



London Ambulance Service



NHS Trust

Annual Report 2007/08



now & then



## Patient Advice and Liaison Service

**Mail:** London Ambulance Service NHS Trust  
St Andrews House  
St Andrews Way  
London  
E3 3PA

**Email:** [pals@lond-amb.nhs.uk](mailto:pals@lond-amb.nhs.uk)

**Tel:** 020 7887 6678



## Annual Report 2007/08

### CONTENTS

2	Who we are
3	Vision and Values
4	Chairman's views
5	Chief Executive's views
6	Building on success
8	Patients
14	People
18	Performance
24	The Trust Board
26	Financial summary statements
Inside back cover	<i>now&amp;then</i> The history of the Service

# London Ambulance



## Who we are

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

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

We have two principal functions: we provide an accident and emergency service in response to 999 calls and a patient transport service which performs an important role by taking

non-emergency patients to and from their hospital appointments.

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

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

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

In 2007/08, we handled nearly 1.4 million emergency 999 calls from across London and attended more than 945,000 emergency incidents.

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



An early London Ambulance Service control room receives 999 calls. Today our control room handles nearly 1.4 million calls annually



# Service NHS Trust

## Our vision

A world-class ambulance service for London: an organisation of well-trained, enthusiastic, caring, proud people, who are all recognised for their dedication to meeting the needs of the public and all our patients.



## Our 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**

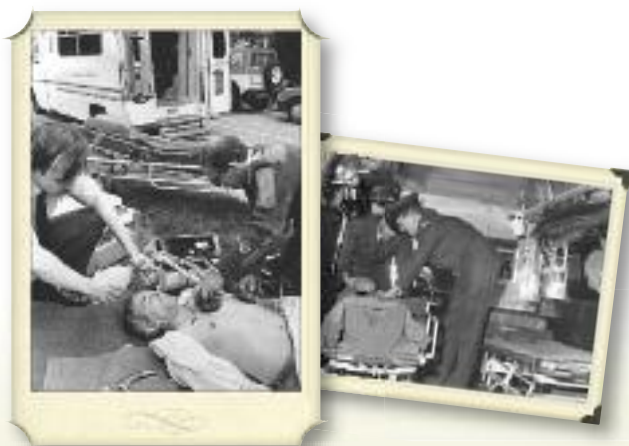
We will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on.

### **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.



Patients receive treatment from our staff at scenes of incidents



## Chairman's views

### What do you see as the highlights and disappointments of this year?

We had yet another successful year, with many new initiatives to improve patient care and response times. We were also encouraged by the results of the Healthcare Commission's 2006/07 health check, published last October, which found us to be the best performing ambulance service in the country.

My one disappointment is that the funding to enable us to be in a position to meet the new, more demanding response time target for serious and life-threatening conditions was only confirmed half-way through the year. As a result, we had to scramble to get there, declaring a heightened level of service pressure, in the last months of the year, in order to be able to start meeting the new target from 1 April 2008.

### What improvements have patients seen?

Faster responses, crews with improved skill levels, wider use of new and better drugs and more patient specific protocols. We now get to many immediately life-threatening calls in five or six minutes, and to 75 per cent within eight minutes. We have introduced new improved resuscitation protocols and consolidated the use of pain relief. We are also evaluating the use of a treatment for patients with acute heart failure called the continuous positive airway pressure, as well as therapeutic hypothermic treatment for cardiac arrest victims in two areas of London. Our cardiac arrest survival rates have again improved (to 15.8 per cent as measured on the internationally recognised Utstein template).

### Looking ahead, how will the Trust maintain its position as best performing ambulance service in the country over the coming year?

Pleasing as it was for the Trust to be rated as the best in the country, we did not do anything in particular with that in mind, and I do not expect that to change. We will continue to do our utmost for our patients and for Londoners, including commuters and visitors. How that leaves us in comparison to other ambulance services is secondary.

### Ambulance trusts now have the option to apply for foundation trust status. What will be the benefits of a successful application for the Trust and for patients?

There will be less change than many imagine. The Trust Board decided at its March 2008 meeting to initiate the application process but the decision was a finely balanced one – there are advantages and disadvantages. What is certain is that we will not suddenly become a profit maximising organisation. Patients and patient care will continue to come first. An important potential advantage, however, is that we would be able to keep any surpluses we make and reinvest them in better services for patients, rather than hand them back as we have to at the moment. In this way, we would be able to plan better, with more certainty. In addition, foundation trust status will be an opportunity for members of the public and patients to have more of a say in how we deliver our service.

### To what extent does the Trust support Lord Darzi's proposals for future healthcare services in the capital?

We worked closely with Lord Darzi and his team when he developed his vision for the NHS in London. We have contributed to the recent consultation process and expect to play an important role when implementation of the changes starts. We support the proposal that the most seriously-ill patients - for example, victims of stroke, heart attacks and serious trauma - should be taken directly to specialist units, but would like to see the implications for local general hospitals thought through. We support the idea of polyclinics and better-integrated urgent care, but would like to see trials of different models, and a broader role for the London Ambulance Service in assessing patients with urgent problems and helping them access the most appropriate care.

Sigurd Reinton CBE  
Chairman



## Chief executive's views

### The Trust had its most successful year in 2007/08 – how was this achieved?

It has been a challenging year. Whilst we had to meet increased demands placed upon us, we also had to prepare for the changes ahead, such as the introduction of new performance targets. Our success was down to a lot of hard work across the organisation, investment in our staff and the introduction of new equipment and technology to help them carry out their work. The way of measuring how successful we are does not just include response times, which of course are very important, it also includes how we manage our risks, treat specific patients with serious conditions and how we manage our finances.

### How will the Trust need to adapt to meet the new Government performance target for life-threatening calls, and how will the changes affect patients?

The impact for patients will be faster 999 call answering and a faster response. This is being achieved through the use of new technology and recruiting additional frontline staff and control room staff. We know that the public are reassured by a fast response to their needs and we will continue to identify and improve our response at times of the day, on days of the week and in areas of London where we know we can do even better.

### More cars, motorbikes and bicycles, as well as community volunteers, are being used to respond to emergency calls. What are the benefits of these for patients over an ambulance?

The important thing to say is that these different responders are not sent instead of an ambulance, but often as well as one. The sooner a first responder attends to a patient the sooner treatment can begin and the sooner the exact nature of a patient's condition can be identified. Our aim is to do the best possible job initially over the telephone of establishing the best resource to send to meet a patient's specific need. For those cases where it is clear that it is a serious call we will always send

an ambulance, but for those calls where it may be better to receive advice or be treated at home we will ask our patients to speak to one of our specially trained telephone advisors first. During the last year we also launched our first ambulance community responder scheme - another means of reaching patients quickly, thus increasing the chances of survival for those in cardiac arrest.

### Demand continues to rise – what is being done to address this?

Demand continues to increase, though not as fast as it has done previously. It used to go up by 10 per cent a year, and it now runs at around three per cent a year – this still represents an extra 25,000 incidents a year however. It is extremely difficult to change people's behaviour and though we will continue to try to encourage the public to use their ambulance service wisely, we are having to deal with calls in a different way. We have had great success with providing advice over the telephone and with our emergency care practitioners attending patients in their homes and providing assessment, treatment and then appropriate referral.

### How will additional funding received for the coming year be used to ensure patients receive a better service?

Almost all of the additional funding we receive this year will be used to employ additional frontline staff which will include student paramedics, emergency care practitioners and more control room staff. We will also be buying more than 120 new ambulances and replacing several pieces of key equipment. In addition we will also be accelerating the recruitment programme to fill all our existing vacancies as soon as possible. Use of our funds in this way will directly contribute to improving patient care and the improved staffing levels will also ease the pressures on frontline staff.

Peter Bradley CBE  
Chief Executive Officer

# Building on success

We are now one year into our five-year Strategic Plan which details where we want to be in 2013 and sees us moving away from a one-size fits all service, to one where all our patients receive care tailored to their needs.

Many of our patients do not need to be taken to hospital for treatment, and already we are providing many of them with more appropriate care. We are treating an increasing number of patients at home and are providing more clinical advice over the telephone. Our staff are increasingly referring people to their GP or social services, or taking them somewhere other than hospital for treatment, such as minor injuries units.

These changes to our service, which are taking place against a backdrop of increased demand and population growth in the capital, are influenced by the national Ambulance Service Review, 'Taking Healthcare to the Patient' (June 2005). We are also working closely with Healthcare for London to influence how recent proposals for improving healthcare services for Londoners are implemented, and to ensure our future plans are aligned with these developments.

## What will be different about our service?

- We will offer a greater range of care options for patients, and are already providing more treatment at home, medical advice over the telephone or access to walk-in centres and minor injuries units, rather than a trip to hospital
- We are increasingly using single responders as our initial response to calls. These staff are developing enhanced diagnostic and treatment skills so they can decide on the best treatment to meet their patients' needs
- People will find it easier to access our services, and we are increasingly engaging with patients and the public as well as our health and social care partners.

Within the plan are the five following programmes of work.

## Access and connecting the Trust for health

We want all our patients to be able to access us as quickly and easily as possible.

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

Alongside this, we are developing an access strategy that considers in detail the needs of our patients who may have a disability or who speak different languages. We will use information technology solutions to make access to information simpler, and allow patients to speak directly to a helpful human.

In 2007/08 we:

- started to automatically dispatch our ambulances as well as our fast response cars to incidents; this helps us to reach patients faster
- continued to take work forward to introduce a new national digital radio system
- upgraded the technology systems used by our Patient Transport Service
- progressed work to replace our current call-taking and dispatch system within our control rooms
- continued with our work to look at introducing a text-based system to enable patients with speech or hearing impairments to contact us more easily.

## Improving our operational response

This programme of work involves developing the resources, skills and equipment needed to be able to meet

new, tougher, national performance standards.

These new targets, introduced in April 2008, significantly change how our responses to Category A (immediately life-threatening) and Category B (serious but not life-threatening) calls are measured. Response times are now recorded from the moment a call is connected to our control room, compared with previous practice, based on Department of Health guidelines, where the clock started only once we had established an address, telephone number and condition of the patient.

Our response is now more closely aligned to that which our patients experience and they will get a better service from us; however, the challenge for us is to now respond almost two minutes quicker than in the past.

In 2007/08:

- we improved our call-taking procedures so that we are now consistently answering 95 per cent of 999 calls within five seconds
- we started to send fast response cars to standby at locations and at times where historical data tells us there will be periods of high demand, rather than basing cars at an ambulance station throughout the shift
- our managers and team leaders began working on fast response vehicles during peak times of the day to enable us to provide a better service to patients
- our bicycle and motorcycle response schemes were extended to more areas of London; these solo responders, introduced initially in central London, reach patients more quickly in built-up areas than other resources
- we helped many patients who call us frequently to access more appropriate care
- we introduced our first ambulance community responder volunteer



project. This involves training volunteers in cardio-pulmonary resuscitation (CPR) and the use of defibrillators (the machine used to re-start a persons heart when it has stopped beating) so they can attend patients in their local area and start treatment before our crews arrive.

## Organisation development and people

We recognise our staff are key in helping us deliver on our Strategic Plan.

In 2007/08 we:

- agreed a new framework with the unions to ensure constructive engagement with the Trust's management.
- Selected Barnehurst and Chase Farm stations to pioneer a new initiative to develop exemplary ambulance complexes – in terms of clinical leadership and the way frontline services are delivered, and in how staff work together
- developed five new training modules for staff covering such areas as obstetrics, major incidents and diversity
- agreed changes to our workforce profile and skill mix which will see more staff trained to paramedic level and we developed a new A&E support role.

## Planning for the London 2012 Games

The Olympic and Paralympic Games in 2012 represent a huge challenge in maintaining our day-to-day emergency service while providing medical cover to the event.

As part of our planning in 2007/08 we:

- seconded staff to the Olympic Security Directorate and Olympic Delivery Authority/London Organising Committee for the Olympic Games
- held two UK ambulance forums to update national colleagues on progress and coordinate future planning
- determined how our command and control structure will work during the Games, and what staff and other resources we will need. We also identified our training requirements



- carried out a survey to identify staff views and concerns about the Games; the findings will be used to inform future planning.

## Governance and corporate processes

We are looking at how we can improve our internal processes so that we can work more efficiently and in a way that provides value for money. In doing so, we will support the delivery of better patient care by frontline staff.

In 2007/08 we:

- set up a web-based stock management system that speeds up our ability to place orders with our suppliers
- took forward work to introduce a system for tracking equipment on our vehicles; this will be implemented in 2008/09
- completed a 'flexible fleet' project which allows us to manage the sharing of vehicles between a number of stations
- progressed work to automate staff administration processes. This will lead in 2008/09 to a more effective method of paying overtime, staff expenses and managing annual leave.

Since we decided in March 2008 that we will apply for foundation trust status, we

will now be one of two pilot ambulance trusts working to develop the application process for ambulance trusts nationally.

## Stakeholder engagement and communication

A communication and engagement strategy has been developed to support the Strategic Plan. It focuses on delivering the Trust's strategic aspirations as well as integrating other strands of work such as public education, media relations and internal communications.

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

The strategy aims to increase Londoners' understanding of our role and future plans and involve the public and patients in shaping the way we deliver our service. We will also work to build relations with our key stakeholders and develop an environment where members of staff feel valued, feel proud to work for the Trust, and actively contribute to improving patient care.

# Patients

Last year we attended 945,776 patients in London – more than ever before.

We know that many of the patients we are called to do not need to be sent an emergency ambulance with blue lights and sirens, and they would receive much more appropriate medical care somewhere other than in hospital.

So whilst over the last year we have continued to improve the care we provide to our patients with life-threatening illnesses and injuries, we have also worked hard to offer other care options for our patients with less serious conditions.

Three years after opening, our urgent operations centre is dealing with nearly 60 per cent of our patients who do not have life-threatening or serious injuries or illnesses.

## Clinical telephone advice

Our clinical telephone advice team, located within the urgent operations centre, is made up of experienced emergency medical technicians, paramedics and an emergency care practitioner who provide medical advice over the phone to callers with less serious conditions.

Team members are well-equipped with the skills necessary to call back and further assess and advise those patients where the initial assessment has determined that they are suffering from illnesses or injuries that are neither serious nor life-threatening.

During the call they aim to establish what the best course of treatment is for the patient. This could involve being cared for at home, being referred to their GP or local pharmacy, or having an ambulance sent to them.

The clinical telephone advice team handled 58,210 calls in 2007/08 compared to 48,813 in the previous year. By advising on more appropriate care options for callers, they kept 35,383 ambulances free for those patients who really needed them.



Patient care has always been at the heart of our Service

## Urgent care service crews

If, following an assessment, the clinical telephone advisor decides an ambulance is required the call is electronically sent to our urgent care desk for allocation and dispatch.

This team also deals with all requests for non-urgent transport and calls which are not reported to be serious which have initially been processed through the main control room.

The fleet of resources managed by the desk includes staff with a wide range of skills from Patient Transport Service, A&E support, emergency medical technicians to paramedics.

A&E support is one of the new skill levels we have introduced in recognition that some of our patients do not need the clinical skills of a paramedic or emergency medical technician, nor an ambulance on flashing blue lights. Some of these patients may not require immediate medical treatment, but rather kindness, concern and reassurance. This role also frees up our accident and emergency crews to attend to patients with serious or life-threatening illnesses or injuries.

## Emergency Bed Service

Another element of our urgent care service is the Emergency Bed Service (EBS), a bed-finding system for NHS healthcare professionals who are making admissions or transfer arrangements for their acutely-ill patients. EBS managed around 10,000 referrals last year.

Following a successful pilot during 2007/08, a new service was introduced that enables our clinical telephone advisors to refer calls which need an out-of hours GP to EBS.

In the same period, EBS has also begun to design a system for collating and

providing information about hospital capacity. This will be developed further in 2008/09 in partnership with acute trusts and primary care trusts.

The team continues to hold the national intensive care bed register for adult and paediatric critical care beds in three-quarters of England. It offers a service to help with antenatal transfers, and acts as the coordinator for the Neo-natal Transfer Service in London, Kent, Surrey and Sussex, which transports sick babies between hospitals.

## Emergency care practitioners

Our emergency care practitioners (ECPs) frequently respond to complex, but less urgent 999 calls.

In many cases, it is suspected that a patient may not need, or even want, to go to hospital, but a face-to-face assessment is required. Emergency care practitioners can treat a wide range of different conditions, particularly related to chronic conditions, minor injuries and illnesses. They work with their local primary care trusts to provide medication plans, make referrals and transport patients to GP surgeries or minor injuries units if required.

We currently have 52 emergency care practitioners working in 11 teams, and during the year they responded to 14,000 calls. We plan to recruit a further 30 practitioners during 2008/09, and the same number again in the following year. Longer term, we see ECPs forming an even more important part of our workforce.



## Ambulance community responder volunteers

During the year we set up our first ambulance community responder schemes, where teams of local volunteers are trained to a nationally-recognised level so they can respond to and provide life-saving treatment to people in their local communities while an ambulance is on the way.

Following training each volunteer is assessed for competence in the delivery of basic life support and the use of a defibrillator. There is also a statutory requirement for them to take refresher training.

We are currently trialling schemes in Feltham (in partnership with St John Ambulance) and Biggin Hill. We have also been recruiting in Walthamstow, Collier Row and Harold Hill (also in partnership with St John Ambulance), Northwood and Harefield (in partnership with British Red Cross) and Haringey.



Examples of our early vehicles: a horse-drawn ambulance and one of the first petrol-driven ambulances



# Patients

## Cardiac care

Survival rates for Londoners who have suffered an out-of-hospital cardiac arrest (when the heart stops beating), have continued to improve. Our latest figures show a trebling of survival rates in the five years up to and including 2006/07, and an increase of almost five percentage points in that 12-month period alone. Now 15.8 per cent of Londoners are discharged alive from hospital following a cardiac arrest that is witnessed by someone and when the heart may respond to a shock from a defibrillator machine.

A number of factors have contributed to this improvement. In 2006/07 our staff reached cardiac arrest patients an average of one minute faster than in the previous year. In addition, we have retrained our staff in the updated national resuscitation guidelines, focusing particularly on delivering high-quality uninterrupted compressions and post-resuscitation care.

We have trained more people in how to use a defibrillator so that life-saving treatment can start prior to the arrival of our staff. During 2007/08, more than 1,200 people were trained or re-trained as part of our community defibrillation programme, and we saw the survival rates for patients who were initially treated by trained members of the public rise by seven percentage points to 45 per cent.

We have now installed a total of 425 defibrillators in public places. In 2007/08 these were provided to organisations or locations including City of London Police, the Metropolitan Police Marine Support Unit, Biggin Hill Airport and the Whitgift Shopping Centre in Croydon. We have been awarded further funding for 79 new defibrillators from the British Heart



*Staff are reunited with patients who benefited from the cardiac care we provide*

Foundation which will be sited during 2008, and we are currently supporting a year-long campaign by the charity to raise money to fund more public access defibrillators.

Our community defibrillation team has also worked closely with a charity called SADS UK (Sudden Adult Death Trust). Defibrillators have been placed in several schools which have a pupil or pupils at high risk of cardiac arrest, and teachers have been trained in their use.

Our community resuscitation team also has an important role in providing cardio-pulmonary resuscitation training to both businesses and members of the public. More than 9,000 people were taught these life-saving skills during the year, with some courses oversubscribed.

Our crews are taking more patients to the nine heart attack centres which operate around-the-clock in London. Our latest

information shows that in 2006/07, 74 per cent of patients (598 people) suffering from an ST-elevation myocardial infarction – a common type of heart attack – were taken directly to a cardiac catheter laboratory for specialist treatment, rather than A&E.

At these specialist centres, patients benefit immediately from primary angioplasty, a procedure where the patient is handed over by the ambulance crew to a cardiology team, who perform a procedure whereby a catheter is passed into the arteries in the heart to identify the blocked area, and a balloon is inserted and inflated to open the artery at the point of the blockage.

This procedure offers a much better chance of survival and a quicker recovery than the standard treatment, thrombolysis, which involves administering clot-busting drugs, followed by transport to the nearest A&E.



*Examples of cardiac care and resuscitation through the years can be found in our museum at Ilford*





## Clinical audit and research

Our clinical audit and research unit coordinates and facilitates all of our audit and research activity.

The team examines whether best practice is being followed by auditing whether the quality of care delivered to our patients by our staff complies with clinical guidelines and protocols.

In 2007/08, we carried out audits covering a broad range of topics including obstetric care, the use of adrenaline in both asthma and anaphylaxis, and the recording of patient ethnicity. In addition, a number of audits reviewing the categorisation of 999 calls were undertaken. Our team leaders carry out routine audits on patient report forms for cases involving cardiac arrests, acute coronary syndrome, difficulty in breathing, and non-conveyance. A random five per cent

sample of forms are also audited to assess the quality of basic documentation.

The results of all our audits are used to inform the development of our clinical practices, and form the basis for providing constructive feedback to staff. To support this, frontline staff can now view information on their own individual clinical performance via the intranet.

We are also involved in a number of research projects. The Smart CPR study, which aims to improve survival from out-of-hospital cardiac arrest through the use of a specially upgraded defibrillator, is continuing and more of our fast response cars are carrying the equipment. This study is examining the effectiveness of defibrillator technology that decides whether a cardiac arrest patient would benefit from an immediate defibrillator shock or a short period of cardio-pulmonary resuscitation. This project is being undertaken in collaboration with New York's Emergency Medical Service and will run to mid-2009.

Another important study is being undertaken in collaboration with King County Emergency Medical Service in the USA. It is examining the effectiveness of chest-compression only instructions provided over the telephone by emergency medical dispatchers. We are currently collecting the final patient outcomes for the project and the data will shortly be analysed – the results are expected to influence future resuscitation guidelines.

Bi-monthly evidence for practice seminars continue to raise awareness amongst our



staff of research, clinical audit, and evidence-based practice. Topics covered in 2007/08 included paediatric emergency tapes and the use of mobile treatment centres.

A monthly journal club has recently been launched which allows staff to discuss the impact of research on the way we care for patients. Additionally, a monthly advice surgery is open to any staff interested in undertaking a clinical audit or research project and who need advice on how to move their ideas forward.

## Patient and public involvement

A survey this year among our operational staff who are involved in public education indicated a high level of commitment to this kind of work.

We are now working with London South Bank University to develop a public education programme for our staff which will include skills training and ongoing learning through peer feedback. It is hoped that the programme will be accredited, offering public education staff a form of qualification for their work and personal development.

In October 2007 new legislation was introduced which will see patients' forums replaced by Local Involvement Networks (LINKs). These will be local authority based, and will work across health and social care services, rather than being attached to one NHS trust. Consideration is currently being given to how we can maximise the benefits of working with LINKs. With 32 LINKs being established across London, it is likely that the most effective model will be a local one, with local management teams getting involved with the LINK in their area and feeding their learning into a central point so that it can be used across the Trust.

Despite the introduction of LINKs, our Patients' Forum meetings are still held monthly and attended by a range of senior managers from the Trust. We have

## Patients

agreed to continue to work with Forum members until membership arrangements are established as part of a future foundation trust application.

We have been chosen as one of the first sites to work with the newly-formed NHS Centre for Involvement (NCI) which has completed a baseline assessment of patient and public involvement in the Trust. They found that we had made significant progress in patient and public involvement work, and made four key recommendations so that we can move from 'good' to 'great'. These have been incorporated into our new patient and public involvement action plan.

As an outcome of the NCI assessment, a joint project began in Tower Hamlets, aimed at improving health outcomes amongst the local Bangladeshi community and building relationships between the Trust and this community. A health education pack, 'Get the Right Treatment', was produced in partnership with Tower Hamlets Primary Care Trust (PCT) and will be used in training sessions with the community. It includes information about accessing local health services and a DVD to prompt discussion about which services should be accessed in a variety of circumstances. Along with other initiatives, led by the PCT, 'Get the Right Treatment' received a regional NHS Health & Social Care Award.

Local events and activities have continued in 2007/08 with school visits, health awareness days and career events. One example was an initiative in Southwark aimed at reducing knife and gun injuries among young people in the area. There were also reconstructions of crashes for young people to raise awareness of road safety and the role of the emergency services.



## Patient Advice and Liaison Service

In the last year our Patient Advice and Liaison Service (PALS) merged with our Complaints department.

One of the department's key responsibilities continues to be to provide information, advice and support to patients, the public and health and social care professionals, both in terms of issues arising from their experience of using the Trust, and practice and policy.

During the year the PALS team dealt with 4,712 enquiries, a 12 per cent increase on 2006/07.

We received 783 expressions of appreciation compared to 661 in 2006/07. There were 720 requests for medical records, which we provided with a comprehensive explanation of their contents. There were also 72 enquiries relating to a delay in an ambulance response, 69 related to conveyance issues and 130 related to clinical care. There were 87 enquiries relating to poor staff attitude or behaviour.

PALS received 518 enquiries regarding lost property, of which only 19 per cent could be resolved. However, a patient property bag scheme to keep closer track of patients' belongings has now been introduced.

The PALS team is also responsible for handling enquiries made under the Freedom of Information Act and dealt with 119 such cases, compared to 89 in the previous year. However, the majority of the requests did not require the use of the Act to access the information.

Complaints to the Trust have continued to decrease. During the year we received a total of 539 external complaints, compared to 557 the previous year. Of these, 231 were written complaints, down from 290 in 2006-07.

We responded to 81 per cent of written complaints within 25 working days, exceeding the Department of Health's 80 per cent target.

We also work with patients and the relevant health and social care professionals in finding more appropriate means of care for those patients who make a high number of 999 calls. A service user who makes more than 10 emergency calls in a calendar month is classed as a frequent caller, and with



Our work in the community has a long history; from fundraising and school visits, to educational fun days

some 200 such callers on our register at the moment, the impact on delivering services is significant.

We have identified our 20 most frequent users and individual action plans have been drawn up. Each patient is being monitored to establish if a reduction in calls is being achieved and whether interventions have been effective.

### Working with our communities

Our staff work within an incredibly diverse city, with hundreds of languages spoken, and many different customs, cultures and religions practised.

We continue to improve the ways we engage with the communities we serve. In March we held an event, 'It's your call', with 90 members of the public to gain their views on our equality impact assessments, and the possible impact of our procedures on particular groups.

In East London, frontline staff in Tower Hamlets have been given the opportunity to take Bengali language classes in order to work more effectively within the local communities. The 60-hour tuition includes modules dedicated to the use of medical terminology.

### Protecting children and vulnerable adults

We continue to see an increase in the number of cases reported by staff of suspected abuse of children and vulnerable adults.

In 2007/08 staff reported 2,720 cases of vulnerable adults who they felt were either at risk or in need of further investigation. This compares to 1,896 in 2006/07.

In addition, 659 children were referred, up from 574 the previous year.

### The impact of alcohol-related calls

In the two years since the introduction of the revised licensing laws, we have responded to 12 per cent more alcohol-related 999 calls.

These calls continue to be a real issue for us, especially on both Friday and Saturday nights, and particularly as alcohol is a factor in many more of the incidents we are attending, such as assaults, minor falls and injuries.

Alcohol-related calls now make up approximately five per cent of the workload for our crews, with this rising to nearly 15 per cent during the busiest hours of midnight to 1am.

We have continued to work with the media throughout the year to raise awareness of the pressure of alcohol-related calls and have urged the public to drink responsibly on a night out and think before calling 999.

### Improved access to patients

Increased demand and a rising population require us to look at where we place our resources, and what those resources are, so we can continue to get to our patients as quickly as possible.

Last year, we opened our new Silvertown Ambulance Station, which along with Poplar Ambulance Station forms the new Tower Hamlets Ambulance Complex. Our Brixton Ambulance Station was also opened, and Wembley Ambulance Station has been rebuilt as a bigger building.

Buckhurst Hill Ambulance Station has been moved further into the London area to Walthamstow, to provide a more effective response for patients. The new site has been placed in a position to access the main arterial roads quickly, including the North Circular, while causing minimum disruption to local residents.

In built-up areas motorcycle and bicycle paramedics and emergency medical technicians can respond to emergency 999 calls more quickly than other resources, and can assess patients and administer life-saving medical treatment while an ambulance is on the way. Motorcycles are now operating in Hackney, Tower Hamlets and the City of London and bicycles are covering Kensington, Knightsbridge, Hammersmith, Croydon town centre, Canary Wharf and the area around St Pancras International station. This is in addition to their traditional areas of operation in central London and inside terminals at Heathrow.

The motorcycles and bicycles carry the same life-saving equipment as ambulances, including a defibrillator.



*Our cycle responders and motorcycle responders were extended to new areas of London in 2007/08*



# People

We are investing in our staff to bring improvements to patient care.

By 2013 we envisage our frontline staff numbers will increase by almost a fifth to more than 3,000, and the number of staff giving clinical advice over the telephone will more than double.

Many of our staff will have enhanced skills so they are able to diagnose and treat patients with a wider range of conditions, and make key decisions about their care which in many cases will require something other than being conveyed to hospital.

During last year our work to achieve this began in earnest. We started to upskill our emergency medical technicians to paramedic status, and created a new support role to work alongside paramedic colleagues. We have recently introduced the role of student paramedic which will see staff developing their skills over a three-year period to become a fully-qualified paramedic.

We have consulted widely with staff on many of the changes that lie ahead, and continue to work closely with the trade unions to ensure the needs of staff are considered in our proposals.

## Engaging with staff

In 2007 a new partnership agreement was signed between the Trust and the recognised Trade Unions (Unison, GMB, TGWU and Amicus). This was followed by the establishment of a forum comprising senior staff representatives and senior managers from the Trust to discuss issues facing the organisation.

## Finding out what staff think

This year's staff survey provided us with mixed responses about how people working for the organisation feel about the work they do.

Out of a sample of 833 members of staff who were randomly pre-selected last autumn to complete the Healthcare Commission NHS staff survey, a total of 371 returned the questionnaires. This response rate of 45 per cent was up from 38 per cent in 2006.

The survey is carried out nationally which allows for comparisons to be made with other trusts across the country.

We were rated above average for ambulance trusts in a number of areas. Support from immediate managers was rated highly, as was team working and the number of staff who feel they work in a well-structured team environment. In addition, 90 per cent of staff who had



Our uniform has changed a great deal over the years, to become more practical for the work our staff carry out



witnessed a clinical error, near miss or incident, said that they, or a colleague, had reported it. This was up from 75 per cent in the 2006 survey.

At the same time, a number of areas were identified as requiring improvement. Although 61 per cent of staff reported receiving appraisals (above the average for other ambulance trusts), a lower proportion felt these reviews helped agree clear objectives for work. The number of staff reporting they have had well-structured appraisals in the last 12 months has dropped by eight per cent since the 2006 survey.

Staff job satisfaction has also decreased slightly since the previous year and perceived work pressure has increased.

Views were also sought from staff at the Chief Executive's consultation meetings, held in the early summer of 2007. More than 1,300 staff attended these meetings and they were an opportunity to raise issues and ask questions, as well as hear about current initiatives.

## Supporting our staff

Occupational health services are now provided by Atos Healthcare, a leading supplier of occupational health, counselling and screening services in the UK. The new service, which came into effect in December, offers telephone consultations for the first time, as well as face-to-face appointments at two main locations and counselling at a variety of venues.

Our peer support scheme LINC (which stands for Listening – Informal – Non-Judgemental – Confidential) entered its fifth year and currently has a team of 55 workers, from different staff groups, spread across the Trust. The scheme involves staff volunteers providing a confidential listening service available to all staff.

In 2007/08 a LINC manager post was permanently established and there has been a continued growth in usage,

awareness and acceptance of the scheme. A 24-hour on-call number has been set up to ensure that staff can access support round the clock.

Furthermore, 20 LINC workers attended a two-day, trauma risk management course and we now have 43 LINC workers trained to give support to staff who have experienced a traumatic incident.

In the next year it is hoped to select and train a further 30 LINC workers and appoint a further four senior LINC workers.

The year saw a number of human resources policies updated, such as a review of flexible working, guidelines on age discrimination and a policy for specific learning difficulties, including dyslexia. We have a new policy for adoption leave in line with new legislation and arrangements for maternity leave. We also have a new policy for managing attendance which includes support for staff who are off work due to ill health.

## Recruiting new staff

Nearly 270 new members of staff joined us during 2007/08 and at the end of the year our workforce totalled 4,127.

Of the new starters, 84 filled our new A&E support role and others took up a variety of posts including emergency medical dispatchers and emergency medical technicians. Meanwhile, staff turnover increased slightly during the year to 6.83 per cent.

In the coming year, as part of our long-term workforce plan, we are embarking on the introduction of a new role of student paramedic. This will allow us to develop both in-house staff and new recruits up to paramedic status over a three-year programme.

## Valuing diversity

We have an established programme of diversity training for all new members of staff which is delivered by our 19 in-house diversity trainers.

We recognise that women and black and minority ethnic staff are currently under-represented in the Trust and we have continued to work towards ensuring that our workforce reflects London's diversity.

This year saw the re-launch of a support group for black and minority ethnic staff. London Ambulance Black and Ethnic Liaison (LABEL) has been working on setting up a mentoring project for new recruits as well as a support network for existing staff. LABEL hopes to be a source of guidance to managers and is raising ideas about how to encourage more applicants to the Trust from black and minority ethnic backgrounds.

We also joined the Stonewall Diversity Champions programme and now have access to Stonewall guidance on how to improve diversity as an employer and service provider for lesbian, gay and bisexual staff and members of the public. In the future, this also means the Trust will be benchmarked against Stonewall's 100 top employers each year.



We have received generations of support from the royal family

## People

In addition, 20 members of staff took part in the Europride 2007 parade through central London, which celebrated the capital's gay and lesbian life.

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

### Investing in higher education

We have nearly 300 students enrolled in one of three higher education programmes at the University of Hertfordshire, the University of Greenwich and St George's University of London.

At the University of Hertfordshire, we run a part-time paramedic science degree programme for our staff. The programme runs over five years with sponsorship in the form of payment of academic fees and study leave allowance. We are currently sponsoring 41 staff through this part-time programme and to date 184 have attained a certificate award in paramedic science for completing the first year of this course. In addition, 313 of our staff have graduated at diploma level (by completing three years of this course) or degree level (by completing all five years).

We run a full-time paramedic science BSc (Hons) degree in partnership with the University of Hertfordshire which runs over four years. Currently 111 students are enrolled on this programme, and are supported by the Trust.

We also have 144 students on our foundation degree programmes based at the University of Hertfordshire,



*Our staff take part in ongoing learning and development*

University of Greenwich, University of Kingston and St George's University of London.

### Keeping staff safe

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

Reported incidents of physical abuse fell from 298 in 2006/07 to 193 in 2007/08. Reported incidents of non-physical abuse, which includes anti-social behaviour, racism and verbal abuse, have also fallen to 1,190, from 1,260 the previous year.

Although we have seen a decline, the number of incidents is still too high and we continue to do all we can to try to reduce their frequency. We also continued to press for prosecutions against those who assault our crews.

### Rewarding our staff

Internally, we recognise and reward our staff for the work they do.

This year, the Chief Ambulance Officer commendation process, which is designed to recognise highly exceptional actions by staff, was re-launched. A new award was also introduced – the Assistant Chief Ambulance Officer's commendation – which will be administered and awarded at local level.



Traditional classroom based training is now supported with on-line e-learning development



We have recently held our fourth annual awards ceremony which provides an opportunity to recognise colleagues who have a 'can do' approach or who are always willing to go the extra mile to improve patient care or benefit staff.

A new recognition process for staff who have reached long-service milestones has been introduced, with staff recognised for periods of service ranging from 10 to 40 years.

Three members of the Trust were recognised in the New Year Honours List. Chairman Sigurd Reinton was appointed an honorary CBE, while Bromley Ambulance Operations Manager Dave Campbell was made an MBE and non-executive director Sarah Waller was appointed a CBE.

### Improving our working environment

Approximately 150 projects were completed during 2007/08 to improve the working environments across the Trust.

Along with new stations at Brixton, Silvertown and Wembley, a substantial refurbishment of our control room was carried out.

The year also saw a change in procedure for the disposal of confidential waste, with all such documents shredded on site before they are transported for disposal.

We take environmental concerns seriously and continue to look for ways to be more environmentally friendly. Following a successful pilot, our recycling scheme has been extended to include aluminium cans, plastic bottles, paper hand towels, carrier bags, plastic cups, packaging, paper and cardboard and shredded paper.

In the coming year our 'New Ways of Working: Transforming Clinical Leadership' programme will begin to roll out across the Trust. The aim is to create the best possible environment for clinical leadership at a local level, and improve the care given to patients and the job satisfaction of staff.



### Our charitable work

Richard House in Docklands, the Haven House Foundation in Woodford, and Shooting Star in Hampton were adopted as the Chief Executive's charities in 2005/06.

A number of staff ran the Flora London Marathon this year, each of them raising money for the three hospices. Staff also organised and took part in a five-a-side football tournament for these good causes.

In addition, staff across the Trust have participated in a range of charitable events for charities of their choice.

*Staff mark the opening of Brixton Ambulance Station with a visit from the local mayor*



*Staff celebrate completing the 2008 Flora London Marathon*

# Performance

Seriously ill and injured patients in the capital are getting a quicker response from our staff than ever before, despite last year being our busiest ever.

We were the highest rated ambulance service in the country in the Healthcare Commission's annual health check in October 2007. In the second annual health check we were judged as 'good' for our use of resources and quality of services – a better rating than that achieved by any other ambulance service in England.

The results are recognition that despite a very challenging few years, we have done well with our key performance targets and have broken even financially. More importantly, patients who suffer heart attacks in the capital are now receiving some of the best treatment in the world and we have also seen continuing improvements in our cardiac arrest survival rates, meaning that we are saving more lives than ever before.



This compares favourably to the first health check in October 2006 when we were given a 'good' for use of resources but also the lowest rating of 'weak' for our quality of services, an assessment which we did not feel reflected our achievements.

From April 2008 new national standards for ambulance trusts mean that the

'clock' that measures our response time to patients now starts as soon as the call is connected to the control room, rather than after key details about the patient (such as the address and the nature of the problem) are recorded. The changes mean that our response is now measured in a way that is more closely aligned to what our patients experience. Our recorded response times now start approximately two minutes earlier than they did, while our response time target of eight minutes remains unchanged – so patients are getting a better service from us.



Developments over the years have ensured trolley beds are now fitted to make lifting both safer and easier for patients and staff



## Meeting our targets

Each time a 999 call is received into our emergency operations centre, our staff assign the call into one of three categories depending on its urgency.

To do this, our call-handlers use the information they are given about the nature of a patient's illness or injury and then a category is determined using a sophisticated software package and the call-handler's own skills.

The most serious calls are those classed as Category A, where it is assessed that there is an immediate threat to life. Serious, but not life-threatening incidents are prioritised as being Category B calls, while those which are neither serious nor life-threatening fall into Category C. Each call then receives a response proportionate with its categorisation.

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

For 2007/08 the targets state that we must have reached:

- 75 per cent of Category A calls within eight minutes
- 95 per cent of Category A calls within 19 minutes
- 95 per cent of Category B calls within 19 minutes

A target to respond to urgent calls placed by GPs within 15 minutes in 95 per cent of cases was removed from the start of the 2007/08 financial year.

In 2007/08 we responded to:

- 79 per cent of Category A calls within eight minutes, an increase on our performance in 2006/07 of four percentage points
- 98 per cent of Category A calls within 19 minutes, matching our performance in 2006/07



- 84 per cent of Category B calls within 19 minutes, an increase of three percentage points on 2006/07.
  - Attended 315,744 incidents which were classed as Category A, compared to 312,377 in the 12 months before
  - Undertook 279,457 special/planned patient journeys, compared to 321,347 in the year before. These journeys are pre-booked through us by healthcare professionals and include hospital and hospice transfers.
- During 2007/08 we also:
- Received a total of 1,389,660 emergency calls into our emergency operations centre, compared to 1,288,819 in 2006/07
  - Attended a total of 945,776 emergency incidents, compared to 865,537 in 2006/07. Last year, for the first time this figure included urgent incidents – these are the lower priority calls we attend
  - Sent 1,279,441 emergency vehicles to these incidents, compared to 1,191,374 the previous year



A London County Council ambulance and crew

Our A&E ambulance performance

The 2007/08 financial year was our busiest ever and by the end of March 2008 we had received an extra 100,841 calls. We had also attended an additional

80,239 incidents when compared to the previous year – although this figure includes urgent incidents which weren't counted in previous figures.

Despite this additional pressure, we managed to exceed our Government targets for attending Category A calls,

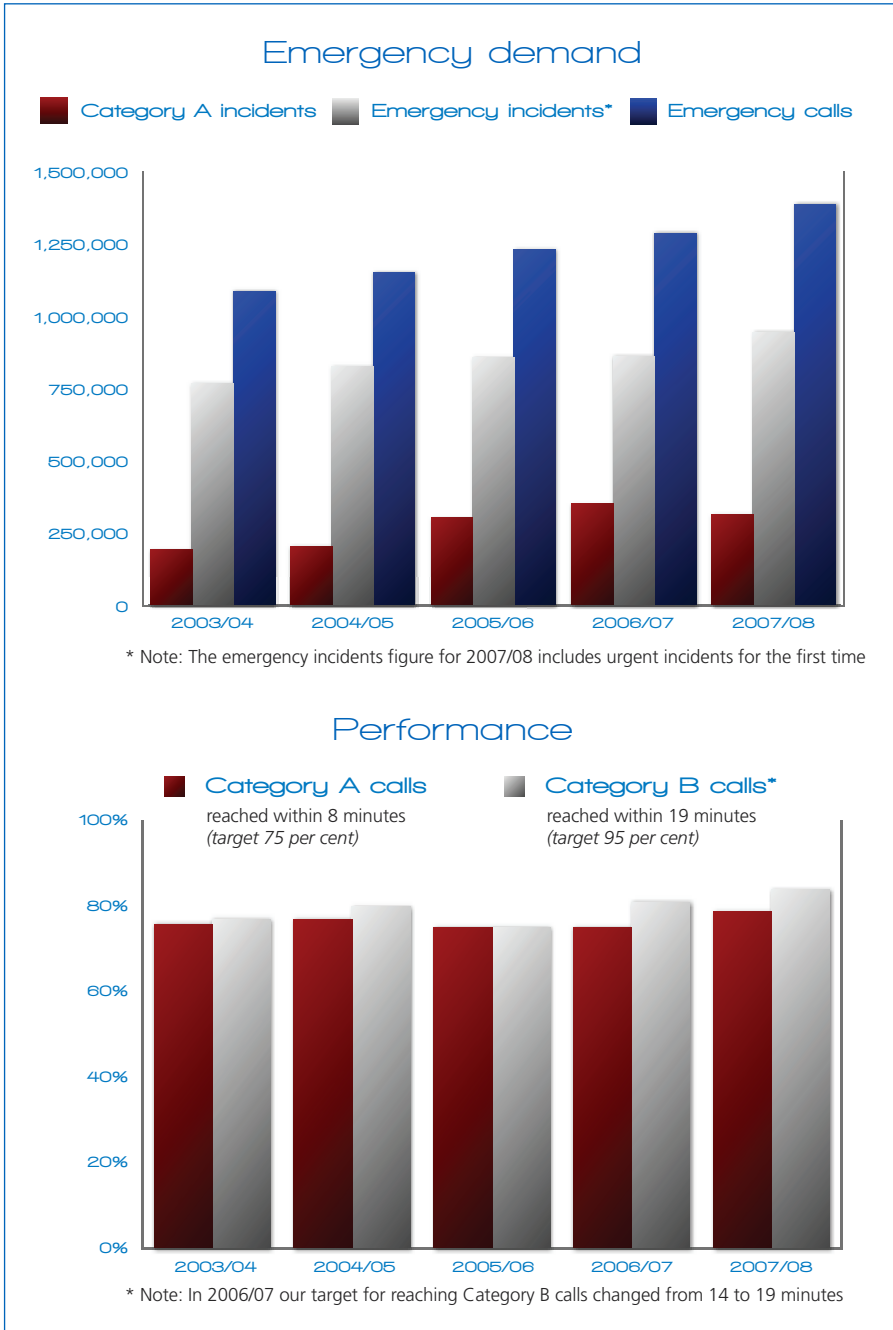
and whilst we improved our Category B performance by four percentage points, we were unable to reach the national target for this category of call.

To help meet demand during the year we introduced a new system which allows us to automatically dispatch our ambulances; so helping to reduce the number of calls waiting to be sent a response and improving our Category A performance. The system has improved the response to the most seriously ill or injured patients by 10 percentage points and the average dispatch time has been cut from two minutes to 12 seconds. The system's success was rewarded with the top prize in the Innovative Information & Communications Technology category of the regional finals of the NHS Health and Social Care Awards.

A rise in the volume of calls in November and December led to the busiest months we have ever experienced.

We also managed an exceptionally high number of emergency 999 calls on New Year's Eve – the busiest since the Millennium. Between midnight and 4am we dealt with 1,825 calls, an increase of 16 per cent on the previous year. We had anticipated high demand on what is traditionally our busiest evening of the year and had increased numbers of frontline staff working across the capital.

We have continued to use a system of monitoring and managing the pressure on our organisation. In the summer, following the failed car bombs in central London, and again during the run-up to Christmas, we escalated to the third of five pressure levels (severe pressure). In February, in the build-up to the new national standards being introduced for reaching patients, this rating once again reached level three. On each occasion the plan involves bringing in a range of measures to help us cope with the extra pressure. During the remainder of the year, pressure was constant at level two (concern).



## Improving our Patient Transport Service performance

Our Patient Transport Service (PTS) had a successful year, with an annual survey showing patient satisfaction has risen to 94 per cent, up from 90 per cent in the previous year.

The PTS operates in an open market in which we compete against other providers, often private companies, to provide pre-arranged transportation for patients to and from their outpatient appointments.

Seven contracts were won or retained during the year. The new contracts are for Lambeth Primary Care Trust, South London and Maudsley NHS Trust, Queen Elizabeth Hospital and Barts and the Royal London renal contract. Contracts were retained at Whipps Cross Hospital, Richmond and Twickenham Primary Care Trust, and Sutton and Merton Primary Care Trust.

However, we lost contracts with Kingston NHS Trust, UCLH Foundation Trust, and primary care trusts in Camden and Barking and Dagenham.

During the year we completed a total of 333,241 patient journeys and our performance at delivering patients to hospital on time improved to 89 per cent, up two per cent on the previous year. Our performance for departing hospital on time remained at 89 per cent and complaints remained low at less than one per 10,000 journeys.

Developments through the year included the implementation of a new system for planning journeys. In the coming year, it is hoped this will be extended to allow journeys to be sent electronically to staff on the road and a real-time update of

data throughout the day to bring greater control in managing the operational day as it unfolds. Two new operations centres are also planned.

Alongside the annual patient survey, a listening event was held for PTS users across London. Three working groups are being established to take work forward to make improvements to PTS provision, standards and regulation in the capital.



*Our Patient Transport Service has seen increased patient satisfaction levels*

## Maintaining good governance

The Trust Board is responsible for good governance, which involves reviewing all our clinical, corporate and information systems and processes and our management of risk. We work to comply with the core standards of the annual health check carried out by the Healthcare Commission.

We enhanced our preparation for the 2007/08 check, the results of which are reported earlier in this section, with an event for stakeholders who provide commentary for our final declaration to see the evidence of our compliance with the 24 core standards.

## Improving our fleet

During the last year, a large number of fast response vehicles were purchased. Eighty-three new cars have been bought, of which 17 are to replace older vehicles.

Once all of these new cars are put into service, we will have a total of 206 fast

response vehicles. Out of these, 13 will be used by our emergency care practitioners.

A major ambulance replacement programme was fully scoped during 2007/08 and 123 new ambulances will be purchased during 2008/09.

All new vehicles we purchase now have diesel engines to lower our carbon emissions and improve our fuel economy. This policy was initiated more than four years ago and we now have 275 of the newer type of vehicles.

The new policy reflects tighter standards for emissions on London's roads. The low emission zone, introduced in 2008, charges the worst polluting vehicles to use the roads. Under a phased introduction of the zone, our vehicles were unaffected in the first stage of the plans in February. However, later stages are affecting some of our larger and older vehicles and we are looking for viable solutions which will adapt the vehicles to meet the emission standards. The alternative is to pay a daily charge of £200.

Over the next four years there will be further planned phases of the zone with even tighter emission standards.



Behind the scenes, staff in our workshops prepare vehicles to go out on the road



## Performance

### Managing large-scale events

One of the most challenging weekends in recent years occurred last summer with large crowds gathering to watch the Tour de France cycle race starting in London for the first time.

More than half a million cycling fans flocked to watch the event's time trials, while similar numbers lined the route out of the capital as the first stage of the race began the next morning.

Nearly 300 people received medical treatment and 34 needed to go to hospital.

The same weekend brought added pressure from extra visitors attending the Live Earth concert at Wembley and the tennis finals at Wimbledon.

Other large-scale events managed during the year included the London Marathon, the Olympic torch relay, New Year's Eve and the Notting Hill Carnival.

### Preparing for the Olympic and Paralympic Games

The Tour de France and the Beijing torch relay have already provided us with a taster of what to expect from the Olympic and Paralympic Games in 2012.



*This year we faced the challenge of the Tour de France starting from central London*

The Games will be the biggest planned event we have ever dealt with. Emergency medical aid will need to be on hand for the estimated 180,000 people who could be on the Olympic site at any one time. Approximately 2,000 construction workers are already on site, and this will peak at about 18,000 in a couple of years. Our challenge will be to ensure we maintain normal service to the rest of London.

Forward planning by the Trust's 2012 Games planning office is gathering pace and the team has expanded to six

members of staff including one staff member seconded to the Olympic Security Directorate, and one to the London Organising Committee of the Olympics Games and Olympic Delivery Authority.

The team's role is to coordinate the work ongoing in other parts of the Trust in relation to the Games. For example, our health and safety department has been involved in work regarding access to the site for vehicles and the emergency planning unit has fed into stadia design issues.

We are also coordinating the national ambulance service response to London 2012 with forums being held to discuss how planning is progressing.

In addition, decisions are being made about how the knowledge gained from the years of planning and during the Games will be recorded and transferred to future Olympic cities.



*An artist's impression of the Olympic stadium*

## Preparing for the unexpected

Potential disaster was averted last summer when two of our staff raised the alarm about a car bomb found in central London.

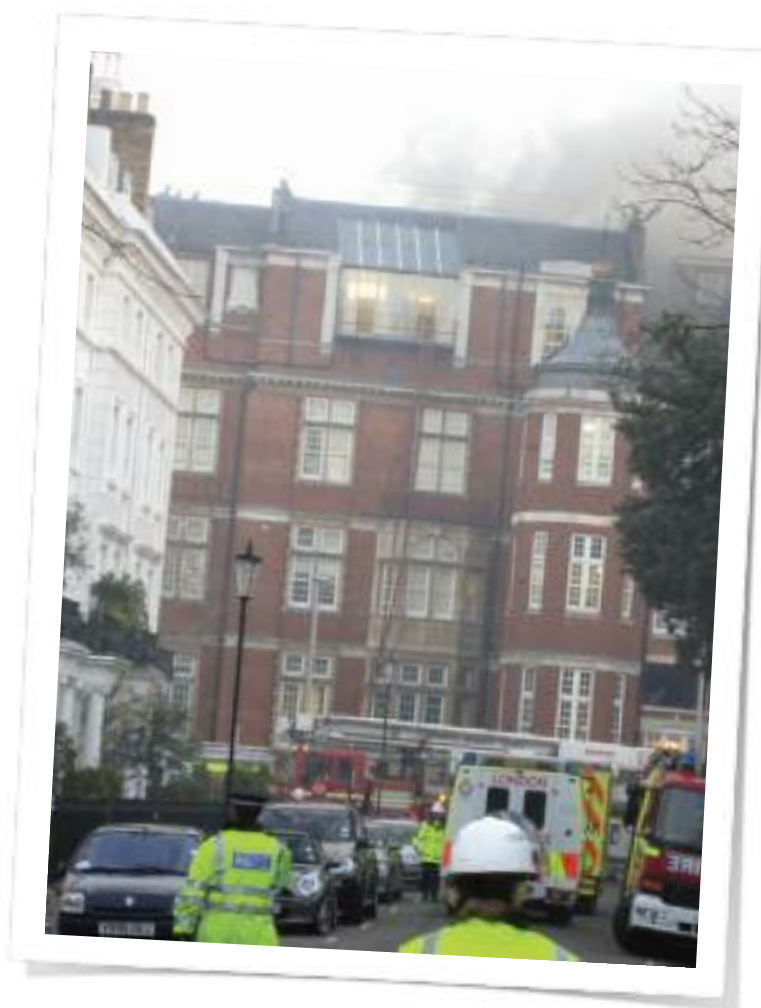
Staff spotted a vehicle containing large quantities of petrol, gas cylinders, and nails, outside Tiger Tiger nightclub on Haymarket. The crew's actions were praised by, among others, Home Secretary Jacqui Smith and then London Mayor Ken Livingstone.

However, the incident highlighted once again how important it is that we are as prepared as we can be for the threat of terrorism, and indeed any major incident.

Since 7 July we have worked hard to take on board recommendations from the London Assembly's Review Committee, which praised the 'open and constructive way' in which the Trust has undertaken work to improve communications systems following criticism in the immediate aftermath of the London bombings.

This year has seen many incidents which have tested our robust plans for dealing and responding to the calls we receive. An example of this was a large fire at the Royal Marsden Hospital in January, which saw around 80 patients transferred to other hospitals in London. We sent more than 60 staff and 16 ambulances to the scene and worked to support the hospital with the evacuation of patients. Our staff were later praised by Prime Minister Gordon Brown, Prince William, and the Chairman of the Royal Marsden, Tessa Green.

Part of our preparation for such unexpected incidents includes practising our response to mock scenarios. Our emergency planning unit organised an event in Teddington to demonstrate changes to both our internal major incident plan and the London Emergency Services Liaison Panel Manual.



*Staff at the scene of the Royal Marsden fire*

We have also joined organisations from across the capital to test the multi-agency approach to major flooding in the Greater London area. The response to a serious incident on the Croydon tram system was also put to the test in a special exercise which saw two busy trams crash during rush-hour with actors playing casualties of the collision.

During the year we tested our back-up arrangements for handling 999 calls. The planned test involved switching over the call-handling and dispatch functions of our emergency operations centre at Waterloo to our back-up centre at Bow for around two-and-a-half hours. The test was designed to ensure that we have a resilient response to anything that may affect our main control room operating normally.



Over the years we have dealt with lots of unexpected events, such as the 1952 train crash at Harrow and Wealdstone

# The Trust Board

## The Board

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

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

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

Our Clinical Governance Committee is chaired by Beryl Magrath, with membership also including Sarah Waller and Ingrid Prescod. Our Charitable Funds Committee is chaired by Caroline Silver.

## Non-executive directors

**Chairman Sigurd Reinton CBE** is a former director of international management consultancy McKinsey & Co and became Trust Chairman in October 1999 after having held the same post with Mayday Healthcare NHS Trust for two years. He is a director of NATS Holdings, the provider of air traffic control services in UK and North Atlantic airspace and for the main UK airports. He was made an honorary CBE in the 2008 New Year Honours list.

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

**Dr Beryl Magrath MBE** took up her post as non-executive director in 2005. She is a former consultant anaesthetist and worked latterly at Bromley Hospitals NHS Trust in Kent. She was a founder of South Bromley HospisCare in 1984 and was Medical Director of Bromley Hospitals NHS Trust between 1992 and 2000. She is now a Trustee of Harris HospisCare and serves as a school governor for a Bromley primary school.

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

**Caroline Silver** took up her post as a non-executive director of the Trust in March 2006. A chartered accountant, she has recently been appointed Vice Chairman, EMEA Investment Banking at US investment bank Merrill Lynch, following 13 years at Morgan Stanley. She specialises in advising on international mergers, acquisitions and financings, particularly in the financial services and healthcare sectors. Prior to her time at Morgan Stanley, she worked at Price Waterhouse (now PwC) and at Morgan Grenfell (now Deutsche Bank).

**Roy Griffins CB** took up his post as a non-executive director of the Trust in March 2006. He is Chairman of London City Airport and of the Channel Tunnel Intergovernmental Commission. He had a 30-year career in the British civil and diplomatic service, and was the UK's Director of Civil Aviation between 1999 and 2004, and Director-General of the Airports Council International Europe 2004-06.

**Dr Ingrid Prescod** took up her post as a non-executive director of the Trust in April 2006. She has acted as a consultant to organisations on a variety of organisational development issues and is the Global Head of Learning & Development for DHL Logistics. Previously, she was an Associate Director in the Centre for Management Development at London Business School. Prior to that she was Director of Management and Professional Development for the Oracle Corporation's Europe, Middle East and Africa region following a period of 15 years in senior management development roles in a number of sectors.

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

The remaining meetings of 2008 will be held on 30 September and 25 November. The meetings of 2009 are scheduled to take place on 27 January, 31 March, 19 May, 28 July, 29 September and 24 November.

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



## Executive directors

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

**Director of Operations Martin Flaherty OBE** joined the Trust in 1979. He holds a BSc in Biochemistry/Biology from the University of London. His career has included time spent as a paramedic, followed by 20 years as a manager in a variety of positions. He became an executive director in April 2005 and was responsible for co-ordinating the emergency medical response to the 7 July bombings that year. He was awarded an OBE in the 2006 New Year Honours.

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

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

**Medical Director Fiona Moore** was appointed in December 1997 and was made an executive director in September 2000. Dr Moore has more than 20 years' experience as a consultant in emergency medicine, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She is a BASICS Doctor and holds the Fellowship in Immediate Medical Care by the Faculty of Pre-Hospital Care of the Royal College of Surgeons Edinburgh. She also chairs our Clinical Steering Group and Clinical Audit and Research Group.

## Directors

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

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

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

## Remuneration report

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

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

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

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

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

For the purposes of this report, the disclosure of remuneration to senior managers is limited to executive and non-executive directors of the Trust. Details of remuneration, including salaries and pension entitlements, are published on page 34.

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

# 2007/08 financial summary statements

## Financial review

The Trust fulfilled all four of its statutory financial duties in 2007/08:

Income and Expenditure £000s								
	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Surplus/deficit(-) in year	101	46	94	89	332	1,258	113	<b>398</b>
Cumulative surplus/deficit(-)	-486	-440	-346	-257	75	1,333	1,446	<b>1844</b>
Cumulative deficit permitted (0.5%)	-618	-678	-804	-843	-963	-1,080	-1,080	<b>-1180</b>

The surplus in 2007/08 meant that the cumulative position improved for the eighth year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

1. On income and expenditure the Trust reported a surplus of £397,804 for the year, and therefore did better than the break even target set for it by the Department of Health for 2007/08.
2. The Trust achieved its external financing limit (EFL) for the year.
3. A return on assets (the capital cost absorption duty) of 3.7 per cent was achieved. This was within the permitted range of 3.0 per cent to 4.0 per cent.
4. In the capital programme £10.8m was spent on a range of projects, including rapid response vehicles, new technology projects, and projects to improve the estate. Overall the Trust underspent by £2,104,000 against its capital resource limit, which it is permitted to do.

The financial year 2007/08 was one of growth overall, as the Trust used extra funding from primary care trusts to implement the new performance standards.

The Trust was able to pay 85 and 84 per cent of its non-NHS and NHS trade invoices respectively within 30 days, which was below the 95 per cent target set for it by the Department of Health.

The Audit Commission was the Trust's external auditors for the year-ending 31 March 2008. The Trust paid the Audit Commission £152,000 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 2007/08 accounts. The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

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

### Opinion on the financial statements

I have audited the financial statements of London Ambulance Service for the year ended 31 March 2008 under the Audit Commission Act 1998. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

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

### Respective responsibilities of directors and auditor

The directors' responsibilities for preparing the financial statements in accordance with directions made by the Secretary of State are set out in the Statement of Directors' Responsibilities.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance included within the Operational and Financial Review and the elements included in the Annual Report, is consistent with the financial statements.

I review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements, set out in 'The Statement on Internal Control 2003/04' issued on 15 September 2003 and the further guidance relating to that Statement issued on 7 April 2006, 2 April 2007, 7 April 2008 and 20 May 2008. I report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' Statement on Internal Control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information, comprising the Foreword, the unaudited part of the Remuneration Report, the Chairman's Statement and the remaining elements of the Operating and Financial Review included in the Annual Report, is consistent with the financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

### Basis of audit opinion

I conducted my audit in accordance with the Audit Commission Act 1998, the Code of Audit Practice issued by the Audit Commission and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

### Opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2008 and of its income and expenditure for the year then ended;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England; and
- information which comprises the commentary on the financial performance included within the Operational and Financial Review, included within the Annual Report, is consistent with the financial statements.

Susan M Exton  
District Auditor  
Audit Commission  
First Floor, Millbank Tower  
30 Millbank, London, SW1P 4HQ

20 June 2008



## Accounts

### Conclusion on arrangements for securing economy, efficiency and effectiveness in the use of resources

#### Directors' responsibilities

The directors are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance and regularly to review the adequacy and effectiveness of these arrangements.

#### Auditor's responsibilities

I am required by the Audit Commission Act 1998 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion in relation to proper arrangements, having regard to the criteria for NHS bodies specified by the Audit Commission. I report if significant matters have come to my attention which prevent me from concluding that the Trust has made such proper arrangements. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

#### Conclusion

I have undertaken my audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, I am satisfied that, in all significant respects, London Ambulance Service made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2008.

#### Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Susan M Exton  
District Auditor  
Audit Commission  
First Floor, Millbank Tower  
30 Millbank, London, SW1P 4HQ

20 June 2008

### Related party transactions

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

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

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

Richmond & Twickenham PCT;  
The NHS Litigation Authority;  
The NHS Supply Chain;  
The NHS Pensions Agency;  
Other primary care trusts

The Trust received an administration fee of £2,500 (2006/07: £2,500) from the London Ambulance Service Charitable Funds.

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

### Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

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

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



Chief Executive Officer

18 June 2008

### Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Services Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing those accounts, the directors are required to:

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

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

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

By order of the Board



Chief Executive Officer

20 June 2008



Finance Director

20 June 2008

## Statement on internal control 2007/08

### London Ambulance Service NHS Trust

#### 1. Scope of responsibility

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

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

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

A summary of the Risk Management Policy can be found on our website.

As part of our strategic planning process, a wide range of stakeholders have been involved in determining our strategic objectives and associated risks.

#### 2. The purpose of the system of internal control

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

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

The system of internal control has been in place in the London Ambulance Service NHS Trust for the year ended 31 March 2008 and up to the date of the approval of the annual report and accounts.

#### 3. Capacity to handle risk

The management of risk within the Trust is delegated by the Trust Board through the Chief Executive, who attends the Audit Committee and is chair of the Risk Compliance and Assurance Group. Risk is divided into corporate, financial, clinical and health and safety; with the Director of Finance having overall responsibility for financial risk and any other corporate risks not covered by other directors. The Director of Finance attends the Audit Committee and chairs the Standards for Better Health Group, which oversees the part of the Annual Health Check that includes the healthcare standards. The Medical Director is responsible for

clinical risk which is reported to and monitored by the Risk Compliance and Assurance Group through the mechanism of the Clinical Governance Committee. The Medical Director is a member of the Risk Compliance and Assurance Group and Clinical Governance Committee. She is the Director of Infection Prevention and Control and monitors the Trust's compliance with Code of Hygiene. Individual executive directors are responsible for, and manage, the corporate risks within their particular areas of responsibility.

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

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

#### 4. The risk and control framework

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

The Risk Management Policy also describes responsibilities for embedding risk management in the organisation. On a local level staff report clinical and non-clinical incidents as indicated in the Incident Reporting procedure. All incidents are assessed using the Trust Risk Scoring Matrix and according to grade and score investigated so that actions can be implemented to prevent a re-occurrence. The Infection Control Steering Group has undertaken an Infection Control Audit Programme by completing a baseline audit of all stations. Information provided from this audit has been returned to managers on every ambulance station. The baseline data has been reviewed by the Infection Control Steering group and was part of the Annual Infection Control Report to the Board. This report also provided assurance regarding the application of the Make Ready Scheme.

The Serious Untoward Incident (SUI) management system of the Trust is set out in detail in the Trust's Serious Untoward Incident policy. This policy has been applied for the period covered by this statement and has embedded within it the core requirements for SUI management as required and monitored by NHS London, the Strategic Health Authority (SHA) for all NHS Trusts in London. The Trust reports all SUIs to NHS London. This enables the SHA Public Health Directorate to monitor the outcomes and action plans derived from our SUI root cause analysis. The purpose of the reporting system is to enable the Trust and wider NHS to actively learn from incidents and ensure that, where required, changes are identified and embedded in practice. Our policy states the details of how we manage our SUIs, and the following summary paragraph sets out key steps in the SUI management system.

When a potential SUI is reported, the Assistant Chief Ambulance Officer (ACAO), Director of Operations and Medical Director review the information and conduct a risk assessment of the incident (using the Trust's Risk Reporting and Assessment Procedure). A decision is then made on whether to recommend to the Chief Executive Officer whether the incident should be classified and dealt with as an SUI or not. If the incident is declared an SUI then the CEO/Director of Operations delegates the authority to the ACAO to ensure the SUI investigation is conducted in full compliance with our SUI policy and the appointment of a case manager is undertaken (at assistant director of operations level). The incident is then managed as described in appendix two of the Trust's SUI policy. SUIs are also reported to other statutory bodies as described in appendix three of the policy.

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

The development of the Assurance Framework is an ongoing process and it will be amended with Board level objectives as they are reviewed and developed in strategic plans. As the Framework covers all of our organisation's main activities, it is a key tool in examining the system of internal control that is in place to manage our risks. The 25 highest scoring risks populate the Assurance Framework and are cross referenced to the domains and core standards of the Annual Health Check. The Standards for Better Health Group updated the controls as they analysed the evidence of compliance with the requirements of the Annual Health Check 2007/08.

The Assurance Framework provides the Board with assurance of compliance with the core standards of the Annual Health Check. On the basis of this evidence the Board uses the Assurance Framework to determine what level of compliance should be declared for the Annual Health Check. The Assurance Framework was also presented to the Overview and Scrutiny Committees of the boroughs of London when the Trust held the 24/7 24/7 compliance event on 13 March 2008 for stakeholders required to provide commentary on the Trust's Final Declaration for 2007/08. It helps contribute evidence in support of the Statement of Internal Control.

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

### Human resources and organisation development

- Criminal Records Bureau checks are in place to ensure that we remain compliant with the national guidance to check staff who have direct patient contact. In addition, and over and above our obligations, this year a further process of undertaking retrospective checks for all relevant staff who joined the Trust prior to the routine requirement becoming mandatory has been implemented. Our compliance with requirements for dealing with children and vulnerable adults, has been monitored by the Medical Director using existing staff to strengthen controls and benchmarking compliance with the London-wide Safeguarding Children professional network.
- The Trust has had a Race Equality Scheme in place that complies with the current legislation. Controls to achieve equality have been strengthened by the introduction of the Disability Equality Scheme and the completion of the project to deliver a robust Gender Equality Scheme. The Trust has established its Equality Impact Assessment methodology and used it with members of the public at an event held on 26 March where the application of our Equality Assessment tool was applied to the five workstreams of our Service Improvement Programme.

### Operational support

- Purchase of an electronic fleet management system has been completed in accordance with NHS procurement guidelines. It will put in place more rigorous reporting processes that will present an accurate real-time picture of vehicle resourcing.

### Clinical

- Documentation of clinical care has been identified as a clinical risk for the Trust. In addition to a robust programme of clinical audit, we have in place a structured Clinical Performance Indicator (CPI) process by which team leaders monitor the standards of clinical care delivered to patients and Patient Report Form (PRF) documentation. Information from the CPIs is used to provide individual feedback to operational staff highlighting areas of concern and good clinical practice. Monthly reports providing compliance to care standards, levels of PRF completion and rates of staff feedback are provided to complex management teams across the Service to enable them to benchmark and monitor performance, and take remedial action where necessary. The findings from these reports are routinely discussed at the Area Business Meeting and in other forums such as the Clinical Governance Committee

### Control services

- The system for responding to calls received by the Trust's Control Services has been enhanced. All doctors' calls are now triaged using the nationally agreed 'Card 35' manual assessment card. The calls are triaged as either a Red call (i.e. requiring a response to be on scene within eight minutes) or as a Green call with an agreed time for our resource to be at the patient of between one and four hours depending upon the patient's condition and the agreement of the attending clinician. This has replaced the previous system whereby the response was calculated as the time of the patient's arrival at the admitting facility as opposed to the patient's location.

### Information management and technology

- Controls have been enhanced to comply with the recent Department of Health Information Assurance initiative to secure person identifiable data. These have included the mapping of information flows, the encryption of all laptops and portable data devices, placing restrictions on the transfer of data and compliance with additional standards based on the Information Governance Toolkit. The Information Governance Group, jointly chaired by the Medical Director and Director of Information Management and Technology, monitors progress and development of key policy documents including the Information Security Policy. The Trust has developed the IT Infrastructure Library (ITIL) to ensure that best practice for IT service management is embedded within the Trust. A training programme is underway to support this development.

### Business continuity

- The Business Continuity Steering Group monitors the Trust's Business Continuity Policy and the Business Continuity Plan. It is chaired by the Director of Finance and has established a programme for testing business continuity plans at departmental level within every Trust directorate. The Trust has been given robust assurance from the audit of compliance with the requirements of the Civil Contingencies Act 2004 commissioned by the Department of Health. The Trust obtained the highest score of all UK ambulance services against the audit



criteria. Business Critical systems are routinely tested and documentation of them held under review. Further links are also being developed to ensure the Trust's business continuity requirements are an integral part of the Trust's major incident and other emergency plans. The Emergency Preparedness Strategy Group chaired by the Deputy Director of Operations strengthens these links and controls by testing them with multi agency exercises involving our partners in other emergency services (eg London Fire Brigade, Metropolitan Police Service).

#### A&E operations

- National Category B targets have been highlighted by internal performance monitoring mechanisms as being at high risk for non-achievement. The senior A&E management team worked with commissioners who agreed to commission the Trust to achieve a 90 per cent Category B target accepting that making significant progress towards Call Connect was more significant in the year than achieving the Category B targets in full. The Trust achieved 84.4 per cent for the year as a whole which is the best performance ever against the Category B target.

Finally, with respect to the risk and control framework, the Complaints and Patient Advice and Liaison Service (PALS) teams have been integrated in accordance with the government's 'Making Experiences Count' programme. Outcome reporting from complaints has been strengthened as evidenced in our Final Declaration for the Annual Health Check 2007/08 in the commentary provided by the Patients' Forum.

#### 5. Review of effectiveness

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

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

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

The Clinical Governance Committee has responsibility for ensuring the provision of high quality clinical care in the Trust. This is achieved through monitoring and making appropriate recommendations on performance in areas of clinical governance reviewed by the Healthcare Commission. The Risk Compliance and Assurance Group has delegated

responsibility for taking a general overview of all risk management activities within the Trust and to pick up any specific risk management issues which are not covered by the specific Audit and Clinical Governance Committees. This committee also receives a report on the management of all identified high priority risks that have been identified by Trust systems and processes. A full Trust-wide risk assessment was undertaken this year.

The structure is supported by the executive managers of the Trust including the Director of Finance who has overall responsibility for financial risk, and for any corporate risks not covered by other directors. The Medical Director has overall responsibility for clinical governance, and is a member of the Clinical Governance Committee and Information Governance Group. The Director of IM&T is responsible for all risks arising out of the provision, use, operation and maintenance of the Trust's technology and communication systems and he also jointly chairs the Information Governance Panel. The Director of Communications is chair of the Patient and Public Involvement (PPI) Committee.

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

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



Chief Executive Officer  
(on behalf of the Board)

20 June 2008

## Accounts

### Income and expenditure account for the year ended 31 March 2008

	2007/08 £000	2006/07 £000
Income from activities	<b>234,117</b>	214,075
Other operating income	<b>2,013</b>	1,801
Operating expenses	<b>(232,451)</b>	(212,003)
<b>OPERATING SURPLUS</b>	<b>3,679</b>	3,873
Cost of fundamental reorganisation/restructuring	<b>0</b>	0
Profit/(Loss) on disposal of fixed assets	<b>(41)</b>	(19)
<b>SURPLUS BEFORE INTEREST</b>	<b>3,638</b>	3,854
Interest receivable	<b>989</b>	526
Interest payable	<b>(3)</b>	(1)
Other finance costs - unwinding of discount	<b>(147)</b>	(132)
<b>SURPLUS FOR THE FINANCIAL YEAR</b>	<b>4,477</b>	4,247
Public Dividend Capital dividends payable	<b>(4,079)</b>	(4,134)
<b>RETAINED SURPLUS FOR THE YEAR</b>	<b>398</b>	113

All income and expenditure is derived from continuing operations.

### Balance sheet as at 31 March 2008

	2008 £000	2007 £000
<b>FIXED ASSETS</b>		
Intangible assets	<b>3,765</b>	1,593
Tangible assets	<b>119,652</b>	113,013
	<b>123,417</b>	114,606
<b>CURRENT ASSETS</b>		
Stocks and work in progress	<b>1,930</b>	1,965
Debtors: Amounts falling due:		
after one year	<b>9,879</b>	6,121
within one year	<b>11,538</b>	9,766
Cash at bank and in hand	<b>10,478</b>	719
	<b>33,825</b>	18,571
<b>CREDITORS: Amounts falling due within one year</b>	<b>(18,471)</b>	(6,998)
<b>NET CURRENT ASSETS/(LIABILITIES)</b>	<b>15,354</b>	11,573
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>	<b>138,771</b>	126,179
<b>CREDITORS:</b>		
Amounts falling due after more than one year	<b>0</b>	0
<b>PROVISIONS FOR LIABILITIES AND CHARGES</b>	<b>(18,589)</b>	(15,464)
<b>TOTAL ASSETS EMPLOYED</b>	<b>120,182</b>	110,715
<b>FINANCED BY:</b>		
<b>CAPITAL AND RESERVES</b>		
Public dividend capital	<b>56,488</b>	55,526
Revaluation reserve	<b>50,605</b>	46,416
Donated Asset Reserve	<b>68</b>	294
Other reserves	<b>(419)</b>	(419)
Income and expenditure reserve	<b>13,440</b>	8,898
<b>TOTAL CAPITAL AND RESERVES</b>	<b>120,182</b>	110,715



Chief Executive Officer

20 June 2008

## Cash flow statement for the year ended 31 March 2008

	2007/08 £000	2006/07 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	<b>18,970</b>	5,380
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	<b>913</b>	526
Interest paid	<b>(3)</b>	(1)
Interest element of finance leases	<b>0</b>	0
Net cash inflow/ (outflow) from returns on investments and servicing of finance	<b>910</b>	525
CAPITAL EXPENDITURE		
Payments to acquire tangible fixed assets	<b>(6,703)</b>	(6,313)
Receipts from sale of tangible fixed assets	<b>6</b>	9
Payments to acquire intangible fixed assets	<b>(1,745)</b>	(1,295)
Net cash (outflow) from capital expenditure	<b>(8,442)</b>	(7,599)
DIVIDENDS PAID		
	<b>(4,079)</b>	(4,134)
Net cash inflow/(outflow) before financing	<b>7,359</b>	(5,828)
FINANCING		
Public dividend capital received	<b>2,329</b>	5,909
Public dividend capital repaid (not previously accrued)	<b>(1,367)</b>	0
Public dividend capital repaid (accrued in prior period)	<b>0</b>	0
Capital element of finance leases	<b>0</b>	0
Net cash outflow from financing	<b>962</b>	5,909
Increase/(Decrease) in cash	<b>8,321</b>	81

## Statement of total recognised gains and losses for the year ended 31 March 2008

	2007/08 £000	2006/07 £000
Surplus for the financial year before dividend payments	<b>4,477</b>	4,247
Unrealised surplus on fixed asset revaluations/indexation	<b>8,341</b>	6,386
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed asset	<b>0</b>	0
Additions/(reductions) in "other reserves"	<b>0</b>	0
Total recognised gains and losses for the financial year	<b>12,818</b>	10,633
Prior Period Adjustment	<b>0</b>	0
Total gains and losses recognised in the financial year	<b>12,818</b>	10,633



Salary and pension entitlements of senior managers

A) Remuneration

Name and Title	2007-08			2006-07		
	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		£20,001-£25,000	£0	
*** Barry MacDonald, Non-Executive Director	£0-£5,000	£0		£5,001-£10,000	£0	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Sarah Waller, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Roy Griffins, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Ingrid Prescod, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	£0	
*** Brian Hockett, Non-Executive Director	£0-£5,000	£0		£0	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
* Peter Bradley, Chief Executive	£120,001-£125,000	£0	£4,300	£130,001-£135,000	£0	£4,300
Michael Dinan, Director of Finance	£110,001-£115,000	£0		£100,001-£105,000	£0	
Martin Flaherty, Director of Operations	£105,001-£110,000	£0	£2,600	£95,001-£100,000	£0	£2,100
Caron Hitchen, Director of Human Resources	£95,001-£100,000	£0		£90,001-£95,000	£0	
** Fionna Moore, Medical Director	£75,001-£80,000	£0		£75,001-£80,000	£0	

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

\* Excludes remuneration recharged to the Department of Health for role as National Ambulance Advisor. 2006-07 salary has been restated to reflect this.

\*\* Fiona Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.

\*\*\* Directors who were in post for part of the financial year. Brian Hockett was appointed Non-Executive Director on 1 February 2008. Barry MacDonald resigned from the post of Non-Executive Director on 30 November 2007.

Salary and pension entitlements of senior managers

B) Pension benefits

Name and title	Real increase in pension at age 60 in pension 2007 (bands of £2,500)	Lump sum at aged 60 related to real increase at 31 March 2007 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2007 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2007 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2007	Cash Equivalent Transfer Value at 31 March 2006	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder To nearest £100
Sigurd Reinton, Chairman	**	**	**	**	**	**	**	
Barry MacDonald, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Associate Non-Executive Director	**	**	**	**	**	**	**	
Ingrid Prescod, Associate Non-Executive Director	**	**	**	**	**	**	**	
Caroline Silver, Associate Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£2,501-£5,000	£5,001-£10,000	£25,001-£30,000	£156,499	£139,810	£9,236	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£0-£5,000	£10,001-£15,000	£59,347	£38,820	£13,690	
Martin Flaherty, Director of Operations	£0-£2,500	£2,501-£5,000	£30,001-£35,000	£100,001-£105,000	£538,562	£493,909	£22,613	
Caron Hitchen, Director of Human Resources	£0-£2,500	£2,501-£5,000	£20,001-£25,000	£60,001-£65,000	£289,009	£259,502	£16,113	
Fionna Moore, Medical Director	£0	£0	£35,001-£40,000	£115,001-£120,000	£686,485	£662,740	£5,023	

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

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

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

## Management costs

	2007/08 £000	2006/07 £000
Management costs	16,509	13,803
Income	236,049	215,866

## Better payment practice code – measure of compliance

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

	2007/08 Number	2007/08 £000	2006/07 £000
Total bills paid in the year	48,791	56,409	50,891
Total bills paid within target	41,478	51,088	45,601
Percentage of bills paid within target	85%	91%	90%

## External financing

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

	2007/08 £000	2006/07 £000
External financing limit set by the NHS Executive	(7,359)	5,828
External financing requirement	(7,359)	5,828
Undershoot	0	0

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

## Explanation of statutory financial duties

### Break-even duty

The Trust is required to break-even on its income and expenditure account taking one year with another.

### External financing limit (EFL)

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

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

Each year, each individual NHS Trust is allocated an EFL as part of the national public expenditure planning process. The Trust has a statutory duty to maintain net external financing within its approved EFL.

### Capital resourcing limit (CRL)

The CRL is part of the Resource Accounting and Budgeting arrangements in the NHS and its purpose is to ensure that resources allocated by the government for capital spending are used for capital, rather than to support revenue budgets. All NHS bodies have a capital resource limits. The CRL is accruals based as opposed to the cash-based EFL in NHS Trusts.

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

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

### Capital cost absorption duty

The financial regime of NHS Trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. The Trust is required to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, bears to the average relevant net assets of the Trust. To meet this duty the Trust must achieve a rate between 3.0 per cent and 4.0 per cent.



now&then

**Photography:**

Royal Free Hospital: inside back cover (colour photo), **Newscast**: page 7, **PA**: page 15 (picture of Prince William), **British Heart Foundation**: page 19 (top left), **London 2012**: page 22 (bottom)

All other photographs taken by the Communications Directorate, London Ambulance Service NHS Trust and Service staff over the years.



Printed on Greencoat Velvet, a totally chlorine free (TCF) paper made from 80% waste fibre. Greencoat Velvet has been awarded two important environmental certifications, the NAPM and Eugropa.



# Annual Report 2007/08



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

Tel: 020 7921 5100  
Fax: 020 7921 5129

[www.londonambulance.nhs.uk](http://www.londonambulance.nhs.uk)

## now<sup>&</sup>then

This year we commemorate the 60th anniversary of the National Health Service. Its central principle in 1948 was that healthcare would be provided free at the point of delivery, funded through taxation. That same principle still stands today.

Our Trust is an integral part of the NHS in London and we work closely with hospitals and other healthcare professionals, as well as with the other emergency services.

To mark 60 years of the NHS we are taking a look back at our own history, to discover how the London Ambulance Service began and evolved into what it is now – the busiest emergency ambulance service in the world.

**NHS60**