



London Ambulance Service **NHS**

NHS Trust



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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 largest ambulance service in the world to provide healthcare that is free to patients at the point of delivery. It is the only London-wide NHS Trust and is 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, five 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 over 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 2004/05, we handled 1.1 million emergency calls from across London - approximately one in five of the 999 calls to the ambulance services in England - and cared for more than one million patients.

We employ 4,000 staff, run 400 emergency ambulances, 195 Patient Transport Service vehicles, 70 rapid-response cars, 14 cycle-response units, 10 motorcycle-response units, five special-care baby units and three baby emergency transfer vehicles. We also task the Helicopter Emergency Medical Service (HEMS), based at the Royal London Hospital.

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



*We are the only
London-wide
NHS Trust*



Chairman's views

We are in the final year of the Trust's Service Improvement Programme.

What has been achieved so far?

Most of what we set out to do has been achieved and, as a result, the Trust has changed almost beyond recognition. Frontline crews have better equipment and support to do their job. Staff morale and our response times have improved, and patients are getting much better clinical care.

What are the priorities for the final year?

They include increasing the number of frontline crews, reviewing our paramedic training to better reflect the work we actually do, developing strategies for long-term medical conditions and for older people, adding more small satellite stations, extending our recently-introduced 'make-ready' system for cleaning and re-positioning ambulances, and implementing the new NHS pay and conditions system Agenda for Change.

The Trust's vision is to become world-class. What do you mean by that?

Our response to the terrorist Tube and bus bombings on 7 July 2005 demonstrated the world-class professionalism and commitment of our staff in the most extreme of situations.

We are working towards our performance – in terms of response times, patient satisfaction and outcomes – being among the best anywhere in the world. We are not there yet but we are getting closer. For example, in the past year, we again met our key response time target for life-threatening calls. More importantly, twice as many of the patients we treated for cardiac arrest survived as five years ago.

We want to lead the way in innovative research, creative thinking and service improvement. Recent examples include clinical trials, jointly with Seattle, of greatly simplified telephone instructions for bystanders involved in resuscitating cardiac arrest victims and, jointly with Oslo and Chicago, of improved quality of resuscitation by ambulance crews.

We have also introduced new protocols with 10 specialist units that enable us to take heart attack victims direct to cardiac units where patients' blocked coronary arteries can be opened, bypassing A&E departments and so saving vital time.

We have introduced a new cycle response team at Heathrow Airport and emergency care practitioners across London who act as first responders and can assess and treat or refer patients with complex conditions for whom admission to a hospital A&E department may be not be appropriate.

How do you see the Trust's services developing in the next five years?

After two years of pilot-testing, we are now ready to expand the emergency care practitioner programme dramatically. In time, these practitioners will become our normal initial response to most 999 calls, with frontline ambulance or other transport to follow where required. Emergency care practitioners will also be responding increasingly to requests for GP home visits – working hand-in-hand with the GPs concerned.

We will support our clinical telephone advice service by putting in experienced clinicians and practitioners, including GPs and emergency nurse practitioners, to provide a telephone consultation straight away, rather than calling back later, in cases where it seems likely from the outset that an immediate 999 response might not be needed.

Some of the time, it will turn out that a 999 or GP response is in fact needed and, in those cases, the crew will have the benefit of the information obtained during the telephone consultation. Many people can, however, be better helped by receiving telephone advice, being directed to the nearest GP or minor injuries unit or, increasingly, by being referred on to the most appropriate form of NHS care.

The tasking of all 'emergency' mobile resources – whether emergency care practitioners, first responders, ambulances, GPs or staff providing care for non-life-threatening conditions – will be brought under one roof, and will be co-located with our upgraded clinical telephone advice service.

What will be the key factors in developing these plans?

Extra funding to get from where we are to the Trust that I have just described will be essential and is problematic, given the financial difficulties facing so many of London's primary care trusts. Once the transition is made, the service we offer will cost the NHS less per patient than today, and will offer much better patient care.

By far the most important factor in the success of the Trust in recent years, however, has been our staff. What we have achieved as a Trust has been because they have delivered. I am confident that we shall become a truly world-class service and develop into the emergency care service I have described because I have confidence in our people. It is truly a privilege to be associated with such a wonderful group.

Sigurd Reinton
Chairman



What were the Trust's biggest challenges and achievements during the last year?

Our biggest challenge came in July this year in the aftermath of the multiple bombings on the capital's public transport system. All of our staff can be proud of the heroic way they worked together and with our partner agencies to save lives in the most taxing of circumstances.

In other ways too, it has been a really busy and testing year. In the face of increasing 999 demand, we achieved our main performance target to reach 75 per cent of patients with life-threatening illnesses or injuries within eight minutes. That is an enormous tribute to the commitment and support of all our 4,000 staff.

In partnership with the unions, we also worked towards the introduction of Agenda for Change, the most significant change to pay and conditions in the history of the NHS.

Other key achievements during the year included our being awarded Improving Working Lives Practice Plus status – we were one of the first ambulance services to achieve this.

In the annual national staff survey we were the 'top' ambulance service in terms of quality of leadership and senior management, and also scored the highest in staff retention.

Were there any disappointments?

It was frustrating that we did not meet one of our key performance targets, as we would have been awarded three stars instead of two by the Healthcare Commission.

It was disappointing to lose one of our biggest PTS contracts at Hammersmith Hospitals NHS Trust when staff there were doing such a great job. Competing with companies from the private sector is challenging but I am pleased that we do not compromise the high quality of our service in order to cut costs. We will continue to seek new contracts and we will carry on our plan to bring our PTS closer to our A&E service.

Demand for services increased again this year. What were the implications for the Trust?

It is clear that demand for our services will continue to increase and we are feeling the pressure. We must continue to find ways of ensuring that those patients with life-threatening, or very serious, injury or illness receive the fastest possible response while, at the same time, ensuring that we are in a position to care for the large numbers of our patients with less serious conditions.

Through the creation of our Urgent Care Service, we are developing a range of different responses so we can deliver more appropriate care to the wide range of patient needs. This consists of a number of elements – more clinical

Chief Executive's views

telephone advisors, a new tier of emergency medical technicians to deal with lower-priority calls and, at the other end of the scale, an increasing number of emergency care practitioners whose extra skills enable them to assess more accurately the needs of patients and arrange for the most appropriate care available. As these initiatives are developed, we will be able to target our core 999 double-crewed ambulances at those patients who most need them.

What changes will patients have noticed during the year?

It is difficult to say, although many will have benefited from our new urgent care initiatives and the enhanced care we are able to offer in our growing fleet of new yellow ambulances, complete with the latest high-tech patient care equipment.

One important development, which may not have been noticed by many people but will have had a crucial impact on the lives of some patients, is our improving cardiac arrest survival rates which, between 1999 and 2004, increased from 4.2 per cent to 8.1 per cent. This is one of the few ways that improvements in patient care can be measured and the huge attention we are giving to improving our cardiac care is clearly paying dividends.

What will follow the Service Improvement Programme?

Work is underway on developing a seven-year plan to run from April 2006 and we have sought the views of many interested parties including patients, staff, union representatives, NHS colleagues, local authorities, the other emergency services and suppliers. All their views will be taken into account as we design and develop the next chapter in our journey to become a world-class service.

What impact will the National Ambulance Review have on Londoners?

Our country is on the verge of a revolution in how pre-hospital care is delivered and ambulance services are at the heart of this huge change. The days of sending an ambulance crew to every patient who has called for medical help, no matter what their medical requirement might be, are now history. Together with our colleagues throughout the NHS, we are designing a range of different responses to meet different needs and to ensure that the patient is at the centre of all our planning.

The National Ambulance Review builds on this theme and paves the way for real change both in raising the skill levels of staff and in raising further the quality of patient care.

Peter Bradley CBE
Chief Executive and Chief Ambulance Officer



The Trust Board

The Board

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

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

Our Audit and Risk Management Committees comprise Barry MacDonald as Chairman and Sarah Waller, the latter committee also being attended by Colin Douglas. The Trust Chairman chairs the Service Development Committee, while he and the non-executive directors make up the Remuneration Committee.

Our Clinical Governance Committee is chaired by Beryl Magrath and our Charitable Funds Committee is chaired by Barry MacDonald.

*We are an integral
part of the NHS
in London*

Non-executive directors

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

Colin Douglas is the Director of Communications at the Health and Safety Executive. He worked previously in a similar post at the Audit Commission, Transport for London and Sport England and for a range of local government and public service organisations in the capital. He has a reputation for, and commitment to, ethnic minority concerns.

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

Barry MacDonald is the Director of Resources and Corporate Development at the Human Fertilisation and Embryology Authority. He has previously been Finance Director of COI Communications (formerly the Central Office of Information), of Scope, and of Reuters Television.

Dr Beryl Magrath took up her post as a non-executive director of the Trust in April 2005, having served as an associate director since December 2003. A former consultant anaesthetist, she worked latterly at Orpington Hospital in Kent and was a founder of South Bromley HospisCare in 1984. She was Medical Director of Bromley Hospitals between 1992 and 2000 and is now Vice-Chairman of Harris HospisCare.

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.

Suzanne Burn left the Trust in December 2004.



Executive Directors

Chief Executive Peter Bradley CBE joined the Trust in May 1996 as Director of Operations and was appointed Chief Executive 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 and holds an MBA from the University of Otago in Dunedin, New Zealand. 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 joined us 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.

Director of Human Resources and Organisation Development Caron Hitchen took up her appointment in May 2005. A qualified nurse, her 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.

Former Director of Human Resources and Organisation Development Wendy Foers left the Trust in June 2005.

Director of Finance Michael Dinan joined the Trust in November 2004. Previously he worked in the Dixons Group where he was involved in restructuring its supply chain. Before that, he had worked for 13 years at the United Parcel Service (UPS) where he rose to position of Group Finance Director for the European logistics business.

Former Director of Finance Mark Jones left us in October 2004.

Medical Director Fionna Moore was appointed in December 1997 and was made an executive director in September 2000. Dr Moore has 20 years' experience as an A&E consultant, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She also chairs our Clinical Steering 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.

Former Director of Technology Ian Tighe left the Trust in January 2005.

Former Director of PTS Keith Andrews left the Trust in April 2005. The decision has been taken to disestablish the post of Director of PTS from October 2005.

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).

Senior managers

Former Deputy Chief Ambulance Officer (West) Philip Selwood left the Trust to join Gloucestershire Ambulance Service NHS Trust as its chief executive officer in March 2005.

The Board meets on Tuesdays from 10am in the conference room at the Trust's headquarters. Agendas for these meetings are available on the Trust's website at www.londonambulance.nhs.uk.

The remaining meetings of 2005 will be held on 27 September and 29 November. The meetings of 2006 are scheduled to take place on 31 January, 28 March, 23 May, 25 July, 26 September and 28 November respectively.

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



Service

Service Improvement Programme

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



The 2004/05 financial year was the penultimate of our five-year Service Improvement Programme that has advanced the way the Trust operates, to the benefit of both its patients and its staff.

The Programme, begun in 2000 and scheduled for completion in March 2006, was designed both to raise the standard of care received by our patients and to improve the quality of working life we provide for all our staff.

Consultation with staff has been key to the success of the Programme because we value their views on how the Trust can be improved. The issues they raised at our annual Chief Executive consultation meetings continue to be fed into the initiatives to be covered by the Programme.

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

Underpinning the Service Improvement Programme is our organisation development strategy which outlines how the Trust must change to ensure that improvements are long-lasting for patients and staff. It emphasises the need for better communication and greater staff involvement; learning and personal development are encouraged, as is closer working across the Trust.

These changes will lead to the development of an organisation that looks, feels and behaves differently, as well as one that is regarded as world-class in different ways by every one of its stakeholders – from the patients we treat to the agencies with which we work.

Beginning the integration of the different care services we provide to those patients who do not require a full 999 response stands as one of the key Service Improvement Programme accomplishments of 2004/05. We also extended our new emergency care practitioner scheme to five boroughs and implemented a 'make-ready' scheme at 10 ambulance station complexes, ensuring that our accident and emergency (A&E) ambulances are clean and ready for use at the beginning of each shift.

In 2005/06, our aim is to build on many of the initiatives that have been launched already: the Urgent Care Service will be expanded with the introduction of a dedicated call centre at our headquarters building; our emergency care practitioner scheme will be also be extended further across the capital, as will our ambulance 'make-ready' scheme.

We will implement new patient and public involvement initiatives, will endeavour to increase our recruitment of black and minority ethnic staff and complete the introduction of Agenda for Change, the new NHS pay and conditions system.

Our achievement of the key Government target of reaching 75 per cent of our most seriously ill and injured patients within eight minutes must be maintained and we must continue to work towards meeting the targets for lower-priority calls.

The proposed integration of our A&E and Patient Transport Service (PTS) operating structures will make for greater cohesion in our delivery of service, helping us meet the high number of non-emergency calls from GPs and other healthcare professionals both appropriately and promptly.

What the Service Improvement Programme achieved in 2004/05

Patients

- Extended the emergency care practitioner scheme to five boroughs
- Introduced the first of 65 new ambulances with enhanced patient-care features
- Replaced all of the defibrillators used in our A&E service
- Installed the first 30 defibrillators on PTS vehicles
- Implemented an action plan following last year's Commission for Health Improvement report
- Agreed our Patient and Public Involvement (PPI) strategy and appointed a PPI Manager.

People

- Introduced a health-promotion scheme for staff including voluntary medical assessments
- Implemented a new emergency medical technician course to reflect new national clinical guidelines
- Ensured that all PTS staff have access to computer and e-mail facilities
- Completed the introduction of new uniform to all uniformed staff.

Performance

- Implemented a 'make-ready' scheme at 10 ambulance station complexes, using an external contractor, to ensure that A&E ambulances are clean and positioned at the correct stations, ready for use at the beginning of each shift
- Made operational the first small satellite ambulance station in the Thames Gateway area of the capital, anticipating a population increase in the area and reducing ambulance response times for local residents
- Implemented a trial in south west London by the Emergency Bed Service that offers healthcare professionals access to a dedicated freephone number for direct access to in-house clinicians and speedier organisation of appropriate care packages for patients.



Improving patient care is the key aim of our Service Improvement Programme

What we plan to achieve in 2005/06

Patients

- Make fully operational the new Urgent Care Service, including a new dedicated operations centre based at our headquarters building
- Implement the PPI strategy
- Complete delivery of 65 new A&E ambulances with a further 65 scheduled for delivery
- Introduce four new specialist ambulances for patients who cannot be carried safely on conventional frontline vehicles.

People

- Implement fully Agenda for Change, the new national pay scheme aimed at harmonising the pay and terms and conditions of service for all NHS staff
- Introduce personal development reviews for all staff.

Performance

- Integrate our PTS and A&E operating structures
- Expand the 'make-ready' cleansing of ambulances to a further 10 ambulance station complexes
- Research and introduce further fixed satellite ambulance stations to bring the Trust closer to population centres
- Undertake initial work to establish user-requirements and identify options for developing a new Trust-wide computer system
- Increase further staffing in Central Ambulance Control to better match demand
- Achieve the Government's targets for Category A (immediately life-threatening), Category B and urgent calls.



Patients

This year we continued to lay the foundations for the most far-reaching changes ever to our delivery of pre-hospital healthcare.



The 'one-size-fits-all' provision of patient care in which every 999 caller, regardless of need, receives a double-crewed ambulance is being superseded by a new way of operating. Together with our colleagues throughout the NHS, we have continued our work to meet different patient needs with a range of different responses.

Progress already made in this area was recognised in an external review carried out on behalf of Londoners and published in April 2004 by the Greater London Authority and the Association of London Government which praised us for the 'enormous improvements' we have made in recent years and noted the 'many complimentary submissions from members of the public' commenting on the professionalism of our staff.

The review also found areas for improvement, including the need for us to develop further our Patient Transport Service and work more extensively on supporting patients with mental-health needs. It was recommended too that the number of our staff who are women, from minority-ethnic communities, or disabled, needed to be increased to reflect more accurately the diversity of the patients we treat.

More details about some of the year's key developments in patient care are highlighted in our Clinical Governance Annual Report, which is available on our website.

We are now preparing for the introduction of the Healthcare Commission's new system for assessing health services in England. This new annual health check comes into effect in 2005/06 and is intended to provide a more accurate

picture of performance against a wide range of standards. An outline of the approach we will take to test our compliance can be found in the Statement on Internal Control on page 32.

Our first response under the new system, which will include comments from stakeholders including the South West London Strategic Health Authority and our Patients Forum, will be submitted to the Healthcare Commission in October 2005.

Building our Urgent Care Service

With research showing that only one in ten 999 calls requires a patient to be taken to hospital by ambulance on blue lights and sirens, we are developing the range of care we provide to patients who do not have life-threatening injuries or illnesses.

Our emergency care practitioners who have enhanced skills in physical assessment and decision-making are increasingly responding to patients with minor illnesses or injuries, or chronic conditions such as asthma and diabetes. They are often able to treat patients in their homes – where they would rather be treated. They are also supported by a new tier of emergency medical technicians who, though



Staff work with London's air ambulance team at the scene of a road traffic collision



not required to carry all of the same drugs and equipment as A&E crews, can use defibrillators, administer oxygen and pain-relieving gas therapies, and complete a blue-light training course as part of their core training.

In addition, non-emergency callers are being offered more advice over the telephone. Our specially-trained telephone advisors refer patients who do not need an ambulance response to more appropriate care so that their needs can be met.

Our new Urgent Operations Centre, which we aim to open by the end of 2005, will bring these services together with elements of our Patient Transport Service and Emergency Bed Service, and will handle these less serious calls.

As part of the Urgent Care Service package, we trialed a priority system for urgent calls received from GPs whereby dedicated control room staff ascertained from them whether their patients required a one-hour response or whether, in reality, a pre-arranged response in two or three hours was better suited to their actual medical needs.

In addition to the new training packages for our control room staff, this measure enabled us to manage and plan workloads more effectively, to the ultimate benefit of our patients.

Giving clinical advice

Also central to the Urgent Care Service is our team of clinical advisors, comprising experienced emergency medical technicians and paramedics, who can call back patients with minor illnesses and injuries to undertake a comprehensive assessment of their condition over the telephone. Following such assessments, our advisors reach a decision with the patient as to the best course of action to help them, which might involve treatment at home, visiting their GP or pharmacist,



We continued to develop our emergency care practitioner scheme

or the dispatch of an ambulance, if this is needed.

This year, 13,938 patients were either referred for other NHS treatment or offered guidance by our clinical advisors on how to treat themselves at home.

In 283 cases, our 'no-send' policy was invoked where 999 callers who did not warrant an emergency response were declined an ambulance and our clinical advisors advised them of other options or treatment instead.

Expanding our emergency care practitioner scheme

Emergency care practitioners (ECPs) travel by car to patients with non-life-threatening, but sometimes complex, conditions for whom a blue-light ambulance response and automatic transfer to hospital is likely to be unnecessary.

This year, we established ECP schemes in the boroughs of Bromley, Havering and Hounslow to complement the schemes set up the year before in the boroughs of Croydon and Wandsworth. By April 2005, we had a total of 50 ECPs in post.

The education and extra skills



Control room staff play a key role in ensuring patients receive the right type of care

Patient perspective Betty Brennan



of our ECPs make them our most highly-skilled operational staff and enable them to look beyond the immediate circumstances of the injury or condition. They are able to provide immediate in-depth assessments, treatments and referrals tailored to each patient's needs. Referral options include transporting patients to hospital, minor injuries units, NHS walk-in centres, GPs' surgeries, social services, eye clinics or even bodies that provide services such as 'meals on wheels', with the final decision always resting with the patient.

With the reduction in out-of-hours healthcare provided by GPs, the role of our ECPs in primary healthcare is expanding. In the Borough of Bromley, for example, we introduced ECPs to cover some out-of-hours calls formerly responded to by doctors.

Another innovation took place in the Borough of Croydon, where our ECPs undertook shifts at the local NHS walk-in centre.

With feedback from our patients confirming high levels of satisfaction with both the thoroughness of the medical assessments and the communication given by our ECPs, there are plans to expand the scheme in 2005/06 to a number of boroughs in the west, north west and north east of the capital.

Developing the Emergency Bed Service

In 1999, we took on responsibility for the Emergency Bed Service (EBS) which was established in 1938 by the King's Fund to help London GPs find hospital beds for their patients.

The Service is an in-house bed-finding service for the NHS, the users of its services being, almost exclusively, healthcare professionals who are making admission or transfer arrangements for their acutely ill patients.

The Service operates the National Intensive Care Bed Register for adult and paediatric critical care beds in two-thirds of England. It offers a service to help with antenatal transfers and also acts as the co-ordinator for the Neonatal Transfer Service in London, Kent, Surrey and Sussex.

Overall, 2004-05 saw a four per cent increase in activity for these services compared to the year before despite demand for the National Intensive Care Bed Register decreasing slightly.

The principal development during the year was the introduction of 'EBS First', which is being piloted in south west London. This is aiming to improve services to healthcare professionals by offering a package of bed-finding and/or ambulance transport, tailored to

I was visiting my son in Woodford Green for the Easter weekend when one morning I was suddenly taken ill. I woke up with severe pain in my left arm. It felt very heavy and I had pins and needles in my hand. My son called my doctor in Gloucester and he advised us to call 999 straightaway.

It seemed as though they were here as soon as my son had put the phone down. A paramedic arrived in a car very quickly and an ambulance crew got there a few minutes later. The staff were wonderful. They did some tests and agreed that I needed to be taken to hospital. They explained exactly what was going to happen which gave my son and I the reassurance we needed. They were not only efficient but kind and caring, with a gentle sense of humour.

As they took me in the ambulance to nearby Whipps Cross Hospital, they explained what the cause might be and my surgeon later told me he was impressed with their diagnosis of my medical condition and that this had helped the medical team at the hospital to get to work fast.

I have nothing but praise for the wonderful work of the London Ambulance Service and am grateful to all those involved in treating me.



CPR training for businesses and the public is crucial in helping to improve cardiac arrest survival rates

the particular needs of their patients. It is also offering healthcare professionals in the community and at three hospitals access to a dedicated 24-hour freephone number which means that they do not need to call our busy 999 control room. Built on the EBS's traditional GP service, but achieved in collaboration with staff from PTS and A&E operations, EBS First is integral to our development of the Urgent Care Service.

Improving our care of cardiac patients

The care and treatment of cardiac patients with the aim of improving their long-term survival rates remained one of our top clinical priorities during the year.

One key advance is that we are now working with all 10 specialist cardiac units in London to take patients who are suffering an ST elevation myocardial infarction, a common type of heart attack, direct to cardiac catheter laboratories instead of taking them to their local hospital A&E departments.

This allows for the immediate opening of patients' blocked coronary arteries by primary

angioplasty, a procedure made possible by the 12-lead diagnostic electro-cardiograms (ECGs) carried in all of our A&E ambulances and the ability of ambulance crews to interpret ECG read-outs and recognise acute coronary syndromes.

In 2004/05, we took over responsibility for training users of the existing defibrillators in public places in the capital. We appointed a community defibrillation officer to support and expand the Defibrillators in Public Places initiative for which we are coordinating the placement and training of users of the 119 new defibrillators earmarked for the capital.

Our Community Resuscitation Training Team provides paid-for consultancy and training to private and public sector organisations which in turn supports our delivery of free cardiopulmonary resuscitation (CPR) Heartstart courses, approved by the British Heart Foundation, to community groups.

During the year, we trained a total of 2,500 people in the life-saving technique of CPR. Commercial clients included Unilever, Morgan Stanley, the Royal College of Physicians, HM Treasury and HMP Belmarsh.

Improving infection control

There has been increased awareness about the risks to patients of bacteria such as methicillin-resistant staphylococcus aureus, or 'MRSA'. For some time we had been examining how to improve clinical hygiene standards, as part of our five-year Service Improvement Programme. The result of this work came in August 2004 when we started the implementation of a scheme whereby every available ambulance is cleansed daily internally and externally, re-stocked, refuelled and made ready for action.

During the year, we worked closely with our external 'make-ready' provider to introduce the scheme at 10 of our station complexes to stringent quality-control levels. Our contract ensures that each vehicle is deep-cleansed every six weeks and that every day our cleansed vehicles are positioned at the correct stations within our complexes prior to the beginning of shifts, so maximising the number of ambulances available.

For 2005/06, we plan to expand 'make-ready' cleansing to a further 10 station complexes prior to extending it again to cover our entire A&E ambulance fleet.



Improving our training and equipment

We value the positive effect of improving the training and equipment we provide to our staff so that they can give the best care possible to our patients.

During the year, we introduced the 2004 edition of the National Clinical Guidelines, issuing manuals and pocket books to all our frontline staff.

Our Patient Transport Service (PTS) staff received training in the use of heart-starting automated external defibrillators. We equipped 30 of our PTS ambulances with these defibrillators and plan to equip the remainder this year. PTS staff also received individual-issue first-aid bags.

We introduced the first eight of a new batch of 65 Mercedes-Benz Sprinter ambulances to our A&E fleet. All of the new vehicles will enhance patient comfort by being air-conditioned, and seven of them will be supplied to us for evaluation equipped with roof-mounted solar panels in addition to ultra-strong, lightweight, carbon-fibre bodies.

Eleven ambulances, designed specifically for use by our Urgent Care Service, were brought into use during the year in addition to the first three of a total of 20 PTS ambulances, finished in corporate yellow livery, and equipped to carry stretcher-patients.

We also took delivery of four other new A&E ambulances, designed to transfer critically-ill patients with bulky life-support systems between hospitals.

Providing a faster response to our patients

During the year, we pioneered a new type of satellite ambulance station in the Thamesmead area of south east London where it is forecast the resident population will increase by 55,000 between 2001 and 2016, and where we had no immediately local ambulance station.

At the end of the 2004, local A&E ambulance crews started operating from the wing of an existing health centre, operated by Greenwich Teaching Primary Care Trust, and immediately began to reduce their response times to patients. We are considering three separate proposals which could see similar satellite stations being attached to health clinics elsewhere in the capital where we predict that similar benefits could be realised for our patients.

At Heathrow Airport, we launched a team of cycle responders who are able to reach patients much more quickly in the congested corridors and passenger precincts of the Terminal Four building, through which more than 30,000 passengers pass daily. The unit is the first of its kind to operate at an airport in Europe.

This extension of the internationally-acclaimed Cycle Response Unit, introduced in the West End of London in 2002, proved its worth within three weeks of going live in October 2004 by saving the life of a young woman who had collapsed and whose heart had stopped.

We continued to upgrade our fleet of ambulances



patient perspective Prakesh Suchdev



In April this year I woke early and found myself suffering from severe chest pains and sweating profusely – a familiar feeling as I had suffered a heart attack once before. My wife, Rama, immediately called the ambulance service and they arrived within a matter of minutes. The crew knew exactly what to say and do, calming me and my family down and beginning the necessary emergency treatment. They took the decision to take me to Harefield Hospital. Although this was not the nearest hospital, they were aware of a specialist cardiac unit there that had just opened offering unique treatment for heart attack patients.

Thanks to the paramedics' quick-thinking, I was in the operating theatre undergoing emergency angioplasty within an hour of the heart attack occurring. In fact, my wife got lost on the way to the hospital and by the time she arrived I was already out of surgery – she could not believe it.

I was out of the hospital in just a couple of days and back at work in my shop in less than a week. It was all down to the London Ambulance Service crew that I was able to get the care I needed so swiftly. Their initial decision to take me to Harefield Hospital made all the difference.

Strengthening links with our patients and the public

We are committed to involving patients and the public in as many aspects of our work as possible.

During the year we developed an excellent relationship with our Patients' Forum. We organised a number of meetings with them, covering a variety of issues, and were also represented at many of the Forum's public meetings.

The Patients' Forum is represented at meetings of the Trust Board and other committees, including the Clinical Governance and Patient and Public Involvement (PPI) committees.

A PPI strategy was agreed during the year and a PPI manager has been appointed to oversee and drive forward the development of patient-engagement initiatives throughout the Trust. The challenge of developing these with the millions of people and many communities across our increasingly multi-cultural capital is considerable and work has begun on developing a local model for PPI which can be adopted and adapted across London.

During the year, we held a breakfast meeting 'Working together with the Community', attended by members of our staff and delegates from partner organisations.

We also held a 'Planning with Patients' day attended by patients and patient-representative organisations. A key message from that successful and well-attended event was the need for continuous engagement and two-way communication with the many communities of London to ensure that patients and their carers drive continuous service improvement.

Improving our Patient Advice and Liaison Service

Our Patient Advice and Liaison Service (PALS) was established in 2003 to provide information, advice and support to patients, the public and health and social care professionals.

Emerging trends of patient concerns are reported to our Clinical Governance Committee via PALS. Examples of changes we initiated where patients' concerns were a contributory factor included the development of initiatives to improve our responses to urgent calls placed by GPs, the provision of more appropriate carrying equipment for babies requiring hospital transfers, and the use of 'reflective practice' where members of staff review their management of incidents that drew a negative reaction

We will provide emergency care for 17,000 residents in the Olympic Village and hundreds of thousands of spectators



We helped build links with members of central London's Chinese community

from patients with a senior manager and any further training or support is agreed accordingly.

PALS also worked with health and social care partner organisations to help to improve the 'journey' through the NHS of patients with often complex care needs. One example of such work during the year was the arrangement by social services for a geriatric mental-health assessment of an elderly, isolated, patient who had made an extremely high number of repeat 999 calls to us. Our intervention and submission of this evidence resulted directly in the placement of this patient in nursing-care accommodation where his needs were properly met.

In 2004/05, PALS received a total of 3,478 enquiries, of which 676 were expressions of appreciation.

PALS continued to evaluate its service against core standards. It also contributed to involving patients directly in the development of policy and organised both collective and individual participation at patient-care events.

In January 2005, principal responsibility for our

responses to enquiries under the new Freedom of Information Act was delegated to PALS.

Resolving complaints

Our Professional Standards Unit manages complaints received from patients and the public, and investigates issues raised by serious internal complaints. It may also investigate serious issues identified by an enquiry made to the Trust.

During the year, the unit received a total of 444 external complaints compared to 534 the previous year.

Of these, 226 were written complaints, 81 per cent of them being resolved within 20 days and therefore above the Department of Health's 80 per cent target. A total of 432 of complaints were resolved locally.

A new complaints procedure was introduced by the Department of Health with which we complied. Presentations are given at corporate induction courses to reiterate these procedures to new staff and we are working to develop a complaints investigation pack for ambulance operations managers and to review the training of duty station officers. Presentations are also given to staff as part of their Continuous Professional Development course on the causes of complaints and on the reasons for, and method of, their investigation.

Reaching out to the capital's communities

With 300 languages spoken and every nation, race and religion represented within its boundaries, London is one of the world's most diverse cities.

This year, our Diversity Team introduced new staff training on equality and diversity issues while supporting programmes which build relationships with minority ethnic communities.

One such pilot scheme, Project Harmony, raised awareness of how to access healthcare within Vietnamese and Somali refugee communities in Deptford. It also served to increase understanding among our staff of some of the difficulties these communities face in accessing ambulance services.





The Diversity Team also supported a workshop, led by one of our paramedics, at the Chinese Community Centre in London's Chinatown district. Attended by over 50 members of the Chinese community, we were able to address concerns they raised about language barriers and the need for medical questioning by 999 call-takers.

We continued to forge links with south Asian communities to improve low cardiac arrest survival rates. We have launched a bi-lingual DVD entitled 'Cardiac Arrest' (above) which, using dramatisation, follows a fictitious south Asian family and the events leading up to their 999 emergency call. A series of training-support materials accompany the DVD.

In 2004/05, we collaborated further with the Communities into Training and Employment charitable organisation with the aim of recruiting more people from Black and Minority Ethnic communities to our service.

Working with children and young people

Last year, we spoke in person to 44,331 children and young people at a total of 461 schools, colleges and youth organisations in the capital.

Almost half of those visits formed part of the Junior Citizen Scheme which aims to instil social responsibility in young people, teach them how to respond to a medical emergency, and raise awareness about the impact of making inappropriate and hoax emergency calls.

In addition to these types of educational visits, we are also participating in a pupil-mentoring scheme involving young people who have been, or may be, excluded from mainstream education. Twenty-three staff received training during the year and began to work in one-to-one and small-group situations with these young people.

Improving the protection of children and vulnerable adults

New operational procedures introduced in 2003/04 gave ambulance staff a clear course of action for reporting the suspected abuse of children and vulnerable adults and implemented a clear line of accountability within the organisation, so that action could be taken by appropriate agencies.

In 2004/05, our staff referred a total of 365 such children and 611 vulnerable adults for further investigation.

Risk management

We achieved the NHS Litigation Authority Risk Management Standard for the Provision of Pre-hospital care in the Ambulance Service at level two. This demonstrates there is a high standard of risk management across all areas of the organisation.

Carrying out clinical audit and research

Our Clinical Audit and Research Unit continued to work on a number of projects aimed at reforming emergency care that often involved collaboration with hospitals, other ambulance services, and universities.



Audit and research is vital to improving patient care



In December 2004, we initiated ground-breaking research into cardiopulmonary resuscitation (CPR) techniques used by bystanders on patients in cardiac arrest before ambulance crews arrive. The research, being run in collaboration with King County Emergency Medical Service (Seattle, USA) and the University of Washington (USA), aims to investigate whether CPR using chest compressions alone has an increased positive outcome for patients compared to standard CPR using chest compressions with mouth-to-mouth ventilations. The project will be run for three years and data on hospital outcomes will be collected for each patient in the trial.

Since September 2004, ambulance crews from four stations have been participating in a trial that examines the effectiveness of direct admission of suspected stroke patients to the Acute Brain Injury Unit at the National Hospital for Neurology and Neurosurgery. This externally-led study is

scheduled for completion in June 2006.

Other examples of research in which we were involved during the year include investigating cardiac arrests in three- to 30-year-olds, and a comparison of the administration of controlled oxygen with standard oxygen therapy to patients suffering from chronic obstructive pulmonary disease (COPD) during transfer by ambulance to hospital. All of our research projects conform to the guidelines set out by the Department of Health on research governance.

The volume of our research projects was complemented by a number of clinical audits, ranging from small 'snapshot' audits such as the use of epinephrine in treating asthma patients and pain management in children to larger, multi-disciplinary, 'central' audits, where we examined for example the care given to routine and emergency maternity patients.

This latter audit involved collaborating with six hospitals to review the care given to these patients from the placing of the 999 call to their discharge from hospital. There is also an ongoing audit programme by team leaders that ensures that patient report forms have been completed satisfactorily by ambulance crews.

We introduced updated clinical guidelines during the year





People

People

We believe that recognising and rewarding staff for their work, giving them opportunities for development and building a quality workforce are central to improving the care we provide to our patients.



In 2004/05 we began the process of introducing Agenda for Change, the new national pay scheme aimed at harmonising the pay, terms and conditions of service for all staff across the NHS.

The scheme provides us with an opportunity to ensure that our staff are recognised properly for the work they do and also generates new opportunities for partnership working between management and the trade unions that represent our staff.

The new package will benefit many staff by providing pay enhancements for working unsocial hours, increases to pay in high-cost areas, the standardisation of overtime rates, increased annual leave and a range of enhanced career options and development opportunities, to be identified in personal development reviews. We estimate the total value to staff of all elements of the package to be £28 million each year.

Implementing Agenda for Change

Our preparations for the implementation of Agenda for Change have included a review of the job descriptions and person specifications for each of our 4,000 staff.

We trained 65 managers, as well as 78 staff nominated by the trade unions, in the job evaluation and the job-matching schemes, in which posts are matched against a library of around 350 nationally-agreed NHS job profiles.

The Trust was one of three ambulance services to contribute to the development of job profiles for emergency medical technicians and paramedics. Three such profiles have now been agreed and published under the title of 'Ambulance Practitioner', enabling

us to take work forward with our trade unions to agree the transfer of our largest group of staff on to Agenda for Change terms and pay rates.

We are also completing a further piece of work to map the level of competency required for each post under the NHS Knowledge and Skills Framework. When complete, the framework will provide the basis for identifying skills gaps, in addition to core and developmental training needs.

Developing our staff personally and professionally

One of the key elements of Agenda for Change is the introduction of updated personal development reviews for every member of staff, which we aim to have completed by the end of March 2006.

During the year, we began training our managers in how to apply this personal development review process which will enable them to have practical discussions with their staff about their performance and personal development.

We are also working on building a structure for the process by matching the posts held by each member of staff to the specifications detailed in the NHS Knowledge and Skills Framework so that managers will be able to set accurate objectives for the personal and career development of their staff.

Staff at the scene of one of the London bombings in July 2005



Patient perspective **George Murray**



I was running around the playground with my friends when I went to jump over the railings to get away from a classmate who was chasing me. I had made the jump the day before and thought that I would make it, but this time I fell and landed awkwardly on my arm. I screamed out to get the teachers' attention and they quickly took me to the school medical room and dialled for an ambulance.

The two men from the ambulance, Chris and Franco, arrived quickly and took a look at my arm. They said that they could not believe that I wasn't crying and that I was braver than most adults when they broke their arm. When they took me to the ambulance, they talked to me and helped me to forget about the pain. I was upset that I had to lie down as I wanted to have a look around the ambulance. When we got to the hospital, I needed an operation to put two pins in my arm. I could not believe when I woke up that I had been asleep for four hours. The next day, Chris and Franco came to visit me in the children's ward to check how I was doing. It was very nice to see them again and to say thank you for looking after me.

Supporting our staff

During the year, we became only the second ambulance trust in the country, and the fourth NHS trust in Greater London, to achieve the third level of the NHS Improving Working Lives standard, 'Practice Plus' status. For three days during February 2005, we played host to an external validation team which identified a number of examples of good practice including the Chief Executive's annual staff consultation meetings, our intranet site and personal safety support for staff.

In March 2005, the Healthcare Commission reported that our staff were more positive than ever about working for the Trust. The findings of the report were based on the answers given by over 400 of our staff to questions in the NHS national staff survey, the purpose of which is to assess the performance of the NHS as an employer and to monitor the implementation of national policies to improve the working lives of staff.

Examples of key findings of the report included the confidence of almost two-thirds of staff that the organisation has a clear vision of where it is heading and that managers support new ideas for improving services to patients.

The report also highlighted areas in which we must make improvements, noting the high levels of work-related stress experienced by many members of staff, thought to be linked to the year-on-year increases in demand for emergency healthcare in the capital.

We continued to offer several initiatives aimed at providing better conditions for our staff. We began to roll out the Linc peer-support programme across the Trust, and a new credit union financial benefit scheme was introduced. The process of reviewing and updating many Human Resources policies in line with best practice continued, an example being the introduction of the revised Whistleblowing Policy.

We also granted extra paid leave to new mothers and introduced optional, free-of-charge, 'well-person' medicals to all of our staff. An occupational health service is provided by King's College Hospital NHS Trust that includes a counselling service available at seven sites across London in addition to satellite nurse-led medical clinics in Bromley, Isleworth and a consultant-led clinic at Caterham in Surrey.

We continued promotion of the Government's Key Worker Living initiative that offers financial incentives to help members of staff to afford their own property in the capital.

Equality and diversity

In 2004 our Diversity Team carried out an analysis of diversity training needs which involved consulting staff from all areas and grades within the Trust, trade unions, and staff support networks, as well as members of a number of minority ethnic community groups. Subsequent to this, we began work on the design and delivery of a comprehensive diversity training programme for all of our staff.

During the year, all new members of operational staff participated in a community awareness session during their foundation training. This follows an introductory managing diversity class which they attend during their induction course.

In early 2005, our Race Equality Scheme and its accompanying action plan were described as 'exemplary' by a consultant commissioned by the South West London Strategic Health Authority to review them. In May 2005, we carried out a full review of the Race Equality Scheme in line with the Race Relations Act.

Improving our higher education scheme

Since 1995 we have worked with the University of Hertfordshire to develop a range of courses in Paramedic Science from certificate level up to BSc (Hons) for both full- and part-time students.

A team of our training officers is based at the University from where it delivers all the vocational aspects of the course, including clinical skills and driver training, and arranges clinical placements for students at our ambulance stations.

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

During 2004/05:

- 28 members of staff on the part-time BSc programme gained a certificate of higher education in Paramedic Science
- 10 members of staff gained a diploma in Paramedic Science
- 27 members of staff graduated from the full-time BSc (Hons) degree course in Paramedic Science, of whom 24 joined the Trust.

A new foundation degree course in Paramedic Science, taught at both the University of Kingston and St

George's Hospital Medical School, will see a total of 34 students commencing study in September 2005. We are in discussions to introduce a third foundation degree at the University of Greenwich, due to commence in September 2006.

We have also developed an access programme in Paramedic Science to be run at Kensington and Chelsea College which will lead students into both of these foundation degree courses.

Recruitment and training

During the year, we recruited 87 frontline A&E staff in addition to 47 staff for our 999 control room. Staff turnover remained low at 5.87 per cent.

We trained 63 emergency medical technician grade 1s (EMT1s), a total of 24 emergency medical technician grade 3s (EMT3s) and 80 paramedics.

Twenty-six members of staff also passed our training supervisor course in 2004/05, qualifying them to mentor trainee emergency medical technicians during their probationary year.

In response to feedback received from staff requesting more training, we completed preparations for a five-day Continuing Professional Development Course that, from April 2005, we began to provide to every member of our staff who treats patients. The focus of the course is to develop, rather than solely refresh, the existing skills of our operational staff to deliver the highest levels of clinical care.

Improving staff safety

There were 371 reports of physical abuse against staff in 2004/05, the number of violent incidents experienced by our staff remaining unacceptably high but showing a decrease on the numbers recorded for the year before.

Levels of assault have shown a decrease of 34 per cent in the three years since personal safety training was introduced in 2002.

All operational staff will benefit from continuing professional development





New staff were recruited to our Urgent Care Service

A total of 1,400 staff have now received this training, with all new EMTs benefiting from it during their induction to the Trust.

During the year, we obtained the first anti-social behaviour order (ASBO) to protect the Trust against a man who had attacked and damaged a rapid-response car while a member of our staff was inside it. The ASBO, issued by the Westminster Council's Anti-Social Behaviour Unit after consultation with the Metropolitan Police Service and the Crown Prosecution Service, banned the man from approaching any ambulance service vehicle or member of staff in the country unless he needs urgent medical care. This order put out a strong message that such abuse of our staff and property will not be tolerated.

We are also working together with NHS Security Management Service to influence policy on reducing levels of abuse to ambulance workers across the UK.

Training was completed this year of all our ambulance operations managers and duty station officers so that they can offer adequate support to frontline staff who have been assaulted.

We have also streamlined our internal system for

reporting assaults so as to encourage staff to record all violent incidents and make it easier for us to update the register held by our control room which automatically alerts us when 999 calls are placed from addresses where our staff have been attacked previously.

As in previous years, manual-handling injuries suffered by our staff continue to be a cause of concern. The Trust has invested substantially in tackling musculoskeletal disorders, introducing new vehicles with tail-lifts and hydraulically operated trolley beds, both of which have reduced the amount of physical lifting required in and out of ambulances.

In 2004, we ordered patient-handling kits for use on all patient-carrying vehicles, including our 400 frontline ambulances. These will be introduced as part of a one-day training course in patient moving and handling.

Reported manual-handling incidents have declined by 26 per cent from 1,031 to 759 in the three years since the Trust's health and safety improvement programme was launched in 2002, the number of manual-handling incidents related to the trolley beds decreasing substantially during this time.

Recognising the achievements of our staff

We continue to recognise the important contributions of individual members of staff to the Trust.

In 2004/05 we held 10 ceremonies for newly-qualified operational staff, in addition to two ceremonies for those retiring and those who had completed long service. In total, 442 staff were recognised for service ranging from 10 to 40 years in duration.

A number of high-profile awards were received by our staff during the year.

One of our duty station officers was named as an NHS Champion for his work in developing a specific treatment protocol for a patient who is allergic to anti-convulsive drugs, ensuring that staff are alerted to crucial information about her allergies and to the fact that her son is her carer.

The ceremony, supported by the Evening Standard newspaper, the King's Fund, and ITV1's London Tonight news programme, also recognised one of our emergency medical technicians as runner-up for his part in battling torrential rain and lightning strikes to resuscitate a 15-year-old girl who had been struck by lightning in Hyde Park.

In September 2004, one of our 999 call-takers was named joint National Emergency Medical Dispatcher of the Year for the professional way in which she dealt with a call about a shooting.

Members of staff who took part in a dangerous rescue operation on a burning boat before the arrival of the fire service were recognised by the presentation of the Ambulance Service Institute Special Incident Award, as was a member of our Patient Transport Service who went beyond the call of duty to rescue two elderly residents from a burning building.



Duty Station Officer Kevin Marshall was named an NHS Champion

Our Chief Executive received a CBE in the New Year Honours list in recognition of the vast range of changes he has initiated that have served to improve our organisation in recent years.

We hosted our inaugural awards ceremony for staff in April 2004 at the Russell Hotel in central London. Staff, representing all sections of the organisation, both operational and non-operational, who had been nominated by their colleagues were recognised for their outstanding contributions during the event.

In March 2005, we celebrated the bravery of children who had showed maturity beyond their years in dealing with medical emergencies before the arrival of ambulance assistance, through our Children's 999 Awards ceremony.



Our first awards ceremony recognised the achievements of a wide range of staff

Perf



Performance

We were awarded two stars out of a possible three by the Healthcare Commission for the second consecutive year in the NHS Performance Ratings despite a 6.9 per cent increase in demand over the previous year.



The two-star rating indicated that the Trust is performing well overall.

Areas in which we scored highly included meeting the Government's eight-minute response target for calls to our most seriously ill and injured patients, our management of the lowest priority 999 calls, the quality of our information governance and our protection of children and vulnerable adults.

The Healthcare Commission also highlighted areas in which we need to develop our services further such as providing more prompt responses to the urgent calls placed by GPs as well as to Category B emergency calls.

The star rating process will be replaced by a new annual health check system in 2005/06. We will be submitting our first response to the Healthcare Commission on our performance against these standards in October 2005.

Meeting targets

The Government asks for all 999 calls received by ambulance services to be categorised as either Category A (immediately life-threatening), Category B (serious) or Category C (neither serious nor life-threatening).

In order to maintain consistently high standards across the UK, national response time targets stipulate that 75 per cent of the most serious Category A calls should be reached within eight minutes and that 95 per cent of Category B

calls should be reached within 14 minutes.

Urgent calls, placed by GPs, fall outside of the 999 service but are also responded to by ambulance services. Depending on the level of urgency, these calls must receive an ambulance response within one, two or three hours of their being placed. The national response time target for these calls is that 95 per cent of them should be reached no more than 15 minutes late.

In 2004/05, we responded to:

- 77 per cent of Category A calls within eight minutes (76 per cent in 2003/04)
- 80 per cent of Category B calls within 14 minutes (77 per cent in 2003/04)
- 58 per cent of urgent calls where we were not more than 15 minutes late (50 per cent in 2003/04).

During the same period:

- Central Ambulance Control, based in our headquarters at Waterloo, received a total of 1,153,948 emergency calls (1,088,559 in 2003/04)
- This number resulted in our attending a total of 827,415 emergency incidents (770,038 in 2003/04) of which 207,106 were classed as Category A, up from 195,362 the previous year
- We sent 1,053,121 emergency vehicles to these incidents (971,119 in 2003/04)
- We made a total number of 54,197 urgent patient journeys (54,417 in 2003/04)
- Special/planned patient journeys are pre-booked through us by healthcare professionals and include hospital and hospice transfers. We undertook 486,528 such journeys (660,410 in 2003/04).

Demand on the 999 system increased by more than six per cent

Improving our A&E performance

As well as a continued emphasis on meeting the Category A target, we are focusing our attention on achieving the Government's 95 per cent target for urgent calls by March 2006.

Achieving this target will be a huge challenge for us. Our new Urgent Operations Centre will work as part of a package with the increasing number of emergency medical technician grade 1s who are being recruited and trained to respond solely to this type of call.

The Government has stated that the lowest-priority Category C calls no longer require a 14-minute response and that ambulance services must agree targets with their own commissioners for this level of 999 call. We are currently in discussion with our commissioners to agree such targets.

The steps we are taking to improve A&E performance are not confined to frontline work. The speed at which 999 calls are answered, particularly at times of peak demand, is also critical and one that depends on our maintaining consistently satisfactory staffing levels. In view of this, we increased the number of call-taking staff, bringing the total number of control room staff to 377.

Improving our Patient Transport Service performance

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

PTS competes in the patient transport market against other providers which comprise private organisations, charities and NHS trusts. Contracts for patient transport are awarded by hospital trusts to the patient transport provider of their choice based on price and quality after a process of tendering has been completed by prospective providers.

A survey of our patients showed that overall satisfaction with PTS stood at 84 per cent, compared to 79 per cent in 2003/04. In addition, 94 per cent of patients were 'very happy' or 'delighted' with the level of care

they received, compared to 85 per cent in 2003/04.

By the end of 2004/05, we were receiving an average of only 0.4 complaints per 100,000 journeys, an achievement of which we are particularly proud.

Our performance at delivering patients to hospital on time remained stable at 73 per cent. We are working to achieve 90 per cent by March 2006. We maintained our performance at departing hospitals on time at around 83 per cent against a target of 90 per cent.

One of the highlights of the year was the Royal National Orthopaedic Hospital's (RNO) awarding of a contract to us to provide management-consultancy services to it. The one-year contract focuses on helping the RNO to improve its patient and non-patient transport services. This was an important contract gain as it marked an area of potential growth for PTS.

A significant loss for us was the announcement that one of our biggest contracts, with the Hammersmith Hospitals NHS Trust, would not be renewed. However, despite the other loss of our contract at Queen Mary's Hospital, Roehampton, which formed a part of the work we undertake for Wandsworth Primary Care Trust, we continued to provide an expanding volume of non-local patient transport for this primary care trust.

Our new Central Services division has made significant inroads as an ad hoc patient transport provider at a number of hospitals in London which do not use the Trust as their main patient-transport provider. This additional assistance gives hospital trusts the opportunity to use PTS to meet their out-of-hours patient transport requirements and to help with occasional over-activity, services which many of our competitors do not provide.

Preparing for emergencies

As the emergency arm of the NHS in the capital, we have a history of responding to major incidents as diverse as nail bomb attacks, train crashes and chemical incidents. In the aftermath of the 9/11 terrorist attacks in America, our plans for how we would respond to similar attacks in London have received

We took delivery of the first batch of new Patient Transport Service vehicles



specific attention from the Government and the media, and been cited as examples of best practice by the Commission for Health Improvement.

The bombings by terrorists of three underground trains at King's Cross, Aldgate East, and Edgware Road in addition to a bus at Tavistock Place on 7 July 2005 compelled us to put into practice the crisis plans we had rehearsed with other emergency services and key agencies.

The bombings gave rise to the unprecedented scenario of managing four major incidents concurrently. We dispatched over 100 ambulance vehicles to the incident scenes and more than 250 staff. Our Gold control room was made operational immediately so that the incidents could be run separately, helping to reduce the impact on the 999 service to the rest of the capital.

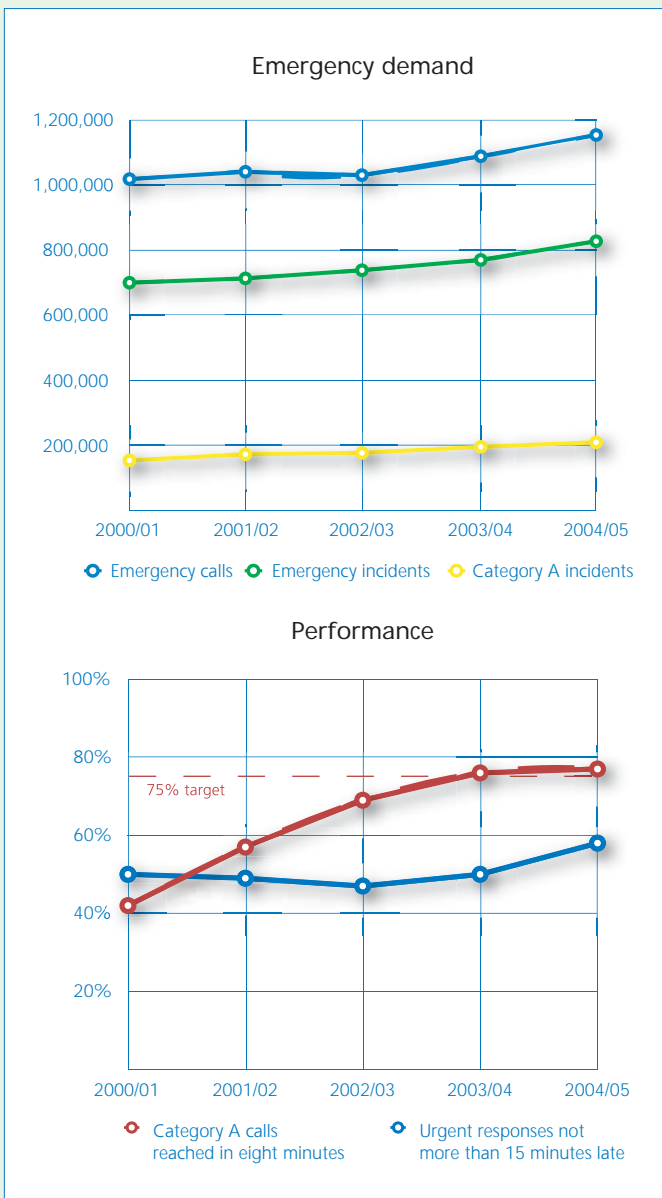
We activated mutual-aid plans that resulted in neighbouring NHS ambulance services supplying staff and vehicles to bolster the large number of our own ambulance crews at the incidents.

Emergency medical technicians and paramedics treated some 45 patients with serious and critical injuries such as burns, amputations, blast injuries and fractured limbs, in addition to some 350 patients with minor injuries such as lacerations, breathing difficulties caused by smoke inhalation, shock, and cuts and bruises.

Ahead of the decision that London will host the Olympic Games in 2012, our Emergency Planning Unit had presented its plans to the International Olympics Committee (IOC) for how the Service would deliver emergency medical care for the event.

The plans included details of ambulance service provision for the Olympic Village area which includes the Olympic residential village and campus, accommodating 17,500 people and six major venues. We demonstrated to the IOC that our role would be extensive, involving major incident management, paramedic and advanced life-saving skills as well as support for British Olympic Association medical staff dealing with athletes and participants in any of the sporting venues. Our plans also included forecasts of how we would deal with the anticipated increase in demand on our core 999 service.

In response to the Asian tsunami disaster, we set up a medical reception centre at Heathrow Airport to receive the large numbers of injured British nationals affected by the catastrophe. We also assembled a national ambulance co-ordination centre at our reserve control room in Bow, east London.



Planned events for which we prepared and in which we were involved included the New Year's Eve celebrations, London Marathon, Notting Hill Carnival at which pedal cycles were deployed for the first time, the 'Formula One comes to Regent Street' event, opera in Trafalgar Square, Arsenal football club victory parade and the Wimbledon Tennis Championships.

We were a vital component in Exercise Atlantic Blue, a live five-day role play of catastrophic incidents caused by terrorists in North America and London, held at the beginning of 2005. We also participated in three exercises which tested our response to a range of transport-related incidents on the Docklands Light Railway, at London Bridge railway station and at Biggin Hill Airport.

2004/05 Financial summary statements

FINANCIAL REVIEW

The Trust fulfilled all three of its four statutory financial duties in 2004/2005:

1. On income and expenditure the Trust reported a surplus of £332,000 for the year, and therefore did better than the break-even target set for it by the Department of Health for 2004/2005.

Income and Expenditure £000s

	2000/01	2001/02	2002/03	2003/04	2004/05
Surplus/Deficit(-) in year	101	46	94	89	332
Cumulative Surplus/Deficit(-)	-486	-440	-346	-257	75
Cumulative deficit permitted (0.5%)	-618	-678	-804	-843	-963

The surplus in 2004/2005 meant that the cumulative position improved for the fifth year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

2. The Trust achieved its EFL (external financing limit) for the year.
3. A return on assets (the capital cost absorption duty) of 4.2 per cent was achieved. This was 0.2 per cent higher than the permitted range of 3.0 per cent to 4.0 per cent.

The financial year 2004/2005 was one of growth overall, as the Trust used extra funding from health authorities to implement the Service Improvement Programme and improve accident and emergency response time performance and its emergency preparedness capability.

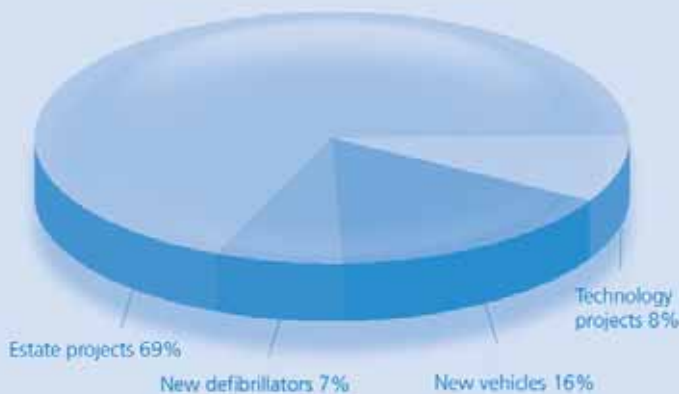
In the capital programme, £6.6m was spent on a range of projects, including rapid response vehicles, tender vehicles and other vehicles, new technology projects, replacement defibrillators, and projects to improve the estate. Overall the Trust underspent by £89,000 against its Capital Resource Limit, which it is permitted to do.

The Trust was able to pay 89 per cent of its invoices within 30 days which was higher than the previous year's figure of 79 per cent. This was below the 95 per cent target set for it by the Department of Health.

The Audit Commission was the Trust's external auditor for the year ending 31 March 2005. The Trust paid the Audit Commission £131,000 for audit services relating to the statutory audit. The Audit Commission did not provide any other services for the Trust.

There were no important events occurring after the year-end that had a material effect on the 2004/2005 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.

Capital expenditure



INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST ON THE SUMMARY FINANCIAL STATEMENTS

I have examined the summary financial statements set out on pages 34 to 37.

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 2005 on which I have issued an unqualified opinion.

Susan M Exton
District Auditor
1st Floor
Millbank Tower
Millbank
London
SW1P 4HQ

7 July 2005

RELATED PARTY TRANSACTIONS

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

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

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

Richmond & Twickenham PCT;
the NHS Litigation Authority;
the NHS Supplies Authority;
the NHS Pension Agency;
Other primary care trusts.

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

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

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

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



Chief Executive

5 July 2005

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.

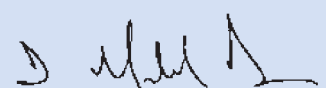
The directors confirm that, to the best of their knowledge and belief, they have complied with the above requirements in preparing the accounts.

By order of the Board



Chief Executive

5 July 2005



Finance Director

5 July 2005

STATEMENT ON INTERNAL CONTROL 2004/05

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 Framework. The Framework defines risk as anything threatening the achievement of our strategic objectives and, by defining the ownership and subsequent management of risk, supports the London Ambulance Service to fulfil its aims. The Chief Executive has overall responsibility for risk management in the Trust. A summary of the Risk Management Framework can be found on our website so that external stakeholders may learn how our risk management system works. In addition to this, a number of stakeholder days have been planned with strategic health authorities and partner organisations to produce stakeholder goals for our future planning process. Part of this planning process will involve identifying and managing risks, so looking at the situation from a wider perspective will be beneficial.

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 2005 and up to the date of the approval of the Annual Report and accounts.

3. Capacity to handle risk

The leadership of risk within the Trust is delegated by the Trust Board through the Chief Executive who is a member of Audit Committee and Risk Management Committee and is chair of the Risk Management 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. He attends the Audit Committee and chairs the Standards for Better Health Group, overseeing part of the process by which we will be performance-monitored from 2005/06 onwards. Individual executive directors are responsible for, and manage, the corporate risks within their particular spheres of activity.

Risks, as identified using the risk assessment tool in the Risk Management Framework, are approved at Risk Management Group and allocated to an appropriate specialist risk management group for management. Those of a high priority will be monitored by one of the sub-committees of the Board. All significant risks are recorded on the Risk Register which is used to help prioritise and make decisions on spending allocations for service development.

The Trust has recently revised its corporate training needs analysis which details which elements of risk management training are statutory, mandatory or desirable for relevant staff groups and which courses they can attend to receive this training. It also indicates how often staff should receive updates to this training. This information is provided in the Training Prospectus. Using the training needs analysis, the Trust has been able to plan a two-year refresher programme for all frontline operational staff which includes items such as manual-handling and the management of

complaints. Identified good practice from audits, benchmarking, complaints-handling and incident-reporting is fed into training courses so that staff can learn from past experiences.

4. The risk and control framework

The Risk Management Framework defines the risk management process which specifies the way risk (or change in risk) is identified, evaluated and controlled. An appendix to this document lists the sources used to undertake a systematic identification of risks including: monitoring of incidents, claims, inquests and complaints and risk assessments on all new major project plans. In addition to this, a Trust-wide risk assessment was held in autumn 2004 which involved a cross-section of staff from all areas and levels of the organisation and included patient representation. This sought to identify new risks to the organisation since the last event of its kind in 2001. When a risk has been identified, a risk assessment form is submitted to the Risk Management Group for approval onto the Risk Register. This form records an evaluation of the risk using the Trust risk prompts and scoring matrix which looks at the impact and likelihood of the risk occurring to give a priority rating. An action plan is drawn up to address the control issues and will then be assigned to a specialist risk management group to manage it. All risks on the Risk Register are reviewed for progress and re-grading on a six-monthly basis. In some cases the priority of a risk may change due to action being completed or a change in circumstance. In the latter case, the risk will be re-defined and re-evaluated.

The Risk Management Framework 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 Trust's Risk Scoring Matrix and, according to grade, investigated so that actions can be implemented to prevent a re-occurrence. The reported information is then recorded in Datix - our integrated risk management system which can be interrogated to produce trend analysis reports, highlighting new areas of risk and providing data for the monitoring of existing risks. Clinical near-miss reporting has increased this year, offering a greater source of information from which we can learn. In addition, the Infection Control Steering Group has implemented an infection control audit programme delivered to all complexes which has been undertaken by trained frontline staff, as local involvement will be critical to minimising the risks.

In addition to the Risk Management Framework and the Risk Register, the Assurance Framework enables us to examine how we are managing risks that are threatening the achievement of the strategic objectives from our service plan and key targets in the new Healthcare Commission health-check system that is awaited. This has been achieved by mapping risks from the Risk Register being 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. This has enabled gaps to be identified for appropriate action.

The development of the Assurance Framework will be an ongoing process and it will be supplemented by further 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. By identifying and examining the review and assurance mechanisms, which relate to the effectiveness of the system of internal control, it will also help contribute to the evidence to support the statement of internal control.

The Assurance Framework has highlighted some gaps in control and assurances to the Board. This is part of an ongoing process where the Board will use the Assurance Framework as a decision-making tool. Currently gaps are indicated in the following areas:

Human Resources and Organisation Development

- An internal audit looked into our system for Criminal Records Bureau and Protection of Children Amendment (POCA) checks. We check all new staff who are considered a risk, for example frontline and payroll staff, but the audit has given us an opportunity to consider retrospective

checks on existing staff to strengthen controls with the management of child protection.

- We have taken action to introduce ethnicity-monitoring in order to meet our responsibilities under the Race Relations Act. The new patient report form (PRF) was implemented in spring 2005. Thus far, the Trust has not received any assurances on the effectiveness of its controls under the Race Relations Act.

Operational Support

- Through our own reporting and learning systems, a clinical incident highlighted the same issue as an internal audit report. This indicates a culture where staff feel that reported incidents will be treated fairly, with confidentiality, and that appropriate action will be taken. Staff compliance issues were identified with the return of drug bags at the end of shift, increasing the risk of administering out-of-date drugs to patients. This issue is being resolved by local teams of ambulance operations managers (AOMs) and their station management teams.
- A Fleet and Transport Management audit highlighted the need for having records of vehicles when they are out of service. This would help to manage risks relating to activating vehicles to respond to calls. Fleet Status Reporting options are being explored starting with a manual-reporting system. A user specification for MDT-based, real-time fleet status reporting is being developed.

Clinical

- Good patient record-keeping is essential for handover of patient care, risk management and clinical audit. The Healthcare Commission recommended in its report that we ensure that the clinical focus is restored to team leaders who perform PRF checks. A three-year plan to reach 100 per cent compliance with Clinical Performance Indicator audits on PRFs has been put in place.

Central Ambulance Control

- The target for achieving 95 per cent performance for doctors' urgent calls within 15 minutes of the agreed arrival time was not achieved. The figure for March 2005 was 56 per cent. Immediate dispatch of calls when there is only one hour to scheduled time of arrival is to be implemented; a triaging system will be introduced and a blue-light response given to one-hour urgent calls.

Information Management and Technology (IM&T)

- Controls to ensure records management is consistent throughout the Trust will be enhanced now an appointment has been made for the post of Records Manager.
- An IM&T strategy is under development to strengthen staff accountability in this area and maintain internal control.
- A fully integrated business continuity contingency plan needs to be developed. The Trust has not received any recent assurance on the effectiveness of IM&T systems and structures.

A&E Operations

- National Category B targets have been highlighted by internal performance-monitoring mechanisms as being high risk for non-achievement, posing significant internal control issues. Operational managers are achieving the optimal level of staffing and also use standby points 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. This system will become more robust once the Complaints Review Panel is established. Although Patient and Public Involvement (PPI) requires further development, a PPI strategy has been written and includes a three-year programme of activity that will be monitored by the PPI Committee. Development of the Mental Health Strategy has involved contribution from patients and will be key to managing the risks for patients with mental health issues. The Patient Advice and Liaison Service (PALS) has had an impact on managing risks: some enquiries have led to totality-of-care reviews taking place with the result of reducing the number of frequent callers and ultimately providing a higher quality of patient care. A PPI

manager has been appointed so that PPI activity can be co-ordinated and will ensure that public stakeholders are involved in all Trust activity including risk management.

Review of effectiveness

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit and Risk Management Committee. 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 of internal control through its sub-committees. The Audit Committee will advise 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 look at 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 the areas of clinical governance reviewed by the Healthcare Commission. The Risk Management Committee has delegated responsibility for taking a general overview of all risk management activities within the Trust and to pick up any specific risk management issues which are not covered by the specific Audit and Clinical Governance committees. This committee also receives a report on the management of all identified high-priority risks that have been identified by Trust systems and processes. Another full Trust-wide risk assessment was undertaken this year and generated a further four high-priority risks to the Trust's risk profile.

The structure is supported by some 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 risk and clinical governance, chairs the Clinical Risk Group and is a member of the Clinical Governance Committee. 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 and he also chairs the Information Governance Panel. The Director of Communications is chair of the PPI Committee.

To supplement this mechanism, information is provided to the Board through minutes and annual reports on risk management, PALS and clinical governance in order for the Board to be confident 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
(on behalf of the Board)

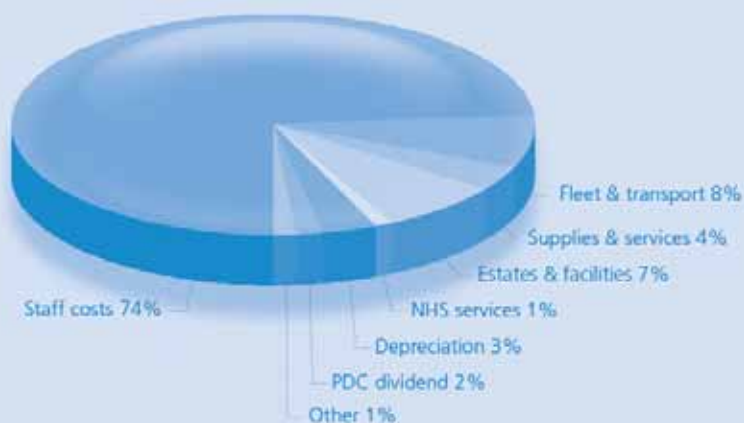
5 July 2005

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2005

	2004/05	2003/04
	£000	£000
Income from activities	189,357	165,103
Other operating income	3,231	3,405
Operating expenses	(189,240)	(165,661)
OPERATING SURPLUS	3,348	2,847
Cost of fundamental reorganisation/restructuring	0	0
Profit on disposal of fixed assets	4	111
SURPLUS BEFORE INTEREST	3,352	2,958
Interest receivable	508	237
Interest payable	0	0
Other finance costs		
- unwinding of discount	(165)	(150)
Other finance costs		
- change in discount rate on provisions	0	25
SURPLUS FOR THE FINANCIAL YEAR	3,695	3,070
Public Dividend Capital dividends payable	(3,363)	(2,981)
RETAINED SURPLUS FOR THE YEAR	332	89

All income and expenditure is derived from continuing operations.

Revenue expenditure



BALANCE SHEET AS AT 31 March 2005

	31 March 2005	31 March 2004
	£000	£000
FIXED ASSETS		
Intangible assets	415	565
Tangible assets	105,085	91,663
	105,500	92,228
CURRENT ASSETS		
Stocks and work in progress	1,938	1,610
Debtors: Amounts falling due:		
after one year	0	0
within one year	16,822	16,585
Cash at bank and in hand	665	911
	19,425	19,106
CREDITORS: Amounts falling due within one year	(14,177)	(13,967)
NET CURRENT ASSETS/(LIABILITIES)	5,248	5,139
TOTAL ASSETS LESS CURRENT LIABILITIES	110,748	97,367
CREDITORS:		
Amounts falling due after more than one year	0	0
PROVISIONS FOR LIABILITIES AND CHARGES	(25,017)	(12,220)
TOTAL ASSETS EMPLOYED	85,731	85,147
FINANCED BY:		
CAPITAL AND RESERVES		
Public dividend capital	39,977	52,838
Revaluation reserve	40,284	28,024
Donated Asset Reserve	698	893
Other reserves	10	10
Income and expenditure reserve	4,762	3,382
TOTAL CAPITAL AND RESERVES	85,731	85,147

Chief Executive

5 July 2005

CASHFLOW STATEMENT FOR THE YEAR ENDED 31 March 2005

	2004/05	2003/04
	£000	£000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	21,930	6,415
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	502	237
Interest paid	0	0
Interest element of finance leases	0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance	502	237
CAPITAL EXPENDITURE		
Payments to acquire tangible fixed assets	(5,976)	(7,295)
Receipts from sale of tangible fixed assets	73	188
Payments to acquire intangible fixed assets	(63)	(195)
Net cash (outflow) from capital expenditure	(5,966)	(7,302)
DIVIDENDS PAID	(3,363)	(2,981)
Net cash inflow/(outflow) before financing	13,103	(3,631)
FINANCING		
Public dividend capital received	0	3,631
Public dividend capital repaid (not previously accrued)	(12,861)	0
Public dividend capital repaid (accrued in prior period)	0	0
Capital element of finance leases	0	0
Net cash outflow from financing	(12,861)	3,631
Increase/(Decrease) in cash	242	0

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2005

	2004/05	2003/04
	£000	£000
Surplus for the financial year before dividend payments	3,695	3,070
Unrealised surplus on fixed asset revaluations/indexation	13,328	5,636
Increases in the donated asset and Government grant reserve due to receipt of donated and Government-grant-financed asset	0	1,051
Reductions in the donated asset and Government grant reserve due to the depreciation, impairment and disposal of donated and Government-grant-financed assets	(215)	(158)
Total recognised gains and losses for the financial year	16,808	9,599
Prior Period Adjustment	0	0
Total gains and losses recognised in the financial year	16,808	9,599

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

A) Remuneration

Name and Title	2004-05			2003-04		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Sigurd Reinton, Chairman	£20,001-£25,000	£0-£5,000		£20,001-£25,000	£0-£5,000	0
Beryl Magrath, Associate Non-Executive Director	£5,001-£10,000	£0-£5,000		£0-£5,000	£0-£5,000	0
** Suzanne Burn, Non-Executive Director	£0-£5,000	£0-£5,000		£5,001-£10,000	£0-£5,000	0
Sarah Waller, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	0
Colin Douglas, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	0
Toby Harris, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	0
Barry MacDonald, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	0
** Ian Tighe, Director of Technology	£70,001-£75,000	*	£1,400	£85,001-£90,000	£0-£5,000	£4,300
Wendy Foers, Director Human Resources	£90,001-£95,000	£40,001-£45,000		£85,001-£90,000	£0-£5,000	0
Fionna Moore, Medical Director	£75,001-£80,000	£0-£5,000		£60,001-£65,000	£0-£5,000	0
** Mark Jones, Director of Finance & Business Planning	£40,001-£45,000	£0-£5,000		£85,001-£90,000	£0-£5,000	0
Peter Bradley, Chief Executive	£135,001-£140,000	£0-£5,000	£4,000	£125,001-£130,000	£0-£5,000	£2,900
** Michael Dinan, Director of Finance	£30,001-£35,000	£0-£5,000				
** Martyn Salter, Acting Director of Finance	£5,001-£10,000	£0-£5,000				

* Other Remuneration - Consent to disclosure withheld.

** Directors were in post for part of the financial year. Michael Dinan was appointed Director of Finance on 15 November 2004. Mark Jones resigned from the post of Director of Finance & Business Planning on 3 October 2004. Ian Tighe resigned from the post of Director of Technology on 3 January 2005. Suzanne Burn resigned from the post of Non-Executive Director on 16 January 2005. Martyn Salter was Acting Director of Finance from 4 October to 14 November 2004.

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

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

B) Pension Benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500)	Total accrued pension and related lump sum at age 60 at 31 March 2005 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2005	Cash Equivalent Transfer Value at 31 March 2004	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Sigurd Reinton, Chairman	**	**	**	**	**	
Beryl Magrath, Associate Non-Executive Director	**	**	**	**	**	
Suzanne Burn, Non-Executive Director	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	
Colin Douglas, Non-Executive Director	**	**	**	**	**	
Toby Harris, Non-Executive Director	**	**	**	**	**	
Barry MacDonald, Non-Executive Director	**	**	**	**	**	
Ian Tighe, Director of Technology	£7,501-£10,000	£150,001-£155,000	£607,617	£539,805	£52,698	
Wendy Foers, Director Human Resources	£7,501-£10,000	£110,001-£115,000	£427,178	£369,049	£47,795	
Fionna Moore, Medical Director	£0-£2,500	£115,001-£120,000	£500,229	£477,447	£9,417	
Mark Jones, Director of Finance & Business Planning	£7,501-£10,000	£95,001-£100,000	£318,573	£275,370	£35,493	
Peter Bradley, Chief Executive	£5,001-£7,500	£30,001-£35,000	£114,042	£90,201	£21,315	
Michael Dinan, Director of Finance	£0-£2,500	£0-£5,000	£4,874	£0	£4,784	
Martyn Salter, Acting Director of Finance	£0-£2,500	£110,001-£115,000	£444,625	£412,854	£20,211	

** 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 from 2004-05 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

	2004/05	2003/04
	£000	£000
Management costs	11,079	9,466
Income	192,256	167,920

BETTER PAYMENT PRACTICE CODE - MEASURE OF COMPLIANCE

The NHS Executive requires that NHS trusts pay their non-NHS creditors in accordance with the Confederation of British Industry (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.

	2004/05	2004/05	2003/04
	Number	£000	£000
Total bills paid in the year	58,523	45,280	50,879
Total bills paid within target	52,036	39,948	40,801
Percentage of bills paid within target	88.92%	88.22%	80.19%

EXTERNAL FINANCING

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

	2004/05	2003/04
	£000	£000
External financing limit set by the NHS Executive	(13,103)	3,631
External financing requirement	(13,103)	3,631
Undershoot	0	0

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

Photography:

DaimlerChrysler: *page 6, 15, 19 bottom*

National Patient Safety Agency: *page 18*

Communications Directorate, London Ambulance Service NHS Trust: *page 2-3, 11, 16-17, 23, 24, 25, 28*

Andrew McArthur: *page 12, 13, 16, 22, 26*

National Gallery: *page 14*

London Safety Camera Partnership: *page 9, 19 top*

Newscast: *page 21*



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