

Remuneration report

Our Remuneration Committee consists of the Chairman and the six non-executive directors. The Chief Executive is usually in attendance but is not present when his own remuneration is discussed.

The Remuneration Committee is responsible for advising the Board about appropriate remunerations and terms of service for the Chief Executive and executive directors. It makes recommendations to the Board on all aspects of salary, provisions for other benefits, including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

In formulating their recommendations to the Board, the Committee takes into account a number of factors, including the requirement of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers' Pay Framework.

Executive directors are subject to normal terms and conditions of employment. They are employed on permanent contracts which can be terminated by either party with six months' notice.

Their performance is assessed against individually set objectives and monitored through an appraisal process.

For the purposes of this report, the disclosure of remuneration to senior managers is limited to executive and non-executive directors of the Trust. Details of remuneration, including salaries and pension entitlements, are published on page 35.

The appointment and remuneration of the Chairman and the non-executive directors are set nationally. Non-executive directors are normally appointed for a period of four years and usually serve two terms in office.

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

Opinion on the financial statements

I have examined the summary financial statement which comprises income and expenditure account, the balance sheet, the cashflow statement, the statement of total recognised gains and losses and the related notes.

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

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

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

Basis of audit opinion

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

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of the London Ambulance Service NHS Trust for the year ended 31 March 2009.

Philip Johnstone 11 June 2009
District Auditor
Audit Commission
First Floor, Millbank Tower
30 Millbank, London, SW1P 4HQ

Related party transactions

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

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

The Department of Health is regarded as a related party. During the year 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:

London Strategic Health Authority
NHS Richmond
Other primary care trusts
NHS Pension Agency
NHS Litigation Authority
NHS Business Service Authority

The Trust received an administration fee of £2,500 (2007/08 £2,500) from the London Ambulance Service Charitable Funds.

The London Ambulance NHS Trust is the corporate trustee of the funds.

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 are set out in the Accountable Officer Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Chief Executive Officer 10 June 2009

Statement of Directors' responsibilities in respect of the accounts

The directors are required under the National Health Services Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, 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 requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Chief Executive Officer 10 June 2009

Finance Director 10 June 2009

Statement on internal control 2008/09

London Ambulance Service NHS Trust

1. Scope of responsibility

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

The accountability arrangements that surround this role are supported by the management structure, processes and monitoring arrangements set out in our risk management policy. The policy defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and the subsequent management of the identified risks. The Chief Executive has overall responsibility for risk management in the London Ambulance Service.

A summary of our risk management policy can be found on our website.

As part of our strategic planning process, a wide range of stakeholders have been involved in determining our strategic objectives and associated risks. The views of our stakeholders have been key to the development of our Strategic Plan 2007-2013 which will enable us to provide Londoners with an ambulance service for the future. A 14-week public consultation about our proposals to become a foundation trust was also launched in February 2009 to gather the views of the public.

The Trust meets with NHS London and the lead commissioners on a regular basis, to ensure that both the national and local targets are met and risk is mitigated to acceptable levels.

2. The purpose of the system of internal control

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

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

The system of internal control has been in place in the London Ambulance Service NHS Trust for the year ended 31 March 2009 and up to the date of the approval of the Annual Report and accounts.

3. Capacity to handle risk

The management of risk within the Trust is delegated by the Trust Board through the Chief Executive, who attends the Audit Committee and is chair of the Risk Compliance and Assurance Group. Risk is divided into governance, business continuity, clinical, corporate, financial, human resources, health and safety, information management and technology, infection control, logistics, operational and reputation; with the Director of Finance having overall responsibility for financial risk and any other corporate risks not covered by other directors. He attends the Audit Committee and chairs the Standards for Better Health Group, overseeing part of the annual health check that includes the healthcare standards. The Medical Director is responsible for clinical risk which is reported to and monitored by the Risk Compliance and Assurance Group through the mechanism of the Clinical Governance Committee. The Medical Director is a member of the Risk Compliance and Assurance Group and Clinical Governance Committee. She is Director of Infection Prevention and Control and monitors our compliance with the Code of Hygiene. Individual executive directors are responsible for, and manage, the corporate risks within their particular areas of responsibility.

Risks, as identified using the risk assessment tool in the risk reporting and assessment procedure, are approved at the Risk Compliance and Assurance Group. The tool uses a numerical scoring system when grading risks. The management of the identified risks is coordinated by the Risk Compliance and Assurance Group. Those of a high priority are monitored by one of the sub-committees of the Board. All significant risks are recorded on the risk register which is used to help prioritise and make decisions on spending allocations for service development.

We hold our governance arrangements under continuous review. We ensure that other infrastructure requirements (statutory, mandatory or desirable) for the organisation are in place. Strengths and weaknesses of current governance practice within the Trust will be amended where necessary to meet the requirements for becoming a foundation trust. Systems of internal control will be fully maintained during the authorisation process for becoming a foundation trust.

4. The risk and control framework

The risk management policy defines the risk management process which specifies the way risk (or change in risk) is identified, evaluated and controlled. In addition to this we are compliant with level one of the revised NHSLA Risk Management Standards for Ambulance Services.

The risk management policy also describes responsibilities for embedding risk management in the organisation. On a local level staff report clinical and non-clinical incidents as indicated in our incident reporting procedure. All incidents are assessed using a risk scoring matrix and according to grade and score investigated so that actions can be implemented to prevent a re-occurrence. A rolling quarterly programme of audit assesses compliance with infection control policy. We have submitted an assessment to the Care Quality Commission confirming compliance with its infection control standard.

In addition to our risk management policy and our risk register, our assurance framework enables us to examine how we are managing risks that are threatening the achievement of our strategic objectives and key targets in the Healthcare Commission annual health check. This has been achieved by mapping risks from the risk register against the standards contained within the health check, identifying the key controls in place that are managing these risks and listing assurances (positive or negative) that we have received assuring the effectiveness of these controls. Progress with mitigating the risks is reviewed by the Risk Compliance and Assurance Group.

The development of the assurance framework is an ongoing process and it will be amended with Board level objectives as they are reviewed and developed in strategic plans. As the framework covers all of our main activities, it is a key tool in examining the system of internal control that is in place to manage our risks. The 25 highest scoring risks populate the assurance framework and are cross referenced to the domains and core standards of the annual health check. The Standards for Better Health Group updated the controls as they analysed the evidence of compliance with the requirements of the annual health check 2008/09.

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

The assurance framework is used as a decision-making tool and it has highlighted some gaps in control and assurance to the Board. Notably controls around the booking of annual leave were strengthened and ongoing actions are being taken to ensure that the processing of patient report forms adheres to our procedures.

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

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

Human resources and organisation development

We have implemented a new generic equality and diversity strategy, taking forward the work from the previous race equality, disability equality and gender equality schemes and encompassing the three additional strands of age, religion or belief and sexual orientation in preparation for the new Single Equality Act. We have established of a new senior management-led Equality and Diversity Steering Group. We have recruited an additional 340 student paramedics to improve the delivery of the Category B target.

Clinical

Documentation of clinical care has been identified as a clinical risk for the Service. In addition to a robust programme of clinical audit, we have in place a structured clinical performance indicator process by which team leaders monitor the standards of clinical care delivered to patients and patient report form documentation. Information from the clinical performance indicators is used to provide individual feedback to operational staff highlighting areas of concern and good clinical practice. Monthly reports providing compliance to care standards, levels of patient report form completion and rates of staff feedback are provided to complex management teams across the Trust to enable them to benchmark and monitor performance, and take remedial action where necessary. The findings from these reports are routinely discussed at area business meetings chaired by assistant directors of operations. Area reports are then presented to the Clinical Governance Committee.

Control services

In the year, the basis for the measurement of our performance changed. The measurement now commences from the point at which the call is connected to our emergency operations centre. This on average reduces the time to respond to an incident by two minutes. Our procedures have been streamlined and we have invested in systems to deliver against the changed method of measurement.

Information management and technology

The project to replace the control system with a new system is underway. This will significantly enhance its resilience and capability. Software to automatically dispatch fast response units and ambulances has been installed to help meet operational targets. We have introduced Smartcards for the storage of clinical data. We have undertaken work on the establishment of a third data centre to improve robustness of the network.

Business continuity

A programme of testing departmental plans was carried out last year. A review of all business continuity plans was undertaken on 5 February 2009.

As a result of these actions changes were made to our business continuity plan.

A&E operations

National Category B targets have been highlighted by internal performance monitoring mechanisms as being at high risk for non-achievement. Our senior A&E management team worked with commissioners and NHS London to overcome hospital challenges experienced over the winter months. We achieved 84.5 per cent for the year as a whole which is the best performance ever against the Category B target.

5. Significant control issue

We were not compliant with the core standard for better health (C4d) between the period January 2009 and March 2009. Instances were found of weakness in the management of non-controlled drugs carried by ambulance crews. We took immediate action to address the issues and ensure that there are sufficient drug packs in circulation. Only new packs are used and all used or out–of-date packs are returned to logistics on a timely basis. I consider that we are now compliant with the core standard. It must be emphasised that patient safety was not compromised during the period in question.

6. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by bodies such as external auditors, the Healthcare Commission (now replaced by the Care Quality Commission), the Health and Safety Executive and the validation team of Improving Working Lives.

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

The Board is informed of the effectiveness of the system on internal control through its sub-committees. The Audit Committee advises the Board about how well we are operating the risk management system. To carry out this responsibility it receives reports from the Chief Executive and from both internal and external audit when they review risk management systems and processes.

The Clinical Governance Committee has responsibility for ensuring the provision of high quality clinical care in the Trust. This is achieved through monitoring and making appropriate recommendations on performance in areas of clinical governance reviewed by the Healthcare Commission. From April 2009 the Care Quality Commission will do this. The Risk Compliance and Assurance Group has delegated responsibility for taking a general overview of all risk management activities within our organisation and to pick up any specific risk management issues which are not covered by the specific Audit and Clinical Governance Committees. This committee also receives a report on the management of all identified high priority risks that have been identified by our systems and processes.

The structure is supported by our executive managers including the Director of Finance who has overall responsibility for financial risk, and for any corporate risks not covered by other directors. The Medical Director has overall responsibility for clinical governance, and is a member of the Clinical Governance Committee and Information Governance Group. The Director of Information Management and Technology is responsible for all risks arising out of the provision, use, operation and maintenance of our technology and communication systems, and also jointly chairs the Information Governance Panel.

To supplement this mechanism, information is provided to the Board through minutes and annual reports from the Audit Committee, and on risk management, infection control, patient experiences and complaints, and clinical governance to assure the Board that sufficient progress has been made.

To conclude, procedures are in place to ensure a robust system of internal control is in place which is reflected in the risk and assurance frameworks.

Chief Executive Officer
(on behalf of the Board)

10 June 2009

Income and expenditure account for the year ended 31 March 2009

	2008/09 £000	2007/08 £000
Income from activities	251,378	234,117
Other operating income	10,154	2,013
Operating expenses	(256,832)	(232,451)
OPERATING SURPLUS	**4,700**	**3,679**
Cost of fundamental reorganisation/restructuring	0	0
Profit/(loss) on disposal of fixed assets	(52)	(41)
SURPLUS BEFORE INTEREST	**4,648**	**3,638**
Interest receivable	651	989
Interest payable	0	(3)
Other finance costs - unwinding of discount	(160)	(147)
SURPLUS FOR THE FINANCIAL YEAR	**5,139**	**4,477**
Public dividend capital dividends payable	(4,414)	(4,079)
RETAINED SURPLUS FOR THE YEAR	**725**	**398**

All income and expenditure is derived from continuing operations.

Balance sheet as at 31 March 2009

	31 March 2009 £000	31 March 2008 £000
FIXED ASSETS		
Intangible assets	6,752	3,765
Tangible assets	107,061	119,652
	113,813	123,417
CURRENT ASSETS		
Stocks and work in progress	2,600	1,930
Debtors: Amounts falling due:		
after one year	4,173	9,879
within one year	8,294	11,538
Cash at bank and in hand	2,651	10,478
	17,718	33,825
CREDITORS :		
Amounts falling due within one year	(14,462)	(18,471)
NET CURRENT ASSETS/(LIABILITIES)	**3,256**	**15,354**
TOTAL ASSETS LESS CURRENT LIABILITIES	**117,069**	**138,771**
CREDITORS:		
Amounts falling due after more than one year	0	0
PROVISIONS FOR LIABILITIES AND CHARGES	(11,931)	(18,589)
TOTAL ASSETS EMPLOYED	**105,138**	**120,182**
FINANCED BY:		
TAXPAYERS' EQUITY		
Public dividend capital	57,523	56,488
Re-valuation reserve	32,810	50,605
Donated asset reserve	9	68
Other reserves	(419)	(419)
Income and expenditure reserve	15,215	13,440
TOTAL TAXPAYERS' EQUITY	**105,138**	**120,182**

Chief Executive Officer
(on behalf of the Board)

10 June 2009

Cash flow statement for the year ended 31 March 2009

	2008/09 £000	2007/08 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	7,867	18,970
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	625	913
Interest paid	0	(3)
Interest element of finance leases	0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance	625	910
CAPITAL EXPENDITURE		
Payments to acquire tangible fixed assets	(11,082)	(6,703)
Receipts from sale of tangible fixed assets	3,912	6
Payments to acquire intangible fixed assets	(4,375)	(1,745)
Net cash (outflow) from capital expenditure	(11,545)	(8,442)
DIVIDENDS PAID	(4,414)	(4,079)
Net cash inflow/(outflow) before financing	(7,467)	7,359
FINANCING		
Public dividend capital received	1,035	2,329
Public dividend capital repaid (not previously accrued)	0	(1,367)
Public dividend capital repaid (accrued in prior period)	0	0
Capital element of finance leases	0	0
Net cash inflow from financing	1,035	962
Increase/(decrease) in cash	(6,432)	8,321

Statement of total recognised gains and losses for the year ended 31 March 2009

	2008/09 £000	2007/08 £000
Surplus for the financial year before dividend payments	5,139	4,477
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	(16,742)	8,341
Increases in the donated asset and Government grant reserve due to receipt of donated and Government grant financed asset	0	0
Additions/(reductions) in "other reserves"	0	0
Total recognised gains and losses for the financial year	(11,603)	12,818
Prior period adjustment	0	0
Total gains and losses recognised in the financial year	(11,603)	12,818

Salary and pension entitlements of senior managers

A) Remuneration

Name and Title	2008/09 Salary (bands of £5000)	2008/09 Other remuneration (bands of £5000)	2008/09 Benefits in kind rounded to the nearest £100	2007/08 Salary (bands of £5000)	2007/08 Other remuneration (bands of £5000)	2007/08 Benefits in kind rounded to the nearest £100
Sigurd Reinton, Chairman	£20,001-£25,000	£0		£20,001-£25,000	£0	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Sarah Waller, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Roy Griffins, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Ingrid Prescod, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Brian Huckett, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
* Peter Bradley, Chief Executive	£105,001-£110,000	£0	£3,700	£120,001-£125,000	£0	£4,300
Michael Dinan, Director of Finance	£120,001-£125,000	£0		£110,001-£115,000	£0	
Martin Flaherty, Director of Operations	£115,001-£120,000	£0	£1,300	£105,001-£110,000	£0	£2,600
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£95,001-£100,000	£0	
** Fionna Moore, Medical Director	£80,001-£85,000	£0		£75,001-£80,000	£0	

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

* Excludes remuneration recharged to the Department of Health for role as National Ambulance Advisor.
** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.

Salary and pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2009 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2009 (bands of £5,000)	Cash equivalent transfer value at 31 March 2009	Cash equivalent transfer value at 31 March 2008	Real increase in cash equivalent transfer value	Employers contribution to stakeholder to nearest £100
Sigurd Reinton, Chairman	**	**	**	**	**	**	**	
Barry MacDonald, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Non-Executive Director	**	**	**	**	**	**	**	
Ingrid Prescod, Non-Executive Director	**	**	**	**	**	**	**	
Caroline Silver, Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£(0)-(£2,500)	£5,001-£10,000	£25,001-£30,000	£278,943	£159,729	£80,654	
Michael Dinan, Director of Finance	£2,501-£5,000	£5,001-£7,500	£5,001-£10,000	£15,001-£20,000	£106,371	£59,347	£31,878	
Martin Flaherty, Director of Operations	£5,501-£7,500	£10,001-£12,500	£35,001-£40,000	£115,001-£120,000	£788,142	£538,562	£165,281	
Caron Hitchen, Director of Human Resources	£0-£2,500	£0-£2,500	£20,001-£25,000	£65,001-£70,000	£386,437	£289,009	£63,142	
Fionna Moore, Medical Director	£0-£2,500	£2,501-£5,000	£40,001-£45,000	£120,001-£125,000	£968,526	£686,485	£185,415	

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Management costs

	2008/09 £000	2007/08 £000
Management costs	17,414	16,509
Income	253,399	236,049

Better payment practice code – measure of compliance

	2008/09 Number	2008/09 £000	2007/08 Number	2007/08 £000
Total non-NHS bills paid in the year	62,971	78,469	48,791	56,409
Total non-NHS bills paid within target	53,776	70,888	41,478	51,088
Percentage of non-NHS bills paid within target	85%	90%	85%	91%
Total NHS bills paid in the year	489	3,001	474	2,934
Total NHS bills paid within target	436	2,798	397	2,675
Percentage of NHS bills paid within target	89%	93%	84%	91%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

EXTERNAL FINANCING

The Trust is given an external financing limit which it is permitted to undershoot.	2008/09 £000	2007/08 £000
External financing limit set by the NHS Executive	7,467	(7,359)
External financing requirement	7,467	(7,359)
Undershoot	0	0

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

The summary financial statement does not contain sufficient information to allow for a full understanding of the results of the Trust, state of affairs of the Trust, nor of its policies and arrangements concerning director remuneration. Where more detailed information is required a copy of our full accounts and reports is obtainable free of charge.

A copy of our full accounts is available from the Financial Controller at the following address:

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

Explanation of statutory financial duties

Break-even duty

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

External financing limit (EFL)

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

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

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

Capital resourcing limit (CRL)

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

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

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

Capital cost absorption duty

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

One of our A&E support staff members takes a patient's blood pressure

Photography:

Royal Free Hospital: *front cover,* ***Mark Sepple:*** *page three (third picture from top),* ***London 2012:*** *page eight,* ***BAA Heathrow:*** *page 10 header image and page 12 (second from top),* ***Department of Health:*** *page 11,* ***Michelle Heseltine:*** *page 13 header image and page 20.*

All other photographs taken by the Media Resources Department, London Ambulance Service NHS Trust

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Use your ambulance service wisely.

Annual Report 2008/09

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

Tel: 020 7921 5100
Fax: 020 7921 5129

www.londonambulance.nhs.uk

Above: an image from our campaign encouraging the public to use the ambulance wisely by only dialling 999 in an emergency. Around two million commuters saw our posters at London Underground stations and in local and regional newspapers.