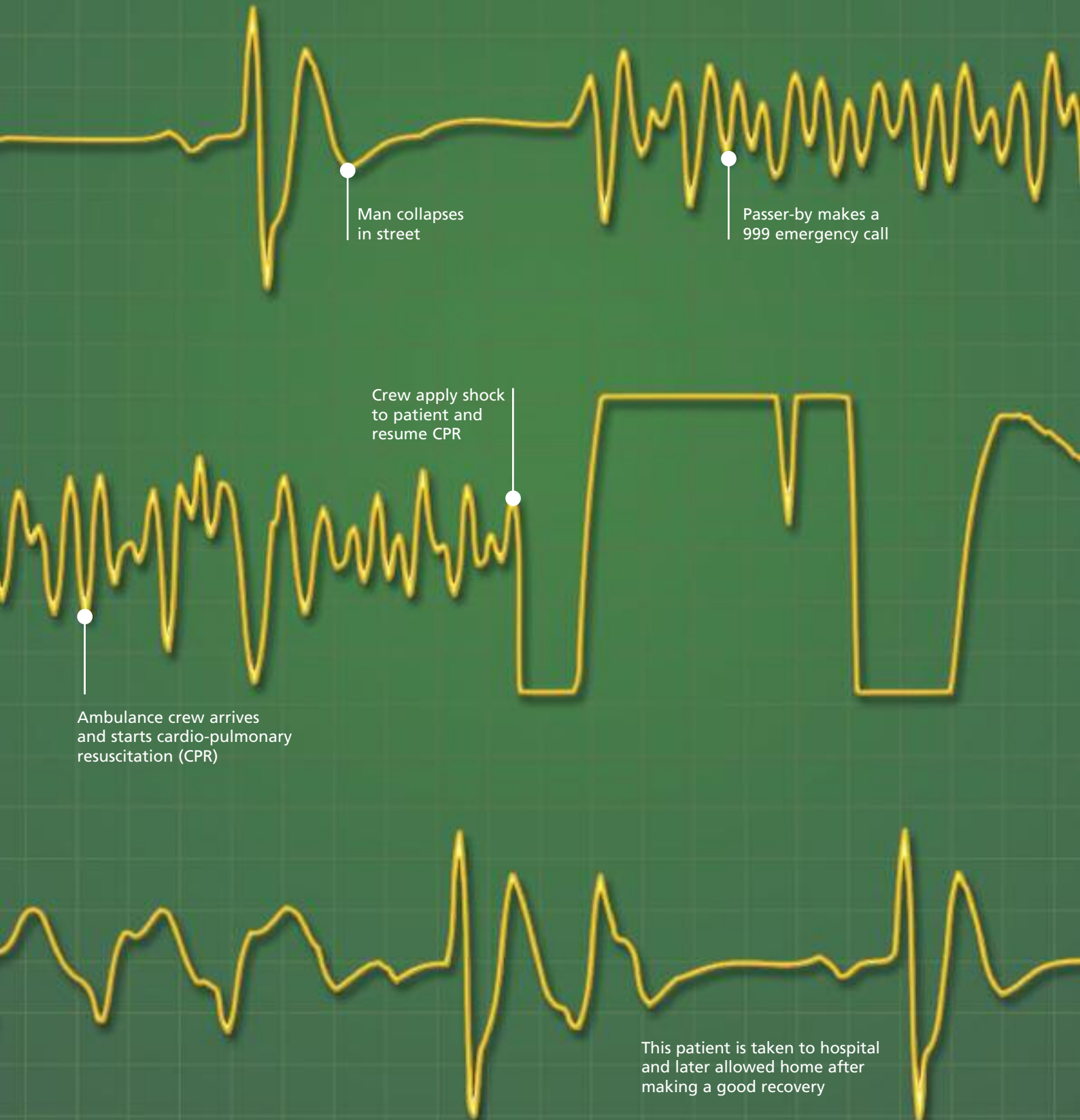




Annual Report
2006/07



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VISION

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

VALUES

Clinical excellence

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

Respect and courtesy

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

Integrity

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

Teamwork

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

Innovation and flexibility

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

Communication

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

Accept responsibility

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

Leadership and direction

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





WHO WE ARE

The London Ambulance Service NHS Trust is the busiest emergency ambulance service in the world providing healthcare that is free to patients at the point of delivery.

We are the only London-wide NHS Trust and are at the frontline of the NHS in the capital.

We have two principal functions: we provide an accident and emergency service in response to 999 calls and a patient transport service which performs an important role by taking non-emergency patients to and from their hospital appointments.

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 the other emergency services. We are also central to the emergency response to major and terrorist incidents in the capital.

We serve a resident population of more than seven million people in an area of approximately 620 square miles, from Heathrow in the west to Upminster in the east, and Enfield in the north to Purley in the south.

In 2006/07, we handled more than 1.2 million emergency calls from across London and attended more than 865,000 emergency incidents.

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

CHAIRMAN'S VIEWS

What kind of a year has it been for the Service?

In one word: tough. People have had to work really hard to meet our key performance targets while maintaining financial balance despite a further increase in the number of 999 calls. This was achieved despite the unexpected removal of some of our funding halfway through the year in order to help support NHS Trusts in London in deficit, and despite the effects of the introduction of formal rest breaks as part of Agenda for Change. It is to the credit of everyone concerned that they rose to the challenge and continued to improve patient care.

Last year the Healthcare Commission described the quality of services provided by the Trust as "weak". How would you describe them?

The criteria the Commission used did not properly measure the quality of care – neither as patients experience it nor clinically. Rather, they required us to achieve or adhere to a set of targets and clinical protocols that are too rigid or, in one case, out of date. A survey carried out for us by Ipsos MORI showed that 91 per cent of Londoners who had used the Service, either for themselves or someone else, were satisfied with the service they received. Turning to clinical quality, the Commission measured year on year increases in the number of patients with myocardial infarction (a heart attack) receiving thrombolytic drugs within a certain time.

Meanwhile the Trust was pioneering a different and more effective approach, whereby patients with an ST elevation myocardial infarction (a common type of heart attack) are taken directly to a specialist heart unit for immediate primary angioplasty. This is now accepted as best practice but we were penalised by the Commission for having shown no increase in the number of patients being given thrombolytic drugs. We hope that, as a result of our discussions with the Commission, this year's assessments will be more focused on outcomes and our patients' experience.



What are the biggest challenges currently facing the Trust and how can these be overcome?

Changing the skill mix in our workforce and how we deploy staff. It has been clear for some time that the historic emphasis on immediately life-threatening conditions was being overtaken by a shift in the reality of the calls we get, to the point where only around 10 per cent fall into this category. The vast majority of calls concern people who do have a genuine problem or worry but where it is not clear that the best response is taking them to the nearest A&E by a 'blue lights' ambulance. That will be appropriate for many, but for the majority we need to get better at understanding what the problem is and coming up with solutions more tailored to the needs of each patient. That means developing much stronger diagnostic and assessment skills (on top of the traditional skills in resuscitation and preservation of life and limb), to be applied in a wider range of settings (on ambulances but also as single responders in cars or over the telephone).

At the same time, medical advances mean that our crews will increasingly be called upon to take decisions about where patients should be treated. Consequently, we will need to upskill a large number of staff to paramedic level and refocus the paramedic training on assessment and diagnostic skills.

How do you see the Trust influencing the changing NHS in London in the coming years?

I believe we should take the lead in improving the way the NHS delivers urgent and emergency care in London so that patients get a seamless service regardless of where they happened to call first. To do this, we need a much closer collaboration between GP out-of-hours services, NHS Direct and ourselves, amounting to a virtual integrated service.

In addition, I think we will need to play a central role in the debate around the configuration of clinical services where, for practical reasons, a 999 call is the first step on the patient's journey. We are well down the road with cardiac patients and I believe that trauma, stroke and paediatrics might be next.

How do you think that the Trust has changed in the eight years that you have been here?

Beyond recognition. The Trust then had financial troubles and was failing to meet response time targets. Staff morale was at an all-time low and relations between frontline crews and management were poor.

That has changed. Response time performance has improved dramatically, clinical care is now central to everything we do, and outcomes in key areas have been transformed. We have suffered a recent drop in morale (much of it down to the introduction of Agenda for Change) but it is much better than it was then. Finance is not why we are here, but we now balance the books year in, year out.

There is still much to do to meet new response time targets, to further improve clinical outcomes and to provide better solutions to the majority of callers who have a problem that is not immediately life-threatening. But we now have a solid base from which to do that work.

A handwritten signature in black ink, appearing to read 'Sigurd Reinton'.

Sigurd Reinton
Chairman

CHIEF EXECUTIVE'S VIEWS

What have been the highlights and disappointments of the year?

Last year's highlights include yet another improvement in our cardiac arrest survival rates. The work of our clinical telephone advisors has helped to keep the increase in the overall number of ambulance responses down, and we also did well with our key performance targets and broke even financially. In terms of disappointments, I would say the biggest was that we had to cancel more training than we would have liked to maintain ambulance cover. We are now bringing in a new programme to ensure that staff get a minimum level of training during the year.



There are plans to have more paramedics working on their own in cars, and fewer ambulances – what is the rationale for this?

In short, it will improve the care we give our patients. Increasingly we will be sending an ambulance with two staff only to those calls where it is clear that kind of resource is needed, including to cardiac patients, or where there may be safety concerns for staff. For those other patients - who we assess as needing more than telephone advice but who don't have life-threatening conditions - we believe it would be better to send a fast response car with a single responder in the first instance. If on assessing the patient they decide an ambulance is needed, they will request one. A move to more single responders will enable us to use ambulances for those patients who really need them.

You had to make cuts last year – how did this impact on service delivery? How will funding pressures affect the Trust in the coming years?

We did our utmost to find savings in those areas which did not compromise our standards of patient care, such as deferring some non-essential estates maintenance and non-clinical training. We have had to reduce overtime, but the filling of vacancies and an increase in our frontline staff numbers has meant we have been less reliant on overtime than in previous years. Over the next year things are going to be equally as tough financially, if not tougher. We are having to look at all aspects of spending to identify where we can make savings. We will do all we can to minimise the impact on patient care.

that start in April 2008. In terms of our staff, the priority is to identify key issues that have been raised at recent staff consultation meetings and ensure we take steps to address these.

How can the Trust continue to deal with an apparent year-on-year increase in demand?

Nationally, the ambulance service is changing the way it delivers care, which means not everyone will get an ambulance and be taken to hospital in the traditional way in the future. We need a national public education campaign to ensure that the public understand our changing role. We have shown through the work of our emergency care practitioners and clinical telephone advisors that we can develop alternative kinds of care that are better for patients with non-life threatening illnesses or injuries, and that help to reduce demand on our A&E service. Although our workload has increased this year, it has been the smallest increase in demand we have seen for over a decade. If we continue building on what we have been doing I think we can see demand actually start to reduce in the next couple of years.

How close is the Trust to achieving its vision of being world-class?

In the areas of cardiac care and clinical audit and research, I would say that we are world-class. However, in other areas there is a bit further to go. But being world-class remains our goal, and one I am sure we will take another step closer to over the next year.

Peter Bradley CBE
Chief Executive Officer

What are the priorities for this year?

We need to make sure that we use all the money we do get to the best effect for patients, while ensuring we do not overspend. We have a good record of financial management and that must continue. We also need to build on the excellent work we have done in cardiac care and extend this to our stroke patients and other key patient groups. Additionally we must prepare ourselves for new challenging performance targets

Taking the Trust

Our Strategic Plan outlines where we want to be in 2013, the year after the capital has hosted the Olympic Games.

Approved by our Trust Board in January 2007, it sees us moving right away from a one-size fits all service, to one where all our patients should get care tailored to their needs.

Historically we have designed our service around a small number of our patients – those with life-threatening conditions. We are now turning our attention to our largest group of patients whose conditions, whilst not life-threatening, still need medical care; many of these need different treatment to that offered at an A&E department.

We would like to see far fewer patients being taken to hospital in the future – around 200,000 less a year. It would be much more appropriate for many of our patients to be treated at home, referred to their GP or social services, or taken elsewhere for treatment such as minor injuries units or walk-in centres. We are working locally to identify at least five alternative care options for patients in each London borough to enable us to do this. In addition, by increasing our capacity to deal with patients over the phone, we think we could provide clinical advice to around 150,000 callers a year.

It is important to note that changes to our service will take place against a backdrop of increased demand and population growth in the capital; and as we embark on this challenging programme of work, reconfiguration of NHS services is high on the agenda.

Our plans for the future are influenced by the national Ambulance Service Review, 'Taking Healthcare to the Patient', which was led by our Chief Executive Peter Bradley and published by the Department of Health in June 2005.

What will be different about our Service?

- We will offer greater care options for patients, for example treatment at home, access to walk-in centres and minor injuries units, rather than a trip to hospital

- We will increasingly use cars for the initial response to calls
- Our staff in these cars will have enhanced diagnostic and treatment skills so they can decide on the best treatment to meet their patient's need
- People will have easier access to our services
- We will engage more with patients and the public as well as our health and social care partners.

We will achieve this through five programmes of work, underpinned by stakeholder engagement and communication.

Access and connecting the Trust for health

Our aim is for all patients to be able to access us quickly and easily, regardless of language or disability. Our access strategy will consider the use of information technology solutions that make access to information simpler and allow patients to speak directly to a helpful human.

Our processes for internal and external information sharing will also be streamlined by technological advances, so whether it is a GP trying to find a bed for a patient or the police needing our assistance at an incident, it will be easier to connect with us.

One of our priorities over the next 12 months will be to introduce a new digital radio system called Airwave which is being rolled out nationally to ambulance services. We will also continue to work to

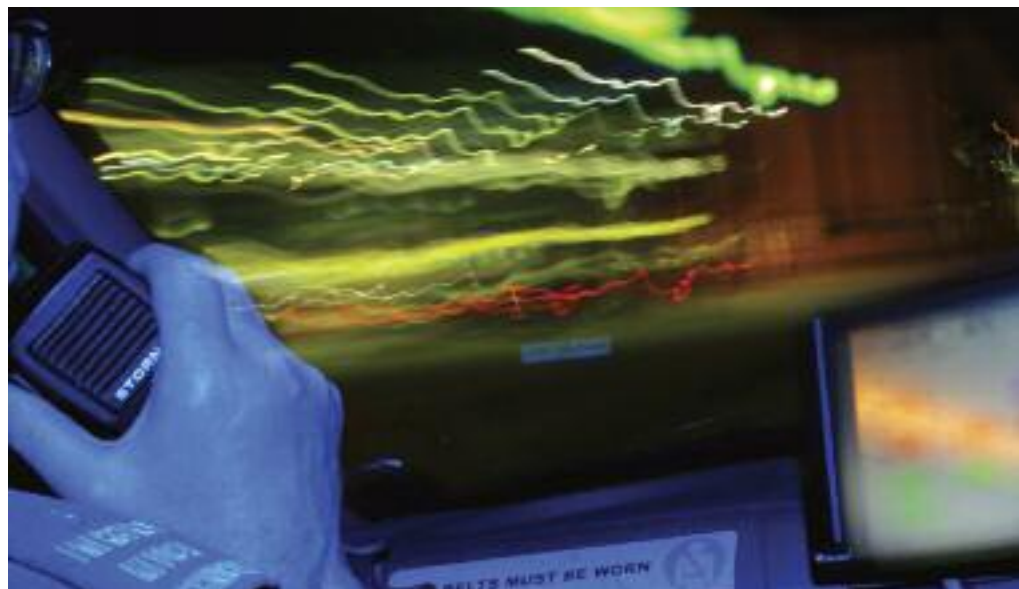
replace our current call handling system which we use to take emergency calls and send out resources to patients.

Improving our operational response

We continue to improve the way we respond to our patients, and this programme of work will focus on the development of the resources, skills and equipment needed to be able to deliver appropriate definitive care first time to more of our patients.

As previously mentioned, in 2013 we expect to be taking 200,000 fewer patients a year to emergency departments. Instead, our patients will benefit from a greater range of care options such as telephone advice, treatment at home, emergency care from a single responder or direct referral to alternative means of assistance such as walk-in centres, minor injuries units, community psychiatric services, or intermediate care teams. We will work more closely with our partner agencies to ensure that patients receive a seamless service.

In the shorter term, one significant change from April 2008 will be that for measuring Category A (immediately life-threatening) and Category B (serious but not life-threatening) responses, the clock will start from the moment the call is connected to our control room. This compares with current practice, based on Department of Health guidelines, where the clock starts once we have established an address, telephone number and main condition of the patient.



to 2013

These changes will align our response more closely to that which our patients experience. It means that our recorded response times will start approximately two minutes earlier than they do now, while our response time target of eight minutes to attend life-threatening calls remains unchanged – so patients will get a better service from us.

This supports what Londoners told us in a recent survey conducted on our behalf by Ipsos MORI – they said they felt our most important role was to get to patients quickly, and this was the area where they felt we most need to improve.

In the coming months we have got to make some fundamental changes to how we dispatch resources and respond to patients if we are to be in a position to meet the new target.

The first phase of improvements took place last year and focused on 11 projects. They looked at reducing the proportion of calls that are inappropriately classed as Category A, increasing our dispatch capacity, and improving our dispatch of fast response cars.

We also began a management restructure of our 999 control room, introduced uninterrupted rest breaks for our staff, and brought in individual performance monitoring.

Additionally, we considered how to reduce the overall time it takes to deal with a call from the time the phone is answered to completing our treatment of the patient, and started work to improve our response at the times when our frontline shifts begin and end.

Organisation development and people

Staff development is at the heart of our organisation and the contribution of our 4,200 employees is key in helping us deliver on our Strategic Plan.

Many opportunities will arise for staff to learn additional skills so that they can progress in new roles that are established to better meet patients' needs.

Supportive and visible management will be key to provide leadership at all levels of the organisation, and to work with our NHS partners to develop the many alternative routes to care needed in the future, so staff can use them with confidence.

Work on this programme started last year, and a new workforce plan – including proposals to reconfigure the make-up of frontline staffing roles – was published in February.

Planning for the London 2012 Olympic and Paralympic Games

When the Olympic and Paralympic Games come to London in five years' time, our challenge will be to maintain our day-to-day emergency service across the capital whilst providing medical care to Olympic-related patients.

The main lesson from other ambulance services in cities that have hosted the Games in the past is that it is never too early to start planning. We have already set up a small team which has the

job of planning for our activity during the Games and liaising with our partner organisations.

Governance and corporate processes

There are few ways of quantifying our performance other than the Government-specified targets, but our consultation with patients has shown that this is not what is most important to them.

Whilst we will continue to deliver on our national targets and financial obligations, through this programme we will also be introducing new performance management systems that actually evaluate the quality of the care we give, rather than just the time in which it is given.

We will also be looking at how we can improve many of our internal processes so we can work more efficiently and in a way that provides value for money. Over the next year we will be mapping the different processes we use so we can identify better ways of working. In the short term we will be bringing in a web-based stock management system that will speed up our ability to place orders with suppliers; we will be introducing a system to ensure we know where all of our equipment is at any one time; and we will finalise our review of how we can use our fleet more flexibly across the whole of the capital.

Stakeholder engagement and communication

Stakeholder engagement and communication is key to the delivery of our Strategic Plan.

A stakeholder engagement and communication plan is being developed, taking account of the objectives of the five main work programmes, and integrating other strands of work such as public education, media relations and internal communications.

The plan will also be influenced by findings of the research carried out by Ipsos MORI in 2006. Londoners were asked what they think about the role of the Trust, our plans for the future, how they perceive us as an employer, and what experience they have had of using our service.



Patients

Last year we received more than 1.2 million calls in our Emergency Operations Centre, making it our busiest year ever.

Urgent Care Service

While many of the calls we received were true emergencies, it has become increasingly clear that, in the majority of cases, our patients' needs are not best served by the traditional response of an emergency ambulance with blue lights and sirens.

Only one in 10 calls that we receive is to somebody who is in a life-threatening condition, so we are working hard to provide our patients with the kind of response they really need - care which is more closely tailored to their particular situation rather than the traditional 'one-size-fits-all' approach.

This work has placed more emphasis on the development of our Urgent Care Service, which deals with those patients who do not have life-threatening injuries or illnesses.

The service is made up of Clinical Telephone Advice, Urgent Care Dispatch, Urgent Care crews, Patient Transport Service Central Services, the Emergency Bed Service, and our Ambulance Train Ambulance team, which is responsible for arranging the longer distance transfer of patients.

Together, these teams are responsible for co-ordinating our response to those patients who we have already assessed as being in no danger of immediate or potential threat to life or limb.

Since it opened in November 2005, our dedicated Urgent Operations Centre has continued to develop and grow and currently handles around one third of all our non-urgent calls.

This share of the workload will rise significantly in coming years as we continue to adapt to the changing pattern of 999 use.



Clinical Telephone Advice

Located within the Urgent Operations Centre is our Clinical Telephone Advice (CTA) team. It is made up of experienced emergency medical technicians and paramedics, who are well-equipped with the skills necessary to assess and advise those patients where the initial triage has determined that they are suffering from 'minor' illnesses or injuries.

Advisors call back and carry out a full assessment of the patient's condition over the telephone and then advise what the best course of treatment is for them. This could involve being cared for at home, being referred to their GP or local pharmacy, or having an ambulance sent to them.

CTA currently handles in the region of 50,000 calls a year. Of these, around half are dealt with without there being a need



to dispatch an ambulance. This helps ensure that these emergency vehicles are kept free for those patients in a life-threatening condition.

As we look to further expand our use of telephone advice, we will increase the number of clinical advisors from 35 to 50. We are also looking to expand the variety of staff in the team to include other healthcare professionals, such as nurses. Additionally, we are investigating the role our emergency care practitioners could play in helping to provide clinical leadership to the team.

Urgent Care Service crews

On those occasions when a clinical telephone advisor decides that an ambulance does need to be sent, many of the vehicles will be staffed by our Urgent Care Service crews, meaning that we can continue to keep our A&E staff free to deal with other emergency calls.

We currently have more than 100 Urgent Care Service crew staff, and in the last year their workload has more than doubled to 2,900 patients a month.

Our training programme provides these staff with the necessary skills to be able to respond to patients with minor injuries or illnesses. They drive traditional

blue-light ambulances and are trained to carry out basic life support, use defibrillators, and administer oxygen and pain-relieving gas therapies.

Emergency Bed Service

Also sitting within our Urgent Care Service is the Emergency Bed Service (EBS), a bed-finding system for NHS healthcare professionals who are making admissions or transfer arrangements for their acutely ill patients.

EBS also has responsibility for the National Intensive Care Bed Register for adult and paediatric critical care beds in three-quarters of England. It offers a service to help with antenatal transfers, and acts as the coordinator for the Neo-natal Transfer Service in London, Kent, Surrey and Sussex, which transports sick babies between hospitals.

In the last year EBS introduced the National Cot Locator Service, which has been commissioned by the Department of Health, in partnership with First Response at West Midlands Ambulance Service. It helps to locate cots for pre-term babies.

EBS and CTA have also recently piloted a new service, which sees EBS referring calls identified as appropriate by CTA to the GP Out of Hours Service. We

have also introduced our call-taking software to EBS to enable doctor's urgent calls to be entered directly into our system.

Emergency care practitioners

Our team of emergency care practitioners (ECPs) have highly-developed skills in physical assessment and can treat a wide range of different conditions.

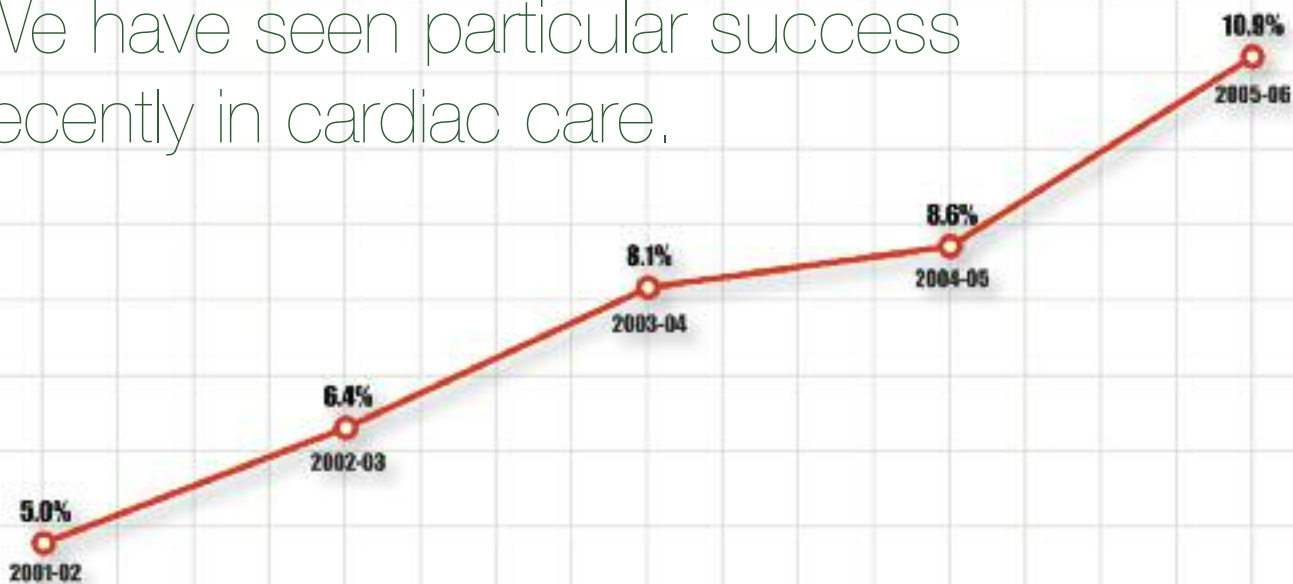
Their main role is to respond to complex but less urgent 999 calls when it is suspected that a patient may not need, or even want, to go to hospital, but where a face-to-face assessment is required.

ECPs work closely with their local primary care trust and can prescribe drugs, make referrals and transport patients to GP's surgeries or minor injuries units if required.

The current financial climate in London has made it difficult to fund as rapid an expansion of ECPs as we would like. We currently have 56 ECPs under the leadership of an Assistant Medical Director (Primary Care), a Practice Development Manager, and clinical leads, and we will continue to expand towards a total of 200 practitioners, integrating them fully into our operational workforce.

Cardiac care

We have seen particular success recently in cardiac care.



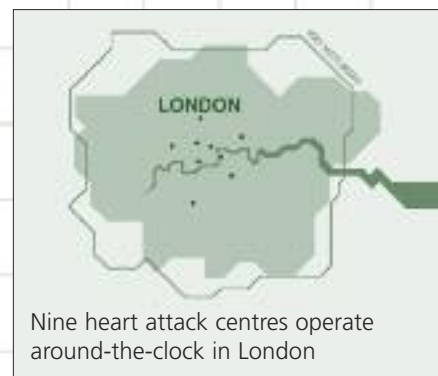
Our latest figures, which relate to the year 2005/06, indicate that 10.9 per cent of Londoners who suffered a bystander-witnessed out-of-hospital cardiac arrest were discharged alive from hospital – double that of six years ago.

Our crews are now making increased use of the network of nine heart attack centres which operate around-the-clock in London. Using this system, if staff diagnose an ST-elevation myocardial infarction - a common type of heart attack - using a 12-lead electro-cardiogram, they can make the decision to take the patient directly to a cardiac catheter laboratory for specialist treatment, bypassing A&E departments.

This enables patients to benefit immediately from primary angioplasty, a procedure which involves a catheter being passed through the artery and a balloon inserted and inflated to open the artery at the point of the blockage.

This procedure offers a much better chance of survival and a quicker recovery than the standard treatment, thrombolysis, which involves administering clot-busting drugs.

Figures for the first six months of the year indicate that of those



patients suffering from an ST-elevation myocardial infarction, 73 per cent - more than 270 patients - were taken directly to a catheter laboratory, rather than A&E. A report by the Department of Health, 'Mending hearts and brains', used our practice as an example of the future of heart attack care, and said bypassing local hospitals to deliver angioplasty would save more lives.

Staff and one of our cardiac patients attended an event at 10 Downing Street to celebrate the successes of the NHS in tackling coronary heart disease, and the Trust also played host to more than 250 representatives from ambulance services across the UK and Europe at the country's first national conference dedicated to pre-hospital cardiac care. Using an educational grant from pharmaceutical company Lilly, we arranged for internationally renowned experts to discuss state-of-the-art practices in pre-hospital cardiac care. Speakers also shared advice for paramedics when dealing with difficult electro-cardiograms and cases of sudden cardiac death.

Along with better training, it appears





Staff can provide extensive treatment before a patient arrives at hospital

that patients are also benefiting from a greater awareness of the symptoms which indicate that they could be suffering from a heart attack. The British Heart Foundation (BHF) has been running a national campaign to raise awareness of these symptoms and what to do when they occur. The 'Doubt Kills' initiative encourages people to call 999 immediately if they experience chest pain and has used powerful billboard posters to get the message across. We have supported the BHF and have been measuring the impact it has had on the number of calls we receive from people experiencing chest pain. In the first month after the launch, calls from patients reporting chest pain rose 24 per cent when compared with the monthly average for the previous year.

One of the factors which has contributed to the improved cardiac survival rate is effective bystander cardio-pulmonary resuscitation (CPR), which is known to double a person's chance of survival. The number of people trained to carry out this life-saving technique has improved the public's

ability to help people in a cardiac emergency while our crews are on the way. Our Community Resuscitation Team has a very important role in training people in CPR, and during the year they taught approximately 9,000 people this life-saving skill. Organisations whose staff were trained included Barclays Bank, Houses of Parliament, Westminster Primary Care Trust, National Archives, and Morgan Stanley. Money generated from these paid-for courses has helped to fund our free community CPR Heartstart courses.

In total there are now 413 defibrillators - machines that can deliver an electric shock to re-start a patient's heart - in London which have been installed in busy public places as part of our Community Defibrillation Project, more than any other city in the UK. In the last year our Community Defibrillation Officer has co-ordinated the installation of defibrillators at places such as Piccadilly Circus Underground Station and the Roundhouse Theatre in Chalk Farm, and has trained more than 3,000 people in the use of the devices.



City of London Police are among those we have trained to use defibrillators



We worked with a range of NHS staff to help save the life of James Yeaman, after he was hit by a cricket ball

Clinical Audit and Research

A wide range of research and clinical audit projects have been undertaken by our Clinical Audit and Research Unit.

The unit carries out audits of the quality of care delivered to our patients to ensure that our staff are complying with clinical guidelines and protocols. These reviews cover a broad range of topics including the care given to stroke patients, the use of morphine in the management of pain, and obstetric emergencies. In addition, patient report forms for cases involving cardiac arrest, acute coronary syndrome, difficulty in breathing, and non-conveyed patients are among those which are routinely audited by team leaders. A random sample of five per cent of forms is also audited to assess basic documentation. The results of all our audits are used to inform the development of our clinical practices, and form the basis for providing constructive feedback to staff.

On a wider scale, we have also been involved in undertaking a series of clinical audits examining the appropriateness of the categorisation of certain types of calls. The results of these audits have helped

inform decisions made by the Department of Health's Emergency Call Prioritisation Advisory Group regarding the prioritisation of certain types of 999 calls.

We are also involved in a number of different research projects. This year we began the SMART CPR research project as part of our commitment to improving the survival rate of patients who have suffered a cardiac arrest. The new FR2+ defibrillator contains a SMART CPR software feature which analyses the heart rhythm in order to predict whether a cardiac arrest patient with a 'shockable' rhythm would benefit from either an immediate shock or a short period of cardio-pulmonary resuscitation first.

Ambulance stations taking part in the project have supplied electro-cardiogram data from cardiac arrest incidents and we are collating hospital outcome data for these patients as part of the research into establishing the potential impact of the SMART CPR software. The project is being run in collaboration with the New York Fire Department, and is expected to run for another two years.

We are currently involved in developing a research protocol that is looking at enhancing the recognition of stroke. We are collaborating in other work in this area through our partnership with the

Thames Stroke Research Network.

We also run bi-monthly Evidence for Practice seminars to raise awareness of research, audit, and evidence-based practice by presenting findings of recent projects and giving staff the opportunity to discuss projects and raise any questions they have. Seminars have covered a vast range of topics, from cardiac care to alternative responses.

Additionally we run a monthly audit and research surgery, where those undertaking a project, or interested in starting one, can speak to members of our Clinical Audit and Research Unit for assistance and guidance.

Governance

The Trust Board has overall responsibility for good governance and we continually review and assess our corporate, clinical and information governance, and our management of risk.

We are compliant with the core healthcare standards and have a comprehensive risk management framework in place which includes reporting from our frontline crews to check our compliance with corporate and clinical governance arrangements.

Patient and Public Involvement

We remain fully committed to engaging with our patients and the public and have extended this work more widely across the Trust during the year.

Examples of Patient and Public Involvement (PPI) events and activities during the year include visits to community organisations, attendance at careers events, and health awareness days.

At a corporate level, patient representatives were involved in workshops to develop a long-term conditions strategy, a Strategic Plan launch event, and our annual awards ceremony.

Our Events and Schools team have been involved in a number of initiatives, including Junior Citizens' schemes, crime and safety awareness days with the police, fire and prison services, and 'Safe Drive, Stay Alive', a high-profile project aimed at young people as they start driving, which was piloted in the borough of Havering.

Tragically, an educational visit to a nursery school in west London in June 2006 ended in the death of a young boy after an ambulance rolled backwards down a slope. We carried out a full investigation into what happened and have since put in place new procedures for all educational visits to make them as safe as possible.

Our Public Education Strategy was approved during the year and has been incorporated into our Strategic Plan. This recommends a standard reporting structure, greater co-ordination, and a way of focusing activity on priority areas and communities.

We were also chosen as one of the first sites for working with the newly-formed NHS Centre for Involvement (NCI) and a project started in Tower Hamlets, focusing on the local Bangladeshi community. Activities within the project include the provision of information on health promotion and access to NHS services, basic life support training, and recruitment opportunities.

NCI also started a baseline assessment of PPI in the Trust. This involved looking at the organisational structure, key documents, and carrying out a survey of 30 stakeholders. This data, and follow-up telephone interviews, will be used to produce a report which will be fed into a revised PPI Strategy.

Our Patients' Forum meets monthly and meetings are attended by senior managers who provide forum members with updates and information about various aspects of care and developments

and invite comments and feedback about them. Towards the end of 2007/08, it is likely that new legislation will replace Patients' Forums with Local Involvement Networks. These will be local authority based and will involve a more formal relationship with the voluntary sector. It will therefore be essential to develop relationships with each of the boroughs and other local organisations, and we have already built up many of these links.

Public perceptions of the Trust

We commissioned Ipsos MORI to carry out research into Londoners' perceptions of the Trust. Residents were asked what they think about the role of our service, our plans for the future, how they perceive the organisation as an employer,

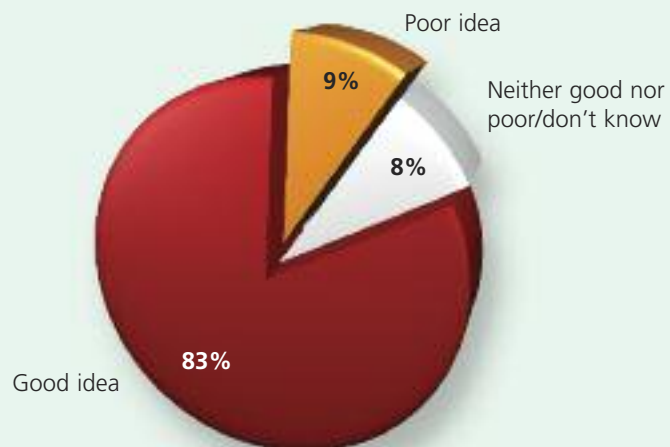
and what experience they have had of us.

Telephone interviews were carried out with 1,010 Londoners (quotas were representative of the capital's population) and focus groups were held with young people, people with long-term conditions, Bangladeshi men and women, parents, Afro-Caribbean people, and non-car owners. Five face-to-face in-depth interviews were also held with homeless people.

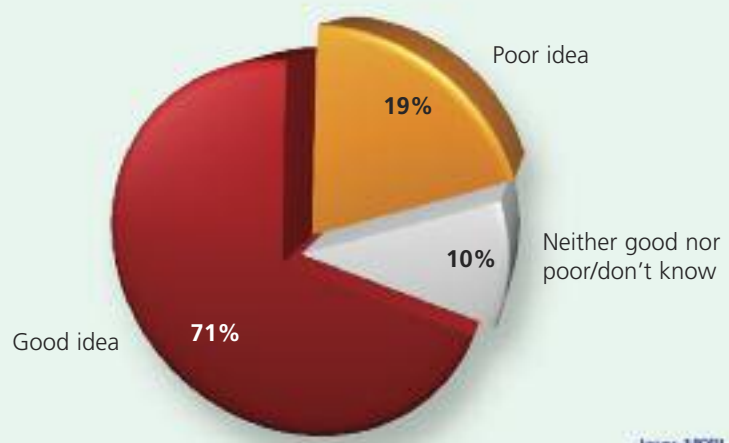
The research showed that most people in the capital think that our plans to provide more advice over the phone and treat more people at home are a sensible way forward. However, it also indicated that the public believe that getting to calls quickly is the main area where they would like to see improvements.

The findings will help to influence future changes to service delivery along with the Trust's public education and recruitment plans.

Ipsos MORI asked Londoners what they thought about the expansion of the emergency care practitioner scheme



Londoners were asked for their views on the Trust providing more treatment over the phone



Ipsos MORI

Patient Advice and Liaison Service

Since being established in 2003, the work of our Patient Advice and Liaison Service (PALS) has continued to grow. Its primary responsibility is to provide information, advice and support to patients, to the public and to health and social care professionals, both in terms of issues arising from their experience of using the Trust and practice and policy.

This year the team dealt with 4,200 enquiries and reached the milestone of receiving its 15,000th enquiry in its relatively short life.

We received 661 expressions of appreciations and 75 enquiries relating to poor staff attitude or behaviour. There were 298 requests for medical records, which we provided with a comprehensive explanation of their contents, and 217 enquiries in relation to our policies and practices - twice as many as in the previous year.

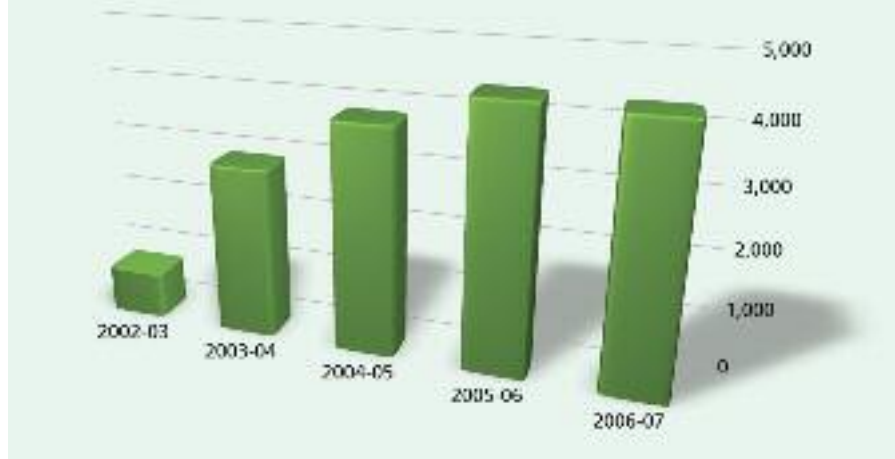
The PALS team is also responsible for handling enquiries made under the Freedom of Information Act and this year dealt with 89 such cases. Although this is fewer than the previous year, some enquiries were concerned with high profile issues.

PALS also has responsibility for dealing with any concerns raised by our staff about external agencies, and this year received 197 such referrals.

We also work with patients and the relevant health and social care professionals in finding more appropriate means of care for those patients who make a high number of 999 calls, and this has resulted in saving an estimated 6,000 emergency journeys.

We continue to monitor any emerging trends in patient concerns and

Patient Advice and Liaison Service enquiries



to identify any individual patients who have complex needs. For example, following a report about an elderly patient's poor domestic environment, which presented a fire hazard, we made a referral to the local authority to arrange an inspection of the premises and for a community care assessment to be undertaken. PALS also advised the staff concerned of the application of the 'vulnerable adult' procedure.

Handling complaints

Following a restructure of our Professional Standards Unit in the wake of a review of how we handle complaints from patients and the public, these are now managed by our Complaints Department.

During the year we received a total of 557 external complaints, compared to 544 the previous year. Of these 290 were written complaints.

We responded to 76 per cent of written complaints within 25 working days, but unfortunately did not meet the Department of Health's 80 per cent target.

While we will continue to work towards meeting this target, we are also ensuring that lessons are learned and practice changed if required as a result of complaints.

Working with our communities

With more than 300 languages spoken in London and many different customs, cultures and religions practiced, we work hard to connect with all the communities we serve.

Our race, gender, and disability equality schemes have been published on our website and we are working to pull these together in a single equality scheme.

We have highlighted the importance of carrying out equality impact assessments, which ensure that the possible impact of our procedures on particular groups are properly considered.

We continued to carry out ethnic monitoring of our patients, using documentation available to us such as our patient report forms, and more work is being undertaken to improve the collation of this important information.

Protecting children and vulnerable adults

Our staff are provided with clear guidelines for reporting suspected abuse of children or vulnerable adults so that action can be taken by the appropriate





A scene from a video for 'Safe Drive, Stay Alive', a project aimed at young people as they start driving

agencies. Such referrals often play a crucial role in the early identification of vulnerable people who need help.

In 2006/07 staff referred on the cases of 1,896 vulnerable adults who they felt were either at risk or in need for investigation. This averaged 36 cases a week, compared to 24 the previous year.

In addition, 574 children were referred, compared to 449 the previous year.

Since the procedure for reporting suspected abuse was introduced in 2003/04 the number of referrals has continued to increase as more staff are trained in the reporting process and confidence in the system continues to grow.

Helping the homeless

Our staff have worked in partnership with the London Street Rescue charity to set up referral guidelines for patients who are believed to be sleeping rough. The system enables ambulance crews to



refer patients to the charity either directly, using a telephone number programmed into their phones, or via the Emergency Operations Centre. Volunteers from the charity are then able to assess the patient and offer them help, support, and shelter.

Impact of alcohol

Alcohol-related cases continue to form a significant part of the Trust's workload and the number of incidents that we respond to where alcohol is a factor has grown, despite the introduction of new licensing laws.

In the year following the introduction of the revised laws in November 2005, we responded to nearly 39,000 alcohol-related incidents, an increase of three per cent.

One of the aims of the new laws was to eradicate the 11pm to 2am disorder flashpoints experienced on Fridays and Saturdays. However, this has remained the busiest period of the evening for our crews responding to alcohol-related incidents.

New stations

As London's population continues to rise, we are preparing for the extra pressure this will place on our service.

Over the next few years we plan to open a number of smaller-scale satellite stations at locations across the capital. These offer basic facilities for staff, enabling them to serve areas where there may be a large population but no immediate local ambulance station. This will help to reduce the time it takes for us to get to our patients.

We have been granted planning permission to build a new station in east London. It will be called Silvertown Ambulance Station and, combined with our Poplar station, will form the new Tower Hamlets Ambulance Complex. This station will not only help to deal with the Olympic and Paralympic Games in London in 2012 but also cope with an increased local population in the area.

We have also expanded our Cycle Response Unit to the City of London. The team of four emergency medical technicians and paramedics use bikes to respond to all categories of calls in the area. For minor illnesses or injuries, the bicycle-ambulance can be sent on its own and the staff member can then request further assistance if required.

People

We continue to work with, and listen to, our staff, so that we can further improve our service to patients.

Improving terms and conditions

During the year we continued to transfer our staff over to the new Agenda for Change terms and conditions.

Agenda for Change represents a radical shake-up of the NHS pay system and introducing it has been a lengthy and sometimes difficult process.

The new system aims to provide equal pay for work of equal value and we have worked in close partnership with the trade unions to agree the basis on which our staff have been transferred over.

This year, as part of the introduction of Agenda for Change, we have brought in arrangements for our operational staff to have proper rest breaks.

This was necessary to comply with terms and conditions and health and safety regulations, but we also felt it was the right thing to do for our staff and, ultimately, for patient safety. The new arrangements aim to give all A&E, Patient Transport Service, Control Services, and Resource Centre staff a formal, uninterrupted rest break during each shift that they work.

To help our staff progress, we have extended the use of personal development reviews to give every employee the opportunity to meet with their manager to discuss their performance and identify areas where they would like to develop.

The reviews give staff the chance to contribute towards a personalised plan to increase their skills, gain experience, and progress with their careers.

The Trust is committed to reviewing individuals' progress, setting opportunities and providing development opportunities, and we have worked particularly hard this year to introduce reviews for our frontline staff.

Staff records go electronic

We have introduced the new NHS-wide human resources and payroll computer system called the Electronic Staff Record, which aims to ensure that all staff data is managed consistently.

In order to bring in the new system, we have had to integrate and replace our two previous separate payroll and human resources systems.

Along with modernising our practice, the use of the Electronic Staff Record also enables the Trust to monitor when professional registrations, memberships and qualifications expire, thereby ensuring that we remain up to date and minimise risk.





Gathering staff views

Our survey of a sample of staff reflected the fact that we had another difficult and challenging year. Questionnaires were randomly sent to 839 staff, of whom 38 per cent responded, to enable us to collate detailed information about our people's feelings and perceptions.

Of those who responded, 57 per cent said that they felt positive about working for the Trust, compared to 60 per cent the previous year.

The percentage of people who said that the Trust is a good employer to work for remained broadly the same at 51 per cent, while those who said they were proud to work for the organisation numbered 69 per cent, down two per cent from the previous year.

The Healthcare Commission used our results in the national NHS staff survey to

allow comparisons to be made with other trusts across the country. Overall, our results were consistent with last year's.

Positive findings from the survey included the number of appraisals being carried out, the level of training and the general organisational climate. Work-related stress was one of the issues highlighted as being of concern, and we will look closely at all the findings of the survey so that we can continue to try to improve the working lives of our staff.

Our Chief Executive, with support from the Medical Director, has continued to hold consultation meetings with frontline staff at all our ambulance complexes, with our Emergency Operations Centre and Urgent Operations Centre staff, and with Patient Transport Service staff. Similar events are also held twice a year with managers and support staff.

The meetings provide staff with an opportunity to be updated on current issues and to ask questions about issues which matter to them. This year we also introduced a new internal publication called TalkBack, which aims to update staff on progress made on issues raised at the consultation meetings.

Staff support

We run a number of initiatives which are designed to offer support to our staff in their day-to-day roles.

Our peer support scheme, LINC - which stands for Listening, Informal, Non-judgemental, Confidential - continues to develop. It provides a confidential listening service which is available to all our staff, enabling them to share their concerns with carefully



Staff are trained to deal with a full range of emergencies

selected and trained colleagues. This year we trained a further 23 staff as LINC workers, giving us a peer support team of 60 staff.

In the run-up to the first anniversary of the 7 July bombings in London we made staff aware of the support available to them at what was, for many people, a particularly distressing time. This help included not only LINC but also our counselling service and our Employee Assistance Programme.

Our Occupational Health service continues to be provided by King's College Hospital NHS Foundation Trust and offers counselling services and free 'well-person' medicals.

During the winter we increased the number of flu vaccination clinics available for our staff at locations across the Trust and, for the first time, our team of emergency care practitioners ran some of the clinics and administered the vaccine. Other clinics were provided by Occupational Health staff.

In support of accommodation issues we continued to promote the Housing Options scheme, which provides financial assistance to our employees to help them afford a property in London.

Recruitment

During the year our staff numbers rose to more than 4,200 as we recruited 208 new frontline A&E staff. They filled a range of posts including emergency medical technicians, paramedics, emergency care practitioners, and a new A&E support role.

We also took on 61 staff to work as emergency medical dispatchers in our Emergency Operations Centre.

Although staff turnover increased marginally this year, it remained low at 5.64 per cent.

Diversity

We recognise that women and black, minority, and ethnic staff are currently under-represented in the Trust and we have continued to try to work towards ensuring that our workforce reflects the various communities we serve in what is one of the most diverse cities in the world.

This year, for the first time, we celebrated Black History Month with a number of events over one week which recognised the contribution of black and ethnic staff to the organisation and the wider NHS over the years. While the events focused on black history, we aimed to include all staff in the celebrations in order to inspire a greater understanding of the wealth of diversity within the Trust. As part of the week, Muslim members of staff set up an information stand at our headquarters, providing an opportunity for others to find out more about Islam.

Nine members of staff took part in the EuroPride 2006 parade through central London, which celebrated the capital's gay and lesbian life.

More than 800 staff have attended our diversity training course as part of the Continuing Professional Development course, which covers issues such as gender, disability, mental health, religion, and sexual orientation. We have also developed a group of 19 in-house diversity trainers who deliver the session.

All new operational crews receive training on diversity issues during their



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foundation training. Other new members of staff are also given diversity training as part of our corporate induction programme. Several members of staff have taken part in the Breaking Through Programme, which is run by the NHS Institute for Innovation and Improvement with the aim of supporting black and minority ethnic staff who are progressing into management and senior management positions.

Our equality schemes are available on our website and reflect our responsibilities towards our patients and our employment duties.

Paramedic Science degrees

We work with the University of Hertfordshire, St George's Hospital Medical School and the University of Greenwich to help provide courses in Paramedic Science at various levels.

The partnership with the University of Hertfordshire has been in place for a number of years, and a team of our training officers work at the university, from where they deliver vocational aspects of the course such as clinical skills and driver training. They also organise

clinical placements for students within our Trust.

Ten part-time students graduated with a BSc (Hons) in Paramedic Science from the University in summer 2006, with one graduating with a certificate. This year we received 23 new recruits from the full-time BSc course, who graduated in May 2006. A further 21 staff on the BSc course are currently waiting for their final results, along with one person studying for a foundation degree.

This year we will be welcoming our first graduates from the St George's Hospital Medical School foundation degree course in Paramedic Science, which has been running for three years, with 10 students currently awaiting their results.

We have also worked with the University of Greenwich to set up a three-year Paramedic Science course. The first intake of 18 began in September 2006, and a further 18 students will start there in September 2007.

Staff safety

Our staff suffered 298 reported incidents of physical abuse in 2006/07, with a further 1,260 reported incidents of non-

physical abuse, which includes anti-social behaviour, racism, and verbal abuse. Another 15 physical incidents and 469 verbal incidents were recorded as being 'near misses', where an incident occurred but the staff involved did not report any injury or distress.

Although the level of physical abuse is down on previous years, it is still too high and we continue to do all we can to try to reduce its frequency. We also continue to press for prosecutions against those who assault our crews.

We provided 278 members of staff with personal safety training, which teaches them the safest way to approach a patient and how to adopt non-aggressive body language.

Our high risk register holds information on addresses where our staff have experienced incidents of violence. This information is shared with police so that adequate support can be provided if we are called to the same address at a future date.

During the year we issued our frontline staff with emergency cards setting out the essential safety steps they should take when attending rail and underground incidents, and reminded them that their own safety is the first priority when attending any incident.

We hold regular training courses to improve the knowledge and skills of our staff





A number of staff were recognised for their efforts at our annual awards night

Rewarding our staff

We recognise the importance of showing our appreciation to our staff for the work they do.

We have recently restructured our awards department, broadening its area of responsibility to encompass the organising of conferences and inductions, along with awards ceremonies and passing-out ceremonies for newly-qualified staff. We are also finalising plans to ensure that our staff are properly recognised when they reach key long-service milestones from 10 to 40 years.

Our third annual awards ceremony was held to honour the work of some of our most exceptional members of staff. Once again, the nominees were voted for by their colleagues, with staff asked to put forward those who they felt had gone above and beyond the call of duty. Seventeen operational and non-operational members of staff were honoured at the event. Several former patients were among those who were



invited to attend the ceremony and they were reunited on the night with the ambulance crew staff who had treated them when they were taken ill. These patients later presented framed certificates and engraved glass blocks to the winners and to those who had been highly commended in the award categories.

We also held a special commemorative event to honour staff who worked on 7 July 2005, and remember those who lost their lives or were injured during the bombings that day. The event was attended by 250 members of staff from across the Trust.

Gill Hicks, a survivor of the bombings, spoke at the event to thank staff for saving her life and a recorded personal video message from then Prime Minister Tony Blair was played, in which he praised the courage and commitment of all those involved in our response to the bombings. Framed certificates signed by Mr Blair were also presented for display at stations and other buildings. Messages of thanks and support from Londoners were also played which expressed their gratitude and pride in the way the Trust had responded on the day.

Two members of staff were awarded MBEs in the New Year Honours list, one

Bombings survivor Gill Hicks, centre, and staff with certificates signed by Tony Blair



for promoting the use of bicycle-ambulances, and the other for re-introducing first aid training to the Royal Air Force's Air Training Corps.

Working environments

We have continued to work hard to improve the working environments for our staff and a number of our stations have been refurbished, with significant work taking place at Hillingdon, Shoreditch, Edmonton, and Friern Barnet ambulance stations.

There have been noteworthy improvements for our support staff, too. An extensive refurbishment of our office accommodation at London Bridge took place, enabling our Information Management and Technology Directorate to move there from our headquarters at Waterloo, while our Management Information and Professional Standards Unit were relocated from headquarters to our premises at Bow. A number of changes to the layout of office space at our headquarters will take place over the next year.

During the year we also undertook an important fire safety project, upgrading existing detection and alarm systems and installing appropriate new systems as required, to every ambulance station.

Working conditions for our staff across the organisation were also improved with the replacement of 233 PCs which were more than three years old. We also set up a new Information Management and Technology Service Desk to provide a single point of contact for all IT-related issues.

Going green

We continue to take steps to ensure that the Trust is a 'green' place to work.

We have made a decision to purchase new frontline vehicles which have diesel engines so as to improve our fuel economy and lower our carbon emissions. This replacement process began more than three years ago and we now have 260 of the newer type of vehicles. These consume around 2.5m litres less fuel each year, meaning the engines are not releasing as much carbon dioxide into the atmosphere.

Our manufacturers are also continuing to look into various emerging technologies but we will only introduce these once they prove themselves to be viable.

We are linked with the London Liftshare scheme to encourage our staff to share their car journeys to work. The scheme puts people in touch with others

who make similar journeys in their area, with the aim of reducing the number of cars in the already-congested capital.

When building or refurbishing ambulance stations we use extra insulation where possible to reduce our energy consumption.

We also provide recycling facilities for paper and printer cartridges and encourage staff to turn off lights, computers and televisions in order to not waste energy.

We have also begun printing our internal staff magazine on chlorine-free paper which is made from 80 per cent waste and has been awarded two important environmental certifications. Additionally, we have reduced our paper usage by stopping the printing of our weekly information bulletin and making it only available via our intranet.

Charitable work

We have continued to support the three children's hospices in London, which were adopted as our Chief Executive's charities in 2005/06.

Our staff have raised thousands of pounds for Richard House in Docklands, the Haven House Foundation in Woodford, and Shooting Star in Hampton, by taking part in a series of fund-raising events.

These included a five-a-side football tournament organised by staff, and a number of people from across the organisation ran through the pain barrier to compete in the Flora London Marathon, raising thousands of pounds in sponsorship in the process.



Performance

More calls to patients reported as being seriously ill or injured led to us experiencing our busiest ever year.

Meeting our targets

When a 999 call is made into our Emergency Operations Centre our call-handlers use their skills and sophisticated computer software to prioritise the urgency of the call, based on information about the nature of a patient's illness or injury.

Each call is assigned to one of three categories and will receive a response proportionate with its categorisation.

The most serious calls, where it is assessed that there is an immediate threat to life, are classed as Category A. Serious incidents are prioritised as being Category B calls, while those which are neither serious nor life-threatening fall into Category C.

Government-set performance targets require us to reach patients within nationally-agreed timescales, depending on the categorisation of the call. These targets were adjusted slightly on 1 April 2006.

The revised targets state that we must reach:

- 75 per cent of Category A calls within eight minutes
- 95 per cent of Category A calls within 19 minutes (previously 95 per cent within 14 minutes)
- 95 per cent of Category B calls within 19 minutes (previously 95 per cent within 14 minutes).

We also have targets for our response to urgent calls placed by GPs. When these requests are made, the GP must state the urgency of the response required, whether it be one, two, or three hours from the time they place the call. We are required to arrive at the agreed destination within 15 minutes of the agreed time in 95 per cent of these cases.

In 2006/07 we responded to:

- 75 per cent of Category A calls within eight minutes, matching our performance in 2005/06
- 98 per cent of Category A calls within 19 minutes. There is no direct comparison with last year, as the target was different
- 81 per cent of Category B calls within 19 minutes. Again, there is no direct comparison with 2005/06, as the target has been adjusted
- 75 per cent of urgent calls within 15 minutes of the booked time, compared to 51 per cent in 2005/06.

During 2006/07 we also:

- Received a total of 1,288,819 emergency calls into our Emergency Operations Centre, compared to 1,231,572 in 2005/06
- Attended a total of 865,537 emergency incidents, compared to 856,659 in 2005/06. Of these, 312,377 were classed as Category A, compared to 305,300 in the 12 months before
- Sent 1,191,374 emergency vehicles to these incidents, compared to 1,103,010 the previous year
- Made 46,077 urgent patient journeys, as requested by GPs, compared to 47,402 in 2005/06
- Undertook 321,347 special/planned patient journeys, compared to 375,705 in the year before. These journeys are pre-booked through us by healthcare professionals and include hospital and hospice transfers.



A&E performance

Last year was another challenging one, with the Trust being put under severe pressure as we received an extra 57,247 999 calls, and attended an additional 8,878 incidents.

Although we met both our Government targets for attending Category A calls, we failed to meet the Category B target. Our improved performance for attending Urgent calls was also not enough to meet that target.

We took steps to manage the increased demand being placed on us,

including the use of our Resourcing Escalation Action Plan, through which we monitor how much pressure we are experiencing and then translate it into one of five levels. For each of these levels, there is a range of measures we bring in to help us cope with the extra pressure. During the year we experienced periods when we reached level three (Severe Pressure) but this was subsequently reduced to two (Concern) in April 2007.

We set up a unit, based in our Emergency Operations Centre, to keep a broad day-to-day overview of our performance and make real-time operational decisions to ensure we were

working as efficiently as possible. The unit is responsible for monitoring hospital capacity and ambulance turnaround delays, managing standby of crews between calls, reducing vehicle downtime, and maximising resourcing.

During the year we introduced a new system of automatically dispatching our fast response cars to reduce the number of calls waiting to be sent a response and to improve our Category A response. The system, which improves our ability to dispatch the nearest available vehicle as soon as possible, had an impact within a month of being introduced.

Despite the introduction of these and



Our Patient Transport Service takes people to and from their hospital appointments

other measures, at times during the year the Trust was placed under particularly heavy pressure. Last summer's football World Cup created huge demand on us and over the weekend the England team was knocked out of the competition, we received more than 9,500 calls. The team's defeat coincided with a spell of hot weather which saw the Department of Health issue a heatwave warning. To try to off-set some of the pressure we expanded our use of a mobile treatment centre in Croydon and other town centres in Bromley, Kingston, and Romford to free up emergency ambulances to respond to seriously ill or injured patients.

In the run-up to Christmas, the number of calls we received on the traditional 'office party night' increased for the second year by 15 per cent. A trial of a treatment centre in the City of London was supported by messages through the media urging people to use our resources wisely. The festive period remained busy, and between midnight and 4am on New Year's Day we received eight per cent more calls than for the same period the previous year and the highest number since the Millennium.

A rise in the volume of Category A calls in January and February created additional pressure for us at the same time as severe financial constraints and the introduction of formal rest breaks for frontline staff stretched our service.

Improving Patient Transport Service performance

Our Patient Transport Service operates in a very competitive market as we have to compete against other providers, often private companies, to provide non-emergency transportation for patients to and from their outpatient appointments.

Like other providers, we are required to go through the tendering process and submit a proposal which not only shows that we can provide a high-quality service, but that we can do so at a competitive price.

In 2006/07 we lost a contract with the Chelsea and Westminster Hospital

worth £837,000 a year after being outbid by a private provider. Although our bid was rated highly in terms of training, quality of staff, and clinical care, other factors - such as price - resulted in our tender bid being unsuccessful.

We also lost a contract to take outpatients to and from their appointments at Hillingdon Hospital after we were again outbid by a private provider.

When we lose a contract we make every effort to redeploy the staff affected elsewhere in the Trust.

The annual PTS survey showed that overall patient satisfaction remained excellent at 90 per cent and complaints continued to remain low at less than one per 10,000 journeys.

Our performance at delivering patients to hospital on time improved to 87 per cent, compared to 82 per cent last year. Our performance for departing hospital on time rose slightly to 89 per cent.

During 2007/08 we aim to make a number of improvements to the Patient Transport Service. These changes are still being negotiated but could include a

revised planning system, two planning centres, revised methods of distributing and procuring vehicles, and a system of 'annualised-hours working' for staff.

The annual health check

The annual health check was introduced by the Healthcare Commission in 2005 to replace the previous star ratings system.

In the first of the new health checks, published in October 2006, we were rated as 'good' for our use of resources and 'excellent' for meeting new national targets.

However, as described by our Chairman on page 4, we voiced our disappointment after we were given the lowest rating for our quality of services, an assessment which we did not feel reflected our achievements.

The 'weak' rating was made because, despite achieving the top two targets concerning our most seriously-ill patients, we did not meet the target of responding within 14 minutes in 95 per cent of cases to Category B patients in the 2005/06 financial year. We were also penalised because the Commission's assessment did not take into account the impressive out-of-hospital cardiac arrest survival rate of patients treated by our staff.

Additionally, our heart attack patients get some of the best treatment in the country because they are taken directly to specialist cardiac centres for angioplasty. However, the Commission still used thrombolysis as the measure in its ratings, which is now widely accepted as being less effective than angioplasty.

We have made our case to the Commission and await the next assessment of our performance later this year.

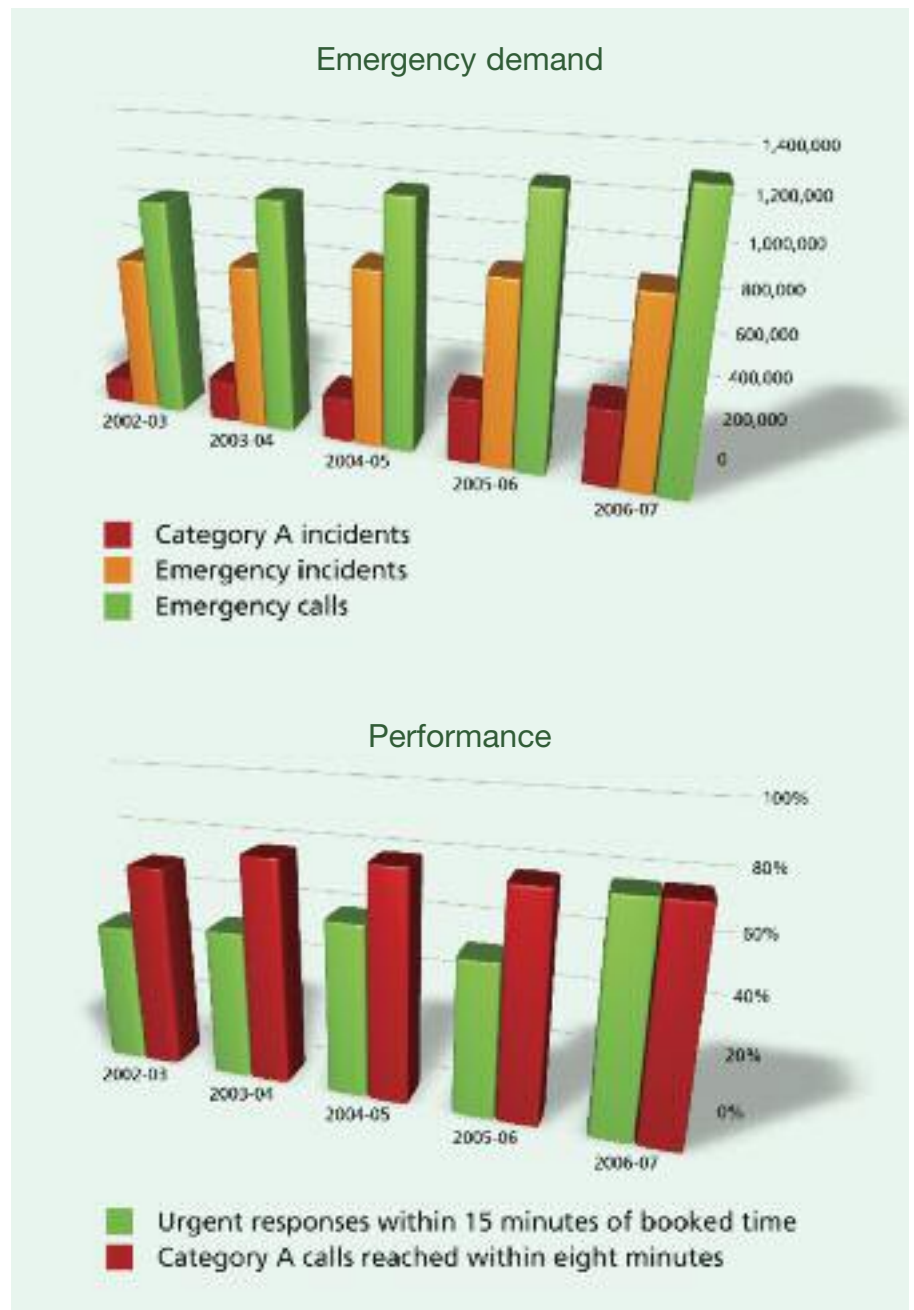
Improving our fleet

Last year we brought in 20 new Mercedes-Benz Sprinter ambulances to replace old vehicles in our fleet.

We acquired an additional 25 fast response cars, meaning that we now have a total of 116 cars, 12 of which are used by our emergency care practitioners.

In addition we have introduced vehicles which are used by our new Hazardous Area Response Team, which is described on page 27.

These include a command and control vehicle which contains a sophisticated IT system, a reconnaissance-and-light equipment vehicle, and an equipment-only vehicle.





A vision of how London could look when it hosts the 2012 Olympics

Managing large scale events

The large-scale events we have managed this year include the Notting Hill Carnival, Flora London Marathon, and New Year's Eve.

On a smaller scale, we are also responsible for managing many other significant events on a weekly basis in the capital, such as football matches and music events.

London Ambulance Service NHS Trust

We are well aware that our ability to handle large-scale events will be put to the test like never before when London hosts the Olympic and Paralympic Games in 2012. Although we had already invested significant time in assessing how the Games will impact on us, this year we took things a stage further by launching a full-time team to plan for the event.

This unit has developed relationships with the teams behind the Olympics and Commonwealth Games in Sydney, Melbourne, Manchester and Vancouver,

to see what their experiences can teach us.

We will act as co-ordinator on aspects of Olympic delivery between ambulance services outside the capital and partner agencies such as the Olympic Delivery Authority and the London Organising Committee of the Olympic Games.

Staff from the team, which will increase in size as we get closer to 2012, will be involved in consultation on aspects of design for the Olympic Park stadia and village, the transport plan, security, and diversity.

Preparing for the unexpected

The events of 7 July 2005 highlighted the need to have robust plans in place for dealing with major incidents.

We have continued to develop our emergency planning, and have used our experiences of the London bombings to ensure we are as prepared as we can possibly be for dealing with these types of events.

In June 2006, the London Assembly's 7 July Review Committee published the findings of its review of the response to the bombings. It praised the courage and determination of emergency service staff on the day, but said some of the processes used by the organisations involved needed to be addressed.

The Committee's main criticisms of the Trust focused on communications issues, the lack of medical equipment at scenes, the delay in the second wave ambulances reaching one of the sites, and the distribution of patients to hospitals.

However, we are proud of the way our staff treated and transported more than 400 patients to hospitals from all of the four incidents within three hours.

We acknowledge that certain things could have been done better and, in particular, we have accepted that we experienced difficulties with communications, and the Committee's findings broadly reflected those of our own debriefs. In November we reported back to the Committee on the progress we had made against its recommendations.

One of the steps we have taken to improving our response is to alter our pre-determined attendance to serious and declared major incidents, to ensure that a significant number of ambulances, senior staff, and supplies are sent to the scene of such emergencies immediately.

We received 200 digital radios as part of the national Airwave ambulance contract and it is envisaged that we will complete the move of all our radio communications over to the new Airwave network in 2008.

We were involved in a number of scenario-planning exercises to test our approach to major incidents, including a training event to test how the emergency services would deal with a boat disaster on the River Thames. The exercise, which was directed by the Maritime and Coastguard Agency, involved the evacuation of a passenger vessel which was in danger of sinking and the rescue of a number of casualties from the water.

In February we also took part in Winter Willow, a Government exercise to test Britain's ability to manage the effects of an influenza pandemic. The exercise involved running through the decision-making processes which would occur at national, regional and local levels when there are widespread cases of flu around the country. We learned many lessons from the exercise, in particular around how we would cope with large numbers of our staff unable to work because they are themselves ill.

Last year also saw the launch of a new Hazardous Area Response Team (HART) trained to work in the area at the heart of an incident. Whilst this team will be our first response to chemical, biological and radiological incidents, they are also trained to operate in any hazardous area. The Department of Health commissioned the setting up of

HART in December 2006 to evaluate a new approach to responding to casualties within the inner cordon of incidents. The lessons learnt by HART will be fed back to the Department of Health and will inform the way that all ambulance trusts in England respond to hazardous incidents in the future.

Our Hazardous Area Response Team works within the inner cordon of serious incidents



The Board

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

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

Our Service Development Committee and Remuneration Committee are made up of all our non-executive directors. Our Audit Committee comprises Barry MacDonald, Sarah Waller, Caroline Silver, and Roy Griffins.

Our Clinical Governance Committee is chaired by Beryl Magrath and is also comprised of Sarah Waller and Ingrid Prescod. Our Charitable Funds Committee is chaired by Barry MacDonald.

Non-Executive Directors

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

Barry MacDonald is a consultant in media and communications, and was formerly Director of Resources and Corporate Development for the Human Fertilisation and Embryology Authority. His previous roles include those of Finance Director of the Central Office of Information and of the National Lottery Charities Board, and General Manager of Reuters Television.

Dr Beryl Magrath MBE is a retired consultant anaesthetist. She was a founder of South Bromley HospisCare in 1984, and was Medical Director of Bromley Hospitals NHS Trust from 1992 to 2000. She is now Vice-Chairman to the Board of Trustees of Harris HospisCare, as well as a primary school governor.

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

Caroline Silver took up her post as a non-executive director of the Trust in March 2006. A chartered accountant, she is Vice Chairman of the Investment Banking Division at US investment bank, Morgan Stanley. In her 13 years at Morgan Stanley, she has 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 of the Trust in March 2006. He was Director General of the Airports Council International (ACI) Europe from 2004-06, having served as UK Director of Civil Aviation between 1999 and 2004. Previously, he worked as Director of Public Affairs at Eurotunnel PLC after a career of nearly 30 years spent in the British civil and diplomatic service, mostly in international, transport and environment posts. He is also Chairman of London City Airport, head of the British delegation to the Channel Tunnel Inter-governmental Commission, and a member of the Franco-British Council.

Dr Ingrid Prescod took up her post as an associate non-executive director of the Trust in March 2006 before being appointed as a non-executive director in April 2006. She acts as a consultant to organisations on a variety of organisational development issues, and is also an Associate Director in the Centre for Management Development at the London Business School. Previously, she was Director of Management and Professional Development for the Oracle Corporation's Europe, Middle East and Africa region. This followed a period of 15 years in senior management development roles in a number of sectors.

Executive Directors

Chief Executive Peter Bradley CBE

joined the Trust in May 1996 as Director of Operations and was appointed Chief Executive Officer and Chief Ambulance Officer in 2000. He worked for 20 years in a variety of posts with ambulance services in New Zealand, latterly as Chief Ambulance Officer of the Auckland Ambulance Service. He holds an MBA from the University of Otago in Dunedin, New Zealand and he 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.

Director of Operations Martin Flaherty OBE

joined the Trust in 1979. He holds a BSc in Biochemistry/Biology from the University of London. 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 co-ordinating the emergency medical response to the 7 July bombings that year. He was awarded an OBE in the 2006 New Year Honours.

Director of Human Resources and Organisation Development Caron Hitchen

joined the Trust in May 2005. A qualified nurse, Caron's career has been predominantly NHS-based, including five years at Mayday Hospital NHS Trust as Director of Human Resources and, prior to that, seven years in human resources management roles at Ealing Hospital NHS Trust.

Director of Finance Michael Dinan

joined the Trust in November 2004. He previously worked for 13 years at the United Parcel Service in a variety of positions including Group Finance Director for the European logistics business.

Medical Director Fionna Moore

was appointed in December 1997 and was made an executive director in September 2000. Dr Moore 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 the Fellowship in Immediate Medical Care by the Faculty of Pre-Hospital Care of the Royal College of Surgeons Edinburgh. She also chairs our Clinical Steering Group and Clinical Audit and Research Group.

Directors

Director of Communications David Jervis

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

Director of Information Management and Technology Peter Suter

began working for the Trust in November 2004, after serving as Head of Information Technology at Sussex Police for 10 years. Previous to that, he had worked for Siemens-Nixdorf, GEC in South Africa, and BT.

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).

The Board meets bi-monthly on Tuesdays from 10am in the conference room at the Trust's headquarters.

The remaining meetings of 2007 will be held on 25 September and 27 November. The meetings of 2008 are scheduled to take place on 29 January, 18 March, 20 May, 29 July, 30 September and 25 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.

Income and Expenditure £000s

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Surplus/Deficit(-) in year	101	46	94	89	332	1,258	113
Cumulative Surplus/Deficit(-)	-486	-440	-346	-257	75	1,333	1,446
Cumulative deficit permitted (0.5%)	-618	-678	-804	-843	-963	-1,080	-1,080

The surplus in 2006/2007 meant that the cumulative position improved for the seventh year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

The Trust fulfilled all four of its statutory financial duties in 2006/2007:

1. On income and expenditure the Trust reported a surplus of £113,629 for the year, and therefore did better than the break even target set for it by the Department of Health for 2006/2007.
2. The Trust achieved its EFL (external financing limit) for the year.
3. A return on assets (the capital cost absorption duty) of 3.99 per cent was achieved. This was within the permitted range of 3.0 per cent to 4.0 per cent.
4. In the capital programme £7.6m was spent on a range of projects, including rapid response vehicles, new technology projects, and projects to improve the estate. Overall the Trust underspent by £2.8m against its Capital Resource Limit of £10.4m, which it is permitted to do.

The financial year 2006/2007 was a challenging one for the Trust. The Trust had to internally generate funds through cost saving initiatives to continue to implement changes in service delivery, meet increased demand in activity and to maintain accident and emergency response time performance.

The Trust was able to pay 83 and 77 per cent of its non-NHS and NHS trade invoices respectively within 30 days, which was below the 95 per cent target set for it by the Department of Health.

The Audit Commission was the Trust's external auditors for the year ending 31 March 2007. The Trust paid the Audit Commission £147,305 for audit services relating to the statutory audit. The Audit Commission did not provide any other services for the Trust.

There were no important events occurring after the year end that had a material effect on the 2006/2007 accounts. The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

Remuneration report

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

The Remuneration Committee is responsible for advising the Board about appropriate remunerations and terms of service for the Chief Executive, executive directors, and 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 three 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 36.

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



Chief Executive Officer

20 June 2007

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

I have examined the summary financial statements set out below.

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

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statements with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion

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

Opinion

In my opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2007 on which I have issued an unqualified opinion.

Susan M Exton, Audit Commission
1st Floor, Millbank Tower, Millbank, London, SW1P 4HQ 21 June 2007

Related party transactions

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

Chairman Sigurd Reinton is also a member of the Ambulance Service Association (ASA). During the year details of related party transactions undertaken by the Trust with the Ambulance Service Association.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due to Related Party
	£	£	£	£
Ambulance Service Association	286,094	2,047	93,752	88

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Richmond & Twickenham PCT;
the NHS Litigation Authority;
the NHS Supply Chain;
the NHS Pensions Agency;
Other Primary Care Trusts.

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

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

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

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



Chief Executive Officer

20 June 2007

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board



Chief Executive Officer

20 June 2007



Finance Director

20 June 2007

STATEMENT ON INTERNAL CONTROL 2006/07

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, process and monitoring arrangements set out in the 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.

The London Ambulance Service NHS Trust is an employer with staff entitled to membership of the NHS Pension Scheme; control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

A summary of the 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.

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 2007 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 corporate, financial, clinical, and health and safety; with the Director of Finance having overall responsibility for financial risk and any other corporate risks not covered by other directors. The Director of Finance attends the Audit Committee and chairs the Standards for Better Health Group, which oversees the part of the Annual Health Check that includes the healthcare standards. 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 Policy, are approved at the Risk Compliance and Assurance Group. The tool has recently been amended to use 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 allocation for service development.

The Trust has recently reviewed its governance arrangements and other infrastructure requirements that are statutory, mandatory or desirable for the organisation. The review considered the strengths and weaknesses of current governance practice within the 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 an assessment was undertaken against the Risk Management Standard for the Provision of Pre-Hospital Care in the Ambulance Service by the NHSLA which involved a cross-section of staff from all areas and levels of the organisation.

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 the Incident Reporting procedure. All incidents are assessed using the London Ambulance Service Risk Scoring Matrix and according to grade and score investigated so that actions can be implemented to prevent a re-occurrence. The Infection Control Steering Group has undertaken a self assessment delivered to all complexes, which has been undertaken by trained frontline staff, and produced an Annual Infection Control Report to the Board which provided assurance regarding the application of the Make Ready Scheme.

In addition to the Risk Management Policy and the Risk Register, the 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's 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.

The development of the Assurance Framework is an ongoing process and it will be amended to include Board level objectives as they are reviewed and developed in strategic plans. As the Framework covers all of our organisation's main activities, it is a key tool in examining the system of internal control that is in place to manage our risks. The Assurance Framework provides the Board with assurance of full compliance with the core standards of the Annual Health Check and was also offered as evidence of compliance by the Overview and Scrutiny Committees of the boroughs of London. It helps contribute evidence in support of the Statement of Internal Control.

The Assurance Framework has highlighted some gaps in control and assurance to the Board. This is part of an ongoing process where the Board uses the Assurance Framework as a decision-making tool. Building on gaps from last year's Statement of Internal Control, developments in controls and assurance have taken place in the following areas:

Human Resources and Organisation Development

- An internal audit reviewed our system for Criminal Records Bureau and Protection of Children Amendment (POCA) checks. Checks are in place building on the previous year's audit to ensure us that we remain compliant with the national guidance to check staff who have direct patient contact. The effectiveness of protection and training guidance for children and vulnerable adults, has been monitored by the Child and Adult Protection Group, led by the Medical Director, using existing staff to strengthen controls with the management of child protection.
- The Trust has had a Race Equality Scheme in place that complies with the current legislation. Controls to achieve equality have been strengthened by the introduction of the Disability Equality

Scheme and the completion of the project to deliver a robust Gender Equality Scheme. Controls are in place to ensure that these schemes are ready for integration into a single Equality Scheme which will continue our compliance with other statutory duties covering religion/belief, sexual orientation and age. Controls remain in place that were achieved by the Trust when it achieved the Practice Plus standard of the Improving Working Lives initiative.

Operational Support

- A Fleet and Transport Management audit highlighted the need for having records of vehicles when they are out of service. Fleet Status Reporting options have been explored, starting with a manual reporting system.

Clinical

- With the development of clinical performance indicators and the ability to utilise electronic recording facilities, the Clinical Audit Research Group will oversee enhanced audit reports from all operational staff. A three-year plan to reach 95 per cent compliance with clinical performance indicator audits from patient report form monitoring has been put in place.

Control Services

- Immediate dispatch of calls when there is only one hour to scheduled time of arrival is to be implemented, a triaging system has been introduced and a blue-light response given to urgent calls required to be in hospital within one hour.

Information Management and Technology

- Controls have been enhanced with the implementation of the Trust's Records Management Policy and the establishment of a Trust-wide records and information team. The team will ensure that systems and processes for the standardisation of records management processes across the Trust are fully effective. The progress made by the Information Governance Panel has enabled the requirements of the Freedom of Information Act to be managed effectively and the Information Governance toolkit to be completed as required.

Business Continuity

- The Business Continuity Steering Group monitors the Trust's Business Continuity Policy and the Business Continuity Plan. It is chaired by the Director of Finance and uses a project management approach to ensure that all departments have in place business continuity arrangements to maintain critical functions should the need arise. Business continuity arrangements are linked to the Trust's major incident and other emergency plans. The Emergency Preparedness Strategy Group, chaired by the Deputy Director of Operations, supports these plans and strengthens these controls by testing these arrangements with multi-agency exercises.

A&E Operations

- National Category B targets have been highlighted by internal performance monitoring mechanisms as being at high risk for non-achievement. The senior A&E management team have implemented a range of high-impact changes in 2006/07 together with linked performance improvement trajectories designed to address this issue.

Finally, with respect to the risk and control framework, complaints are routinely used to help identify risks to the Trust and determine appropriate action to reduce risk and limit the possibility of reoccurrence in the future. Developments of the Mental Health Strategy have involved contributions from patients; plans have been agreed to appoint a Head of Policy and Evaluation to oversee implementation of this strategy. The Patient Advice and Liaison Service has had a significant impact on managing risks, with a comprehensive understanding of inter-agency working producing a higher quality of patient care Trust-wide.

5. 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 the 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, the HSE 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 the Trust is 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. The Risk Compliance and Assurance Group has delegated responsibility for taking a general overview of all risk management activities within the Trust and to pick up any specific risk management issues which are not covered by the specific Audit and Clinical Governance Committees. This group also receives a report on the management of all identified high priority risks that have been identified by the Trust's systems and processes. A full Trust-wide risk assessment was undertaken this year.

The structure is supported by the Executive Managers of the Trust 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 Standards for Better Health Group. The Director of IM&T is responsible for all risks arising out of the provision, use, operation and maintenance of the Trust's technology and communication systems; he jointly chairs the Information Governance Panel with the Medical Director. The Director of Communications is chair of the Patient and Public Involvement Committee.

To supplement this mechanism, information is provided to the Board through minutes and annual reports on risk management, infection control, the Patient Advice and Liaison Service 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 which is reflected in the risk and assurance frameworks.



Chief Executive Officer
(on behalf of the Board)

20 June 2007

Income and expenditure account
for the year ended 31 March 2007

	2006/07 £000	2005/06 £000
Income from activities	214,140	212,984
Other operating income	1,801	2,963
Operating expenses	(212,068)	(210,497)
OPERATING SURPLUS	3,873	5,450
Cost of fundamental reorganisation/restructuring	0	0
Profit on disposal of fixed assets	(19)	22
SURPLUS BEFORE INTEREST	3,854	5,472
Interest receivable	526	391
Interest payable	(1)	0
Other finance costs – unwinding of discount	(132)	(129)
Other finance costs – change in discount rate on provisions	0	(743)
SURPLUS FOR THE FINANCIAL YEAR	4,247	4,991
Public Dividend Capital dividends payable	(4,134)	(3,733)
RETAINED SURPLUS FOR THE YEAR	113	1,258

All income and expenditure is derived from continuing operations.

Balance Sheet
as at 31 March 2007

	2007 £000	2006 £000
FIXED ASSETS		
Intangible assets	1,593	447
Tangible assets	113,013	106,257
	114,606	106,704
CURRENT ASSETS		
Stocks and work in progress	1,965	1,916
Debtors: Amounts falling due:		
within one year	6,121	13,437
after one year	9,766	9,543
Cash at bank and in hand	719	667
	18,571	25,563
CREDITORS:		
Amounts falling due within one year	(6,998)	(9,193)
NET CURRENT ASSETS/(LIABILITIES)	11,573	16,370
TOTAL ASSETS LESS CURRENT LIABILITIES	126,179	123,074
CREDITORS:		
Amounts falling due after more than one year	0	0
PROVISIONS FOR LIABILITIES AND CHARGES	(15,464)	(24,539)
TOTAL ASSETS EMPLOYED	110,715	98,535
FINANCED BY: CAPITAL AND RESERVES		
Public dividend capital	55,526	49,617
Revaluation reserve	46,776	41,261
Donated Asset Reserve	294	508
Other reserves	(419)	(419)
Income and expenditure reserve	8,538	7,568
TOTAL CAPITAL AND RESERVES	110,715	98,535



Chief Executive Officer

20 June 2007

Cash flow statement for the year ended 31 March 2007

	2006/07 £000	2005/06 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	5,380	(558)
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	526	391
Interest paid	(1)	0
Interest element of finance leases	0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance	525	391
CAPITAL EXPENDITURE		
Payments to acquire tangible fixed assets	(6,313)	(5,589)
Receipts from sale of tangible fixed assets	9	35
Payments to acquire intangible fixed assets	(1,295)	(186)
Net cash (outflow) from capital expenditure	(7,599)	(5,740)
DIVIDENDS PAID		
Net cash inflow/(outflow) before financing	(5,828)	(9,640)
FINANCING		
Public dividend capital received	5,909	9,640
Public dividend capital repaid (not previously accrued)	0	0
Public dividend capital repaid (accrued in prior period)	0	0
Capital element of finance leases	0	0
Net cash outflow from financing	5,909	9,640
Increase/(Decrease) in cash	81	0

Statement of total recognised gains and losses for the year ended 31 March 2007

	2006/07 £000	2005/06 £000
Surplus for the financial year before dividend payments	4,247	4,991
Unrealised surplus on fixed asset revaluations/indexation	6,386	2,540
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed asset	0	17
Additions/(reductions) in "other reserves"	0	(429)
Total recognised gains and losses for the financial year	10,633	7,119
Prior Period Adjustment	0	0
Total gains and losses recognised in the financial year	10,633	7,119

Salary and Pension entitlements of Non-Executive and Executive Directors

A) Remuneration

Name and Title	2006-07 Salary Remuneration (bands of £5000)	2006-07 Other Rounded to the (bands of £5000)	2006-07 Benefits in Kind Remuneration nearest £100	2005-06 Salary Rounded to the (bands of £5000)	2005-06 Other (bands of £5000)	2005-06 Benefits in Kind nearest £100
Sigurd Reinton, Chairman	£20,001-£25,000	£0		£20,001-£25,000	£0	
Barry MacDonald, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£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		£0-£5,000	£0	
Ingrid Prescod, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	£0	
Peter Bradley, Chief Executive	£180,001-£185,000*	£0	£4,300	£150,001-£155,000	£0	£5,000
Michael Dinan, Director of Finance	£100,001-£105,000	£0		£90,001-£95,000	£0	
Martin Flaherty, Director of Operations	£95,001-£100,000	£0	£2,100	£90,001-£95,000	£0	£3,000
Caron Hitchen, Director of Human Resources	£90,001-£95,000	£0		£75,001-£80,000	£0	
** Fiona Moore, Medical Director	£75,001-£80,000	£0		£60,001-£65,000	£0	

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

* Includes remuneration for additional responsibilities linked to role as Department of Health National Ambulance Advisor (2 year period)

** Fiona Moore is an employee of Hammersmith Hospital who works part-time for the London Ambulance as Medical Director

Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension at age 60 in pension 2007 (bands of £2,500)	Lump sum at aged 60 related to real increase at 31 March 2007 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2007 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2007 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2007	Cash Equivalent Transfer Value at 31 March 2006	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	£2,501-£5,000	£10,001-£15,000	£30,001-£35,000	£159,001	£132,437	£16,277	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£0-£5,000	£5,001-£10,000	£38,820	£19,087	£13,479	
Martin Flaherty, Director of Operations	£2,501-£5,000	£10,001-£12,500	£30,001-£35,000	£95,001-£100,000	£493,909	£416,909	£46,603	
Caron Hitchen, Director of Human Resources	£0-£2,500	£0-£2,500	£15,001-£20,000	£55,001-£60,000	£259,502	£233,307	£14,254	
Fionna Moore, Medical Director	£2,501-£5,000	£7,501-£10,000	£55,001-£60,000	£110,001-£115,000	£662,740	£584,154	£44,788	

** 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

	2006/07	2005/06
	£000	£000
Management costs	13,803	12,226
Income	215,931	215,645

Better payment practice code - measure of compliance

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

	2006/07	2006/07	2005/06
	Number	£000	£000
Total bills paid in the year	47,974	50,891	52,112
Total bills paid within target	39,782	45,601	43,999
Percentage of bills paid within target	82.92%	89.60%	84.43%

External financing

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

	2006/07	2005/06
	£000	£000
External financing limit set by the NHS Executive	5,828	9,640
External financing requirement	5,828	9,640
Undershoot	0	0

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

Explanation of Statutory Financial Duties

Break-Even Duty

The Trust is required to break-even on its 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% of turnover under the agreed limit. There is no tolerance above the EFL target without prior notification and agreement.

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

Each year, each individual NHS Trust is allocated an EFL as part of the national public expenditure planning process. The Trust has a statutory duty to maintain net external financing within its 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 limits. The CRL is accruals based as opposed to the cash-based EFL in NHS Trusts.

Underspends against the CRL are permitted and can be carried forward. 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. The Trust is 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 the Trust must achieve a rate between 3 per cent and 4 per cent.

Photography:

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NHS Trust: *pages 4-5, 11 (bottom right), 15, 20, 27*

Dan Atkin:
pages 2, 6-10, 11 (top), 14, 16-19, 21 (bottom), 23-25

Evening Standard: *page 12*

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NASA/GSFC/METI/ERSDAC/JAROS, and U.S./Japan ASTER
Science Team: *page 3*



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