



London Ambulance Service



NHS Trust

Annual Report 2005/06



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Vision

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

Values

Clinical excellence

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

Respect and courtesy

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

Integrity

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

Teamwork

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

Innovation and flexibility

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

Communication

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

Accept responsibility

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

Leadership and direction

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



Who we are

The London Ambulance Service NHS Trust is the largest emergency ambulance service in the world to provide healthcare that is free to patients at the point of delivery. It is the only London-wide NHS Trust and is at the frontline of the NHS in the capital.

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

We are led by our 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 over seven million people in an area of approximately 620 square miles, from Heathrow in the west to Upminster in the east, and Enfield in the north to Purley in the south.

In 2005/06, we handled just over 1.2 million emergency calls from across London and attended over 850,000 emergency incidents.

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





What have been the highlights of 2005/06?

It may seem strange to choose such a major tragedy, but I would have to say the magnificent way the Trust responded to the unprecedented challenge of the London bombings on 7 July 2005. Of course, there were lessons to learn (there always are) but considering the magnitude and complexity of what we had to deal with, our staff did really well. While the media understandably focused on the heroism and dedication of frontline crews, our response really was a team effort. Everyone contributed, each in their own way.

And the disappointments?

The upset and confusion that accompanied the implementation of the new national terms and conditions system 'Agenda for Change.' The protracted agony over the right pay bandings for a large proportion of our staff was unwelcome and divisive and led, without doubt, to a drop in morale that may have started to impact on response time performance around October. We thought we could get back on track (and thus maintain the Trust's unbroken record of meeting all our performance commitments since 2000) by running at Pressure Level 3 for a month or two and then get back to normal. That did not work. We had to maintain Level 3 for six months and did meet the targets. But the price paid, in terms of having to keep up pressure on performance, postponing

training etc, was high. I very much hope we can now put these problems behind us and ensure that our members of staff have the training and career opportunities necessary in a modern ambulance service.

The five year Service Improvement Programme came to an end this year – did it deliver what it set out to do?

Absolutely. The programme started in 2000 as a list of things the Chief Executive and I knew that we had to do to secure the extra funding needed to get the Trust back on track. During the consultation process that followed, it grew into the highly ambitious programme of 286 individual initiatives we are now familiar with. Now, looking back, we have successfully implemented one of the largest and most complex service improvement programmes ever attempted in the NHS. We extended it by one year to six to reflect slower availability of some of the funding and a few projects are still incomplete; but the overwhelming majority have been successfully implemented.

The Trust's new strategic plan outlines a programme of change to take it through to 2013. What do you envisage the organisation will look like then?

I expect we shall be an emergency care and ambulance trust, delivering a much wider range of responses and interventions. We might well deliver diagnostic and preventative care in people's homes. I expect us to grow further and to increase the number of people with advanced clinical skills and experience. I expect us to manage or orchestrate the integrated response by the NHS to patients and callers who seek urgent and emergency help over the telephone, using highly qualified and experienced people (including probably GPs) to deal with as many calls as can be done safely over the telephone; to dispatch experienced and appropriately qualified single responders to assess those patients who cannot safely be dealt with over the

Chairman's views

telephone for definitive treatment or referral onto the right pathway. We will focus our classic blue light ambulance responses even more sharply on the immediately life-threatening situations. We will bypass accident and emergency departments to take many more patients directly to specialist units for immediate but definitive treatment, for example heart attack centres, stroke units for immediate diagnostics, specialist burns units and trauma centres.

We shall become even more of a professional clinical services organisation. We will always remain a uniformed service, with all that means in terms of personal identification with the Trust and a sense of responsibility. However, we will operate more on the basis of professionalism and self-discipline and less on the basis of hierarchy and traditional discipline.

What impact will the recent changes to the NHS in the capital have on the London Ambulance Service and its patients?

With the establishment of the London Strategic Health Authority, replacing the previous five, we shall have a single partner which should make it easier to have a high quality dialogue about our overall strategic direction. The primary care trusts remain borough-based, which makes it easy to work at the local level to develop the best pathways for our patients.

Sigurd Reinton
Chairman

Chief Executive's views

Looking back, what kind of year has the London Ambulance Service had?

It has been a difficult year but it has also been a good year. We managed to meet our key performance and financial targets, we dealt with the casualties of the London bombings exceptionally well and we have seen excellent improvements in our cardiac arrest survival rates.

Our staff have continued to work hard. They have remained committed despite the increased demands on our services and the difficulties surrounding the implementation of Agenda for Change. Overall, I think it has been a difficult year but we should not underestimate some of the good things that we have achieved.

The Trust was under severe pressure over the winter period. Why was this, and what long-term changes are being introduced to alleviate the pressures that were faced?

We know that every winter and every summer we experience an increased demand on our services. We have responded to this by putting operational plans in place to deal with the spikes in demand but sometimes, inevitably, demand can outstrip our resources. Traditionally we have relied very heavily on overtime but this year we have been looking longer-term and have recruited more staff to bolster our resources. We aim to be at full establishment later in the year and intend to keep the number of our frontline vacancies to a minimum.

We are looking at the way that we respond to all of our patients. With the introduction of the new Urgent Operations Centre we no longer have to send an ambulance to every 999 call we receive as we can tailor our response, whether that be by offering clinical telephone advice or sending an emergency care practitioner. Our new strategic plan looks in detail at the changes we are making and the foundations for this will be laid over the next 18 months. This will also prepare us to meet the new performance measures when they are introduced in April 2008.

We are also making sure that we have the best technology available to our control room and frontline members of staff.

How do you feel the London Ambulance Service responded to the London bombings? What lessons were learnt and what changes have been made so the Trust is better prepared for any future attack?

Our staff did a fantastic job in responding to this terrible atrocity. They treated and transported hundreds of patients in a very short space of time. As we know, these were very difficult incidents to deal with - the attacks were unprecedented and with that in mind, our staff did the best job they could.

With any major incident there are lessons to be learnt but this was a multi-sited incident, the likes of which we had never dealt with before, and this presented us with many challenges. We have acknowledged that we experienced problems with communications and we have managed to be brought forward in the rollout of the new digital radio system, Airwave. In the interim, we will be receiving 200 new radio handsets for use by our operational managers. We have also made other changes including the opening of our new incident control room, capable of dealing with multi-sited incidents, and changes to our response plan.

I am confident that the changes we have made put us in a better position to respond to any future major incidents.

What are your priorities for the coming year?

Our priorities for the next year will be to continue to meet our key performance targets and to launch our new strategic plan that outlines our long-term direction and will assist us in modernising all aspects of the Trust.

The next twelve months will see us put appropriate technology systems in place that support our work; get our Urgent Operations Centre working at its full



capacity; improve the training and development opportunities available to our staff, and recruit more people.

The issues raised at our staff consultation meetings will be addressed so that people can see that we are listening to their needs and making changes.

We will also improve call categorisation to ensure that we are sending the right responses to all our patients.

How will staff and patients benefit from the changes the Trust intends to make over the next seven years, as outlined in its strategic plan?

Staff will benefit from having far more opportunities to develop their skills, more career opportunities and better job satisfaction from being able to treat people at home and over the telephone.

Our aim is to keep 200,000 patients out of hospital over five years. This will reduce unnecessary transport, and treatment in hospital, and will benefit those patients suffering from minor but complex conditions who would be better cared for at home.

Peter Bradley CBE
Chief Executive Officer

Service Improvement Programme

In 2000, we embarked on a programme of change that would transform the Trust. The Service Improvement Programme aimed to modernise working practices, improve operating systems, encourage innovation and above all, to create a world-class ambulance service that the people of London could depend on and our employees could be proud of. Now six years later, the benefits of this programme for both patients and staff are clear to see.

Over the life of the Programme, almost 250 initiatives have been implemented across three categories – patients, people and performance. Many of these ideas evolved from issues raised by our staff at annual Chief Executive consultation meetings and this valuable feedback has been key to the Programme's success.



What has the Service Improvement Programme achieved?

Patients

- Improved our out-of-hospital cardiac arrest survival rates in the capital from 4.2 per cent in 1999 to 8.6 per cent in 2004/05
- Established an urgent care service, enabling us to move away from a 'one size fits all' approach to patient care and provide a response that is appropriate to patients' individual needs
- Introduced emergency care practitioners who have enhanced skills in physical assessment and decision-making and can, where appropriate, prescribe drugs, make referrals and even treat people at home
- Improved the hygiene of our ambulances through the 'Make Ready' scheme, a new comprehensive cleaning and equipping system that now operates at all station complexes
- Appointed a Patient and Public Involvement Manager responsible for driving forward patient-engagement initiatives
- Introduced clinical supervision across the Trust with the advent of team leaders and sector trainers
- Reduced the number of complaints from 5.2 per 10,000 journeys per month in 2000 to 1.5 per 10,000 journeys per month in 2006
- Carried out three public awareness campaigns.

People

- Improved staff morale substantially from 42 per cent of staff saying they feel positive about working for the Trust in 2000 to 60 per cent in 2005. This was aided by the introduction of regular consultation meetings at stations where staff are given the opportunity to have their say
- Reduced the number of assaults on staff from 153 reported assaults per 1,000 staff in 2000 to 87 reported per 1,000 staff in 2005/06
- Reduced the amount of staff sickness from eight per cent in 2000 to 6.69 per cent in 2005/06
- Obtained Practice Plus status in the 'Improving Working Lives' programme
- Reduced the amount of heavy manual handling undertaken by our staff by introducing tail-lifts on vehicles. Appointed a Violence Prevention and Security Manager and an Ergonomic Advisor
- Brought in a new uniform to enhance the image of our frontline staff
- Introduced conflict management training for all our frontline staff
- Implemented an awards programme that recognises the achievements of our staff
- Introduced staff support initiatives including a peer support scheme.

Performance

- Consistently achieved the Government's target of reaching 75 per cent of Category A calls (calls to the most seriously ill and injured patients) within eight minutes. In 2000 the Trust only reached 40 per cent of Category A calls in eight minutes, while in 2005/06 we successfully reached 75 per cent
- Increased the number of fast response cars from 14 in 2001 to 98 in 2006
- Established the Urgent Operations Centre to handle lower-priority calls and introduced clinical telephone advisors who provide assistance to an average of 150 to 180 callers a day, giving assistance over the phone without the need to send a physical response
- Reduced the number of A&E vehicle accidents from 16.16 accidents per 10,000 activations in 2000, to 5.53 in 2005/06
- Introduced mobile data terminals to our ambulances to provide more accurate location information and to aid data collection
- Achieved 'Centre for Excellence' status for call taking in our control room in March 2003 and maintained this in 2005/06.

The Next Stage

A new era

We are now entering a new era and aim to build on the achievements of the Service Improvement Programme to develop a world-class ambulance service fit for future generations.

We have developed a long-term strategic plan, setting out how we will deliver for patients, the public and other key stakeholders between now and 2012/13, the year London will host the Olympic and Paralympic Games.

Developing the plan

We developed this plan in consultation with stakeholders including patients, staff, NHS colleagues, other emergency services, local authorities and suppliers. Their valuable input will ensure that, in the future, our service meets their needs as best we can.

The fundamental changes taking place in the NHS, particularly the emphasis on out-of-hospital care, have also been taken into consideration. The Government's ten-year NHS Plan, the NHS planning and governance framework Standards for Better Health, the Health White Paper Our Health, Our Care, Our Say and the National Ambulance Review, Taking Healthcare to the Patient, have all been reflected in the plan.



Aspirations

The plan includes five portfolios of work that provide the structure to transform the organisation from the way it is now to the way it aspires to be in 2013. They are:

1. Access and connecting the London Ambulance Service for health

Our aim is for all patients to be able to access us quickly and easily, regardless of language or disability. We are developing an access strategy that considers all our patients' needs and will adopt information technology solutions that make access to information simpler and allow patients to speak directly to 'a helpful human'.

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

2. Operational model: strategy for responding

We have already made changes to the way we respond to our patients and this will accelerate over the coming years.

A new operational model specifies the resources, skills and equipment needed to be able to deliver appropriate definitive care first time to more of our patients.

In 2013, we expect to take 200,000 fewer patients to A&E. Instead, our patients will benefit from a greater range of care options such as telephone advice, treatment at home, emergency care from a single responder or direct referral to alternative providers such as walk-in centres, minor injuries units, community psychiatric services or intermediate care teams. We will work closer with our partner agencies to ensure that patients receive a seamless service.

3. Organisation development and people

Staff development is at the heart of our organisation and the contribution of all our employees is key in helping us deliver on the strategic plan.

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

Supportive and visible management will provide leadership at all levels of the organisation, and work with our NHS partners will give staff the confidence to use the many alternative routes to care available in the future.

We will continue to promote high standards of attitude and behaviour in our staff and will endeavour to recruit people who will adhere to the Trust's vision and values.

4. Partnership and communications

London is constantly changing, with a population that is expanding and growing more diverse every day. We will be developing our patient and public involvement work, to ensure we can meet the needs of all our patients in this challenging environment

We need to give patients places to air their views so that we can listen to their requests and act upon them - this may take the form of holding open days, running workshops or conducting surveys. We have already started this process, carrying out public opinion research to better understand people's perceptions, beliefs and attitudes to the Trust. The results will provide a benchmark against which changes in perception can be measured as we deliver on our plan.

The satisfaction of our partners is of equal importance and we will design a similar programme to engage with them.

5. Governance and corporate processes

There are few easy ways of measuring our performance other than the Government-specified targets, but our consultation with patients has shown that this is not what is most important to them. Courtesy, respect, reassurance and problem-solving may not be tangible but they are factors that matter to our patients. We will of course continue to aim to deliver on our national targets and financial obligations. We will also be introducing new performance management systems that help us monitor the quality of the clinical care and emotional support we give as well as the speed of our response.



Sadly, 2005/06 will be most remembered for one day - 7 July, when London was struck by a terrorist attack which claimed the lives of 52 innocent people and left more than 700 injured.

Emergency response

More than 250 members of staff were involved with the emergency response to the bombings of three Underground trains at King's Cross, Aldgate East and Edgware Road and a bus at Tavistock Square. They treated more than 400 patients, some of whom had sustained horrific injuries, giving them the emergency care and support they needed and clearing all scenes within three hours. It was the courage and professionalism of these people that undoubtedly saved many lives, but they couldn't have done this without the help of their colleagues.

Our Gold control room managed communication with the four scenes; our logistics department worked hard to get

equipment where it was needed; the Emergency Bed Service collated essential information on hospital capacity; and our other ambulance crews maintained the everyday 999 service.

Recognition

Britain's most senior figures have praised the bravery of our staff. Prime Minister Tony Blair visited our headquarters to meet some of the members of staff involved and was also taken on a tour of the control room to see how emergency plans were initially put into action.

Her Majesty the Queen also met several members of our staff when she visited the Royal London Hospital and HRH Prince Charles and the Duchess of Cornwall were introduced to others involved in our response at St Mary's Hospital.

Paying tribute

Ceremonies held throughout the year have given us the chance to pay our respects to those who lost their lives and to remember the injured.

Deputy Director of Operations Russell Smith and Paramedic Andrea Shields were amongst those to address 25,000 people at a mass vigil held in Trafalgar Square a week after the attacks. Other staff showed their respects by laying floral tributes at each of the bomb sites.

In November, Paramedic Joanne Wigggett carried a candle at a national memorial service at St Paul's Cathedral. She was joined by 30 of her colleagues at the service of remembrance which was also attended by Her Majesty the Queen, bereaved families, survivors and emergency and transport workers.

We held our own commemorative event in July this year to show our appreciation to all our staff.

Floral tribute at Regent's Park





Lessons to be learnt

It is widely recognised that more seriously injured patients survived the bombings than usually happens in a major incident and this is a reflection of the quality of care and treatment our staff were able to provide at the various scenes.

However, no response to a major incident is perfect. There are always things which do not go as well as we would hope and there are always lessons to be learnt. This is especially true when faced with multiple simultaneous incidents specifically designed to cause confusion and to challenge all the emergency services' ability to respond.

We have conducted a thorough debrief with all the staff involved, enabling them to give confidential accounts of what they felt worked well and what didn't. We have used these to develop an action plan which we are now implementing to further improve our ability to deal with any future incidents.

In November 2005, we gave evidence to the London Assembly 7 July Review Committee and followed this up with a detailed written report to the Chair of the Committee.

Key learning points included:

• **Communications systems issues**

The sheer demand of traffic on our radio system meant that it was at times difficult for staff to speak to our control room. Our managers were over-reliant on mobile phones and when the networks became overwhelmed, this compounded the difficulties we were already experiencing.

We have now taken steps to bolster our resilience. We have introduced pagers for use by key operational and support service staff and have also

successfully lobbied to be brought forward in the rollout of 'Airwave', the new national digital radio system for emergency services. The system will start to be introduced next summer and will be fully operational in early 2008. In the meantime, we will be receiving an initial allocation of 200 digital radio handsets for our operational managers and are working with other agencies to introduce an interim Underground communications solution.

Special 'no communication' training exercises will also be held where our staff will test worst case scenarios where electronic communication is not possible.

• **Availability of medical equipment at scenes**

With four separate incidents to deal with, it was inevitable that our supplies would run out quickly. The initial supplies came from the first vehicles to the sites and additional supplies were later brought by our equipment support vehicles.

We recognise that we need to improve our ability to replenish supplies and have developed a plan that will enable us to react faster and more effectively in future. We have reviewed the number of equipment support vehicles and their strategic deployment to allow us to be able to support multiple simultaneous incidents more quickly.

• **Delay in sending a second wave of ambulances to Russell Square**

There was a delay in sending adequate resources to Russell Square, due to confusion about the scale and location of the incident as events unfolded.

To prevent this occurring again, we

have developed a pre-determined list of resources that states that a minimum of 20 ambulances must be sent to a scene once a major incident is declared. So, even if there were communications difficulties, sufficient numbers of staff will be available to carry out effective assessment and treatment of patients while better links with the control room are being established.

St Paul's Cathedral memorial service



• **Problems with information collection**

The volume of information generated by these incidents cannot be underestimated and we have learnt that we need to be more effective at collecting, collating and sifting real time details from the scenes. We have opened a new incident control room that is better configured to deal with multi-sited simultaneous incidents. Our staff will be tested at using the room at 'no notice' training exercises to ensure that they are well prepared.



Patients

Only one in ten calls that we receive is to a patient in a life-threatening condition who requires all the specialist equipment of an ambulance and the skills of a highly-trained crew.

In the majority of cases, our patients can be better served by an alternative response, whether that is a visit from one of our emergency care practitioners, advice over the phone or treatment from an urgent care service crew.

Over the last few years we have built up the range of responses that we can offer patients and have invested in developing the skills mix of our staff. In some parts of the capital, patients are already seeing the benefits of this more efficient approach and their initial feedback has been extremely positive. As our plans are rolled out London-wide we hope to provide a more tailored response to all our patients.

Urgent Care Service takes shape

Integral to the changing face of patient care is the Urgent Care Service, comprising of Clinical Telephone Advice, Urgent Care crews, Patient Transport Service Central Services and the Emergency Bed Service. This team of specialist staff are responsible for co-ordinating our response to patients in non life-threatening situations.

Last year, this service really began to develop with the appointment of an Assistant Director of Urgent Care in June 2005 and the opening of the Urgent Operations Centre in November. This integrated control room brings all the different strands of the operation under one roof, making it easier for us to manage

our resources and workload for the benefit of our patients.

Since opening, the Urgent Operations Centre has handled approximately 34 per cent of calls to patients who have been assessed as being in a non life-threatening condition. We expect to see this increase dramatically over the next year as the control room further establishes itself.

Care on call

Clinical Telephone Advice (CTA) is a crucial part of the Urgent Care Service. The clinical advisors are experienced emergency medical technicians and paramedics, who call back patients who have contacted us about minor illnesses or injuries and undertake a comprehensive assessment of their condition over the telephone.

Following their assessment, advisors use their expertise to determine the best course of treatment. They reach a decision with the patient about what help they need – this could involve treatment at home, advising that they visit their GP or pharmacist or in some cases the dispatch of an ambulance.

Since joining the Urgent Operations Centre last year, CTA has seen a huge increase in the number of calls it processes, from approximately 1,500 a month to around 5,000 a month. About half of these calls result in an ambulance being dispatched and on the occasions when this is necessary, a significant number of patients receive assistance from an Urgent Care Service crew, freeing up A&E ambulances to attend patients with serious and life-threatening conditions.

One of the reasons for the large increase in calls handled by CTA is the introduction of new clinical decision support software



We have seen a big increase in the number of patients given clinical telephone advice



Our emergency care practitioners can treat patients at home

which is both quicker and safer than our previous system. Feedback from advisors involved in an evaluation of the product has been very positive.

A further reason for the rise in call volume is that during the year we expanded the scope of CTA to cover all potentially suitable Category C calls (those where it has already been determined that there is no immediate or potential threat to life or limb), whereas in the past it had only handled a proportion of these incidents.

Over the next year we will look to further expand our use of CTA, recruiting more staff to clinical advisor positions.

Urgent Care Service crews

We are investing in a new tier of emergency medical technicians who are tasked specifically with responding to patients with minor injuries or illnesses. The Urgent Care Service crews drive blue-light

ambulances and are trained to use defibrillators, administer oxygen and pain-relieving gas therapies. They are dispatched to calls from the new Urgent Operations Centre and are essential in supporting the work of our A&E crews and emergency care practitioners.

Urgent Care Service crews are currently operating in small numbers across London. They deal with an average of 1,200 calls a month which is expected to rise significantly as additional people are appointed during 2006/07.

More emergency care practitioners

Emergency care practitioners (ECPs) are highly-skilled staff, able to carry out detailed physical assessments and treat a range of conditions, from someone who has fallen at home, to complex and chronic conditions such as asthma and diabetes. Their main responsibility is to respond to complex but less urgent 999 calls when it is suspected that a patient may not need, or even wish, to go to hospital, but where a face-to-face assessment is required.

ECPs work in partnership with their local primary care trust and liaise with other community health agencies, using services such as pharmacies, minor injuries units, walk-in centres and social services. They can prescribe drugs, make referrals and transport patients to GPs' surgeries or minor injuries units if required.

There are currently 11 ECP schemes operating across the capital, with six new schemes introduced during the year in Harrow, Hillingdon, Barnet, Brent, Ealing and Newham.

The management of the ECP scheme has also been developed with the appointment of a Programme Manager, an Assistant Medical Director and two clinical leads.

Our new Urgent Operations Centre



Developing the Emergency Bed Service

Primarily, the Emergency Bed Service (EBS) is an in-house bed-finding service for NHS healthcare professionals who are making admissions or transfer arrangements for their acutely ill patients. It became part of our Trust in 1999 and this year joined the new Urgent Operations Centre.

In 2005/06, EBS undertook a trial in South West London called 'EBS First' that aimed to make its service even easier to access. It set up a 24-hour freephone number so that GPs in the community and healthcare professionals at the three local hospitals could find beds and book ambulance transport in just one call. This new streamlined approach proved to be very effective and there are now plans to expand the scheme in collaboration with other parts of the Urgent Care Service.

EBS also has responsibility for the National Intensive Care Bed Register for adult and paediatric critical care beds in three-quarters of England, offers a service to help with antenatal transfers, and acts as the co-ordinator for the Neonatal

Transfer Service in London, Kent, Surrey and Sussex.

Overall, EBS saw a reduction in activity in 2005/06 compared with the previous year, with the exception of its paediatric service. This could be due in part to low levels of influenza and other respiratory conditions amongst adults over the early winter months.

Cardiac care gets better and better

We have made great strides in recent years in the area of cardiac care. Our latest figures, which relate to 2004/05, show that a patient's chances of surviving an out-of-hospital cardiac arrest in the capital are now at 8.6 per cent, more than double what they were in 1999.

One of the key developments during the year was our work in helping to establish a network of nine heart attack centres across the capital, eight of which are open to our crews round the clock, seven days a week.

Under the new system, if our staff diagnose an ST-elevation myocardial

infarction - a common type of heart attack - using a 12-lead Electro-cardiogram (ECG), they can make the decision to take the patient direct to a cardiac catheter laboratory for specialist treatment instead of their local A&E department.

Here, patients benefit from immediate primary angioplasty, a procedure that involves a catheter being passed through the artery and a balloon inserted and inflated to open the artery at the point of the blockage. A stent is then put in place to keep the artery open.

So far around 1,000 patients in London have benefited from this treatment, which offers a much better chance of survival and a quicker recovery than the standard treatment (which involves using clot-busting drugs either in the ambulance or in A&E).

Other cardiac work has been conducted by our Community Defibrillation Officer, who has co-ordinated the installation of 120 defibrillators in public places across the capital and has trained 1,900 people in the use of the devices and in providing Cardio-Pulmonary Resuscitation (CPR). In total,

We have continued to develop the care given to cardiac patients



there are 400 defibrillators in London, more than in any other city in the UK. They are installed in places such as Underground stations, Heathrow Airport, museums and shopping centres, and it is hoped that next year more defibrillators can be secured and fitted at some of London's busiest venues.

The work of the Community Resuscitation Training team has helped to improve public knowledge of the importance of providing basic life support. During 2005/06 the team trained a total of 8,500 people in the life-saving technique of CPR. Participants included paid-for clients in the public and private sector such as Brent Primary Care Trust and Morgan Stanley. The money generated from these courses helps to fund our free community CPR 'Heartstart' courses, which is an initiative co-ordinated by the British Heart Foundation.

We continuously audit the treatment we provide to our cardiac arrest and heart attack patients. Following such an incident, we collate all the data relating to the care of the patient and evaluate our performance. This information is used by the Service to improve performance and inform decision making. It is also fed into national audits.

Conducting clinical audits and research

Our Clinical Audit and Research Unit undertakes a range of research and clinical audit projects, often in conjunction with our NHS partners and other international health organisations, with the aim of further improving the quality of patient care.

One ongoing project, being run in collaboration with King County Emergency Medical Service (Seattle, USA) and the State University of Washington (USA), is researching different telephone CPR techniques. It is investigating whether conducting CPR using only chest compressions can be just as, or even more, effective than standard CPR using compressions and mouth-to-mouth ventilations. The three-year study, launched in 2004, is now half-way complete. The results will inform future resuscitation guidelines both nationally and internationally.



Working with five London hospitals, we have participated in a national audit project that has been established by the Royal College of Psychiatrists to improve the quality of care for those who self-harm. Hospital staff, mental health professionals and ambulance staff have all provided data about their experiences of caring for this patient group.

We audit the quality of treatment patients receive

Over the year, we have been laying the groundwork for an obstetrics audit. Assisted by four London hospitals, we will assess the care provided by our crews to 400 obstetrics patients – 200 who experienced normal labours and 200 emergency cases – sending out questionnaires to find out how satisfied they were with the care they received and the reason that they called an ambulance. The results will inform the development of our maternity services and our pre-hospital guidelines for obstetric care.

The quality of our patient report form documentation, the records we keep on every patient we attend, is audited throughout the year to ensure that our staff are complying with clinical guidelines and Trust protocols. Forms for the following cases are routinely audited: cardiac arrest, acute coronary syndrome, glycaemic emergency, obstetric emergency, difficulty in breathing and non-conveyed patients. In addition, a five per cent random sample of forms is also audited. The results inform the development of the Trust's clinical practices and are used to provide constructive feedback to staff.





Delivering CPR training at the Brent Sikh Centre

Improving our pain management for patients

The introduction of morphine in December has improved the range of pain relief that paramedics can offer to patients. The class A controlled supplies are stored securely both by paramedics, who must sign their supply in and out at the start and end of each shift, and in drugs safes on stations.

All our paramedics have received familiarisation training covering how and when the drug should be administered. We will be conducting an audit in the coming months to measure the impact that the drug has had on patient care.

In early 2006, we conducted a clinical audit of the pain management that we provide to children under the age of 12 who have suspected broken bones. The audit looked at how our paramedics and technicians assess these patients and how they manage their pain. The results indicate that there are currently limited options of pain relief available and there could be a need for the introduction of paediatric-friendly drugs. This evidence is due to be presented to the Medicines and Healthcare products Regulatory Agency later in the year.

Governance and corporate processes

Good governance is about achieving the desired results in the right way, not simply about meeting targets or national standards, important though these are.

We continually review and assess our corporate, clinical and information governance, and our management of risk, so that we may achieve outcomes which are meaningful for patients and the public.

Although the Trust Board has overall responsibility for good governance, the actual process is undertaken in day-to-day activities and we are taking steps to ensure that all of our members of staff are aware of its importance. We have introduced a presentation on governance to our induction programme for our new members of staff. Our corporate business processes are now more focused on outcomes and to increase efficiency we are streamlining systems for all our managers to improve ease of use and to reduce duplication or error.

Following an extensive governance

review undertaken by Non-Executive director Beryl Magrath, at the request of the Trust Board, progress has recently been made with the updating of our governance systems and processes. The Compliance Unit will be supporting full implementation of the recommendations as part of our new strategic plan.

Improving our links with patients

The care of our patients is our number one priority and involving them in decisions about our development is the only way that we can improve this.

This year we have reached out to patients like never before, and we have recently been commended by the Healthcare Commission and our Internal Auditors Bentley-Jennison for our Patient & Public Involvement (PPI) work.

In July 2005, we appointed our first PPI Manager, who is leading on the implementation of our PPI strategy. Work commenced with an evaluation of our current practices and the development of a database of all our PPI activity that contains more than 100 examples of our community work.

At a local level, the PPI Manager has been encouraging station management teams to undertake more PPI projects and has been offering them support and advice in achieving this. In addition, new staff joining the Trust now attend a session on PPI as part of their induction programme.

We have continued to benefit from our relationship with the Service's Patients' Forum. Members of the forum sit on a number of our committees and regularly attend our Trust Board meetings. In turn, many members of staff have presented at their meetings on issues such as our response to the London bombings, infection control and our preparations for a flu pandemic.

Our annual Patient Care Conference was held in October 2005 and was well-attended by our staff, partner agencies, voluntary organisations and members of the Patients' Forum.

We have been working with the Royal National Institute for the Deaf to address concerns expressed by some members of London's deaf community about difficulties accessing our service. Most deaf people



communicate by SMS technology, but it has not been possible to use this in an emergency because of potential delays in the message being received. We are hoping to learn from other emergency services that have developed systems to enable this type of communication.

We also hope to improve our face-to-face communication when a trial of 'medical visual language translator' cards commences later in the year to allow deaf patients to point to a series of visual images that illustrate their condition.

Looking to the future, we have developed a public education strategy that outlines the general principles for all our PPI work. It recommends a standard reporting structure, greater co-ordination between departments and the need to focus activity on key priority areas. It also highlights the need for core competencies and a recruitment process for staff who wish to work on an ad-hoc basis in public education. This work will be taken forward as part of the new strategic plan.

Listening to our patients

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

In 2005/06, PALS received a total of 4,272 enquiries, representing a 14 per cent increase on the previous year.

We received 646 expressions of appreciation and 83 enquiries relating to poor staff attitude or behaviour. Whilst this number is relatively low, we take any such issues very seriously. We encourage reflective practice so that our staff can learn from any reported negative patient experiences, thus moving away from a 'blame culture'.

There were 283 requests for medical records, which we provided with a comprehensive explanation of the contents, and 108 enquiries regarding our policies and practices.

We responded to a further 97 enquiries relating to the London bombings and have subsequently been able to assist survivors and relatives.

The PALS department also has principal responsibility for our response to enquiries under the Freedom of Information Act and

over the year received 159 enquiries.

From June 2005, PALS was granted responsibility, in conjunction with the Medical Directorate, for dealing with concerns raised by our staff about external agencies. We received 132 such referrals and our subsequent investigations have resulted in a number of improvements to patient care, from the adoption of best practice standards in pharmacy prescription delivery across a whole primary care trust area to the implementation of emergency care protocols in a nursing home.

PALS continues to monitor any emerging trends in patient concerns and to identify any individual patients who have complex needs. One such example was a patient who persistently called the Trust over a six-month period. Following liaison with social services and a community psychiatric nurse, a revised care plan was implemented to better meet the patient's needs and no further emergency calls have been received.

We are now developing the way we work with health and social care agencies. To date, we estimate that our work in this area has saved resources from being sent to 5,000 emergency calls.

Resolving complaints

Our Professional Standards Unit manages complaints received from patients, and the public, and investigates serious internal complaints against staff. It can also

investigate serious issues identified by an enquiry made to the Trust.

During the year the Unit received a total of 544 external complaints compared to 444 the previous year.

Of these, 259 were written complaints. Although, 69 per cent were resolved within 20 days, we did not meet the Department of Health's 80 per cent target.

A review of how we handle complaints has recently been completed and the recommendations from the review will be implemented over the coming year.

Working with all our communities

London prides itself in being the most diverse city in Europe, with more than 300 languages spoken and many different customs, cultures and religions practiced. Our Diversity team has been working hard to help us reach out to all of our communities.

During the year we produced a DVD that describes how we handle calls where English is not spoken. 'Cardiac Arrest', uses actors to depict lifestyle risk factors and signs and symptoms of a heart attack. The DVD was successfully launched at the Brent Sikh Centre in August, and has since been screened at a number of other events.

We have also produced 'Save a Life' cards in four South Asian languages. These describe how to carry out CPR and aim to raise awareness of the increased risk of coronary heart disease amongst people

Visiting the children at Victory Primary School in Southwark



from South Asian backgrounds. The cards have been distributed to station complexes where there are significant South Asian communities so that, when appropriate, staff can give these to their patients. Both the cards and the DVD are also being made available to other ambulance trusts.

We are in the process of developing a Trust-wide language, translation and interpretation policy that will ensure consistent access to all our corporate publications for people who speak different languages - currently only our annual report can be requested in multiple languages and formats. We will then be better equipped to conduct other health promotion campaigns focused on minority communities that are available in alternative languages and formats.

Profiles for each of the London boroughs are now available to all staff through our intranet site, providing demographic information about their local communities, including languages spoken, ethnic and religious make up, and health and economic indicators.

Working with children and young people

In 2005/06 our events and schools team came face-to-face with more than 51,000 children and young people at schools, colleges and events across the capital.

Over half of the contacts we made were with final-year primary school children visiting a Junior Citizen scheme. These events teach children about the dangers they can face in everyday life and our session explains what to do if they find someone unconscious and need to make a 999 call.

In addition to these types of visits, we give guidance to young people about careers in the ambulance service and further education routes into the Trust. In July, we attended Skill City, the largest skills and careers event aimed at young people in the UK. Visitors were attracted to our interactive display which gave them the opportunity to assist a local ambulance crew with a mock emergency and ask questions about what it is like to work for the Trust.

We have continued our work with the pupil mentoring scheme and have 23 members of staff trained in providing



We are working more closely with hospitals to provide the best care for patients who have suffered strokes

independent advice to children who have been excluded from mainstream education.

Protecting children and vulnerable adults

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

In 2005/06 staff referred the cases of 1,234 vulnerable adults for investigation because they felt the person concerned was either at risk or in need. This averaged at 24 cases a week, compared to nine a week for the previous year. In addition, 449 children were referred, compared to 365 last year.

It is likely that the increase is due to more awareness of the procedure - which was only introduced in 2003/04 - more staff being trained in the reporting process and generally having more confidence in the system.

Joint working on mental illness

Our ongoing strategy to improve joint working in relation to the care of patients with mental health problems continued this year. We took part in an event examining the way that ambulance services, A&E departments, the Metropolitan Police and social services currently respond to people who display

signs of mental illness.

A number of role-playing scenarios demonstrated that there is still some confusion about roles and responsibilities of people from the different services when jointly attending these patients. As a result, a number of proposals for working more effectively together have now been put forward. These include joint training.

Raising awareness around positional asphyxia

Following the tragic death of a patient in 2003 we have reviewed our training policies on the effects of struggle and the link to acute behavioural disturbance, and positional and restraint asphyxia. We have also reviewed the training we provide to operational crews on all aspects of mental illness and the roles and responsibilities of staff on the assessment, treatment, transport and monitoring of patients.

We have been working with the Metropolitan Police Service to clarify how mental health patients should be transported, ensuring both parties are clear about their roles and responsibilities. We have also been working with the Joint Royal Colleges Ambulance Service Liaison Committee (JRCALC) to ensure that future editions of their clinical guidelines emphasise the dangers of death due to positional asphyxia.

FAST care for stroke patients

We have been working with Guy's and St Thomas' Hospital to improve our care for patients with suspected strokes. We are also involved in a research project with the brain attack unit at the National Hospital for Neurology and Neurosurgery.

Our A&E crews have been trained in the Face, Arm and Speech Test (FAST), an assessment tool that checks for the signs and symptoms of a stroke. Crews can then alert the dedicated stroke team at the hospital to expect the arrival of a patient.

Quicker recognition and direct transferral to specialist teams means that patients can be assessed for thrombolysis earlier. If this clot-busting drug is administered to patients, where this is safe, within the first few hours, it can reduce the area of the brain affected by a stroke and can improve outcomes dramatically.

The Service's Clinical Audit and Research Unit has been working with St. Mary's hospital to examine both the accuracy of our crews' diagnosis of stroke and the care provided to these patients. The results will inform future training programmes and developments in the area of stroke care.

Looking ahead, we would like to see a significant number of hospitals in London offer direct and rapid access to scans for patients diagnosed by our crews as stroke victims. London is behind other world capitals such as New York in this regard.

An alternative approach to alcohol-related calls

Alcohol is a significant problem for the Trust and we have been trialling a range of innovative approaches to handle the increase in these types of calls.

We have been operating a non-emergency patient transport service vehicle in the West End that is dedicated to responding to patients who are suffering the effects of an excessive night out. The 'booze bus', as it has been dubbed by the media, carries a paramedic and two Patient Transport Service staff and can transport up to five patients at a time to hospital, keeping more of our A&E ambulances on the road for patients who really need them. Between December and May, this initiative saved almost 700 ambulance hours.

In Croydon town centre, we set up a mobile treatment centre to treat patients suffering from the effects of alcohol or who have sustained minor injuries. This initiative was originally trialled in the run-up to Christmas and proved so successful that we are now using it every weekend and even operated it during the World Cup to cater for revellers in town to watch the England games.

Up until May, we had treated more than 380 patients at the centre and needed to convey only 91 of them to hospital. Of these, only one required transport by A&E ambulance.

The trial of both the non-emergency patient transport service vehicle and the treatment centre will be evaluated and a decision will be made as to whether they can operate on a permanent basis, and if there is a benefit to patients to expand the schemes to other parts of the city.

Expanding the 'Make Ready' scheme

We now have in place a comprehensive cleaning and equipping system for all the A&E ambulances in our fleet. 'Make Ready' involves the daily cleaning of vehicles internally and externally, before re-stocking, re-fuelling and returning them to the correct station ready for the next shift. It also sees every vehicle deep-cleaned every six weeks.

Our contractor, LRS, works to stringent quality control levels and it is clear that the scheme is improving the cleanliness of our vehicles. Swabbing, carried out regularly on the vehicles, has produced excellent results with the levels of bacteria below baseline targets and no indication of methicillin-resistant staphylococcus aureus (MRSA) being present.

Being in the right place

London's population continues to rise and with planned developments in East London to accommodate the Olympic and Paralympic Games, and the regeneration of the Thames Gateway expected to create 120,000 new homes, we must prepare for the demands this will put on our service.

Over the next couple of years we are planning to open 25 satellite stations across London. These small-scale stations

offer basic facilities to our staff such as a fridge, microwave oven, tea-making facilities and access to toilets. They will serve areas where there is a large population and there is no immediate local ambulance station, therefore reducing the time it takes for us to get to patients.

This year we opened four such stations in Hillingdon, Bromley, Deptford and Thornton Heath.

Caring for a patient aboard the 'Booze Bus'



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

Developing our people

Agenda for Change is the most radical shake up of the NHS pay system since the NHS was formed in 1948. It aims to provide a system of equal pay for work of equal value. It will facilitate more flexible working so that more patients are treated more quickly and are given higher quality care.

Over the last year, we have worked in partnership with the trade unions to agree the basis on which the majority of our staff would transfer to the new Agenda for Change terms and conditions. This has been a complex and difficult process and has involved lengthy negotiations to secure the best possible outcome for staff.

Agenda for Change also includes a structured framework for personal development, which should help people learn new skills and enhance their career.

Personal development reviews have been introduced to enable every member of staff to meet with their manager to discuss their performance and identify areas where they would like to develop.

We now have 356 managers trained in the process and so far 127 members of staff have completed their review. Of these, 117 have agreed a personal development plan that is based on the knowledge and skills framework that forms part of Agenda for Change.

Every post in the Trust has competencies that are mapped against the knowledge and skills framework. This aids managers in setting accurate objectives for the personal and career development of their staff.



People

Listening to our staff

The Healthcare Commission National Survey of NHS staff attitudes reflected the difficult and challenging year that we experienced in 2005/06. The replies from around 300 of our staff were analysed as part of the annual survey, providing us with detailed information about their feelings and perceptions and enabling us to compare ourselves against the performance of other trusts.

Sixty per cent of respondents said that they felt positive about working for the Trust, a 16 per cent reduction on last year. There was also a drop in the percentage of people who cite the Trust as a good employer to work for – down from 70 per cent to 52 per cent – and those saying that they're proud to work for the organisation, from 84 per cent in 2004/05 to 71 per cent this year.

All of our staff are crucial to our success





We are also concerned about the number of staff reporting high levels of work-related stress, the number of incidents of physical abuse and the low number of staff who said they had received the appraisals they are meant to have.

On the positive side, 89 per cent of staff said they had received some element of training, learning or development in the previous 12 months and 38 per cent said that they had received health and safety training in the last 12 months, up nine per cent on last year. Staff also showed confidence in our reporting procedures with 87 per cent saying that they had reported errors, near misses or incidents, which is above average for ambulance trusts in England.

Overall, the results reflected the frustrations that many groups

raised at our annual Chief Executive's consultation meetings. These focused on the implementation of Agenda for Change and on the continuing pressure to meet targets. We intend to look very closely at all of these issues so that we can improve working conditions for our people in the future.

Supporting our staff

We offer several initiatives specifically aimed at improving the lives of our staff. The LINC peer support scheme – Listening, Informal, Non-judgmental, Confidential – provides a confidential listening service to promote the physical, psychological and emotional well-being of all our staff,

enabling them to share their worries with specially selected and

trained colleagues. This year, 24 staff qualified as LINC workers, making a total of 39 people at locations across the Trust.

As mentioned previously, work-related stress continues to be an issue and we are now working with the Health and Safety Executive to trial new ways of managing stress. As part of this ongoing project, 2,000 staff received a survey about the levels of stress they experience at work. This will be followed up in a number of focus groups and the results will be published later in the year.

Our Occupational Health service continues to be provided by King's College Hospital NHS Trust, offering counselling services to staff, flu-vaccinations and free 'well-person' medicals.

Following the introduction of a smoking ban in all Trust buildings and enclosed areas that came into effect in October, Occupational Health held smoking cessation clinics throughout the year, offering advice to people who are trying to kick the habit. The ban is part of a commitment by the NHS to make all its trusts smoke-free. We will continue to work towards full implementation of such a smoke-free policy in 2006.

Housing

Options, previously known as the Key Worker Living Scheme, continues to be promoted to staff. The scheme provides financial assistance to our employees to help them afford a property in the capital. Previously only



available to A&E staff, this year the scheme has been extended so that our Patient Transport Service and Control Services staff can also benefit.

The Home Computing Scheme, introduced in partnership with Dell, gave all our staff the opportunity to lease a computer at reduced rates for their own personal use. Every member of staff has also now been issued with their own work e-mail address and for many operational employees this is the first time that they have had access to their own individual account.

Recruitment and training

During the year, we recruited 263 frontline A&E staff and 54 staff to work in Control Services.

We trained 32 people as entry level emergency medical technicians to serve in our new Urgent Care Service, 223 staff were trained to become emergency medical technician levels two and three and 88 became paramedics.

Overall, staff turnover for the Trust continues to remain low at 5.22 per cent.

This year we introduced our first formal development course for our 2,400 frontline staff. The Continuing Professional Development course is a five-day programme that will be made available over a three-year period from 2005/08.

Our training processes have been

modernised over the last year by the introduction of web-based exams for vocational qualifications. A total of 59 networked desktop computers, five laptops, and ten printers have been installed at our training centres at Bromley, Ilford, Kenton, New Malden and Fulham to enable online training and assessment.

A degree in Paramedic Science

We have been working with the University of Hertfordshire for more than ten years on the provision of courses in Paramedic Science from certificate to graduate level. So far, we have produced 303 graduates and as a result, 30 per cent of our paramedics now have degrees.

A team of our training officers work at the University, from where they deliver vocational aspects of the course such as clinical skills and driver training and organise clinical placements for students within our Trust.

Each year we offer to pay study leave of 70 hours per semester for those doing part-time paramedic degrees. Last year we paid for 38 members of staff at different stages of their course.

The part time BSc (Hons) in Paramedic Science was completed by one member of staff in July 2005 and nine people will receive their results in summer 2006. A

further 12 members of staff gained a diploma in Paramedic Science in July 2005 and 25 are awaiting their final results this year.

We received 73 new recruits from the full-time BSc (Hons) in Paramedic Science at the University of Hertfordshire.

St George's Hospital Medical School offers a foundation degree course in Paramedic Science. There are currently 29 students on this courses and a further 18 who will start later in the year.

We have also been working with the University of Greenwich to set up a three-year Paramedic Science course, with the first intake of 18 starting in September 2006.

Equality and diversity

London is one of the most diverse cities in the world and it is very important that our workforce reflects the communities we serve.

We have been working with the Ambulance Service Association on a research project to understand the reasons for the low rate of recruitment of Black and Minority Ethnic (BME) staff to the ambulance service nationally. Some of our members of staff from BME communities have contributed their perspectives on working for the Trust, giving examples of their own experience, and passing on views from within their own community. This research has informed our recent review of our recruitment and selection policy.

We have also provided funding for a careers team which will engage in proactive recruitment of women and BME candidates who are currently under-represented in the Trust.

Since the introduction of our new diversity training course, over 590 members of staff have undertaken this session as part of the Continuing Professional Development course. It covers gender, disability, mental health, religion/belief and sexual orientation issues, as well as the general duties under the Race Relations Act. In addition, all new operational crews receive a two to four hour session on diversity issues during their foundation training and all other new members of staff receive a one-hour 'Managing Diversity' session as part of the

New recruits practice their response to road traffic accidents at a training event



corporate induction programme. We now have 67 trainers who have taken part in a five-day diversity foundation course, and 12 trainers who are qualified to deliver diversity training to our staff.

In June, we published our equality and diversity policy, which reflects our responsibilities towards patients and our employment duties. The policy is supported by a specific employment policy that reflects, in broad terms, how equality impacts on matters such as recruitment and selection, learning and development and work-life balance. We also introduced a new policy on bullying and harassment reflecting our concern to take our responsibilities to our colleagues seriously.

In November, the 1990 Trust carried out a review of all London NHS Trusts' Race Equality Schemes on behalf of the Strategic Health Authorities of London. Out of 79 schemes reviewed, we were the only Trust to score top marks. We are now working with the Department of Health Equality and Human Rights Group to develop a single equality scheme which will build on our Race Equality Scheme to include disability, gender, religion and belief, sexual orientation and age.

Improving staff safety

There were 341 incidents of physical abuse against our staff reported in 2005/06, averaging at almost one assault a day. There were also a further 1,172 reported incidents of verbal abuse.

In recent years, there has been a significant reduction in reported levels of violence against our staff. We would like to think that this is a result of a number of initiatives that we have introduced over the last five years.

Conflict management training has now been undertaken by almost 2,000 frontline members of staff. It provides people with the skills to calm potentially volatile situations, teaches them the safest way to approach a patient and how to adopt non-aggressive body language.

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



Whilst members of staff are encouraged to report any incidents of violence or aggression, it is likely that some consider it to be an unfortunate 'part of the job'. We do not think this is right, and are working with the NHS Security Management Service to promote a 'pro-security' culture and, when necessary, to press for prosecutions. In the past some of our people have been left disappointed when aggression against them has not been pursued by the police or Crown Prosecution Service, but now their case can be considered by the NHS Security Management Service Legal Protection Unit to see whether private prosecution or civil action is appropriate.



We are investing in the personal development of our staff



Five members of staff received MBEs

Last year, the Trust's Violence Prevention and Security Manager supported 12 successful prosecutions, with sentences ranging from custodial sentences to community service depending on the nature of the attack. In addition, it is possible that there were other prosecutions where the member of staff liaised directly with the police and did not involve our Violence Prevention and Security Manager.

The Health and Safety Executive (HSE) has commended our work in the field of health and safety, citing us as a best practice example of an organisation employing good health and safety techniques. Our investment in vehicles with tail-lifts, the employment of a full-time Ergonomic Back Care Advisor and our introduction of conflict resolution training and stab vests for all A&E operational staff

HRH Prince Edward visited Greenwich station



were all praised by the HSE.

We have again seen a reduction in the number of manual handling incidents, dropping from 1,031 when we introduced our health and safety improvement programme in 2002, to 596 in 2005/06.

Showing our appreciation

The courage and professionalism of our staff in responding to the London bombings has been recognised throughout the year at a number of prestigious award ceremonies. The Daily Mirror Pride of Britain Awards, a 'Thank You' event hosted by the Mayor of London Ken Livingstone and our own commemorative event, have all shown the appreciation we feel for the remarkable individuals who came to the aid of others in the face of this terrible atrocity.

Four members of staff were given an MBE for the role they played in responding to the bombings and our Director of Operations Martin Flaherty was awarded an OBE. They were joined by one of our longest-serving members of staff who was also awarded an MBE in recognition of his services to the NHS in a 42-year career.

Other members of staff have also received accolades, including five

members of staff who won all the awards in the emergency services category in a local newspaper's community competition.

The annual Ambulance Service Institute Awards recognised the efforts of three members of our staff. An emergency medical dispatcher who has worked in our control room for more than a decade received the Control Staff Award and an ambulance crew who saved the life of a policeman received the Presidential Team Award.

Our Cycle Response Unit beat off more than 2,000 entrants to scoop the NHS Live Award for Innovation and Improvement at the prestigious Health and Social Care Awards.

We held our second annual awards ceremony in July last year to honour the work of our most exceptional members of staff. All of the nominees were voted for by the people who know them best - their colleagues. Nominators were asked to put forward the names of workmates who they felt had gone above and beyond the call of duty over the previous year, from those whose ideas have improved patient care to others whose positive attitude and 'can-do' approach has made a big difference day-to-day. Sixteen members of staff were honoured at the event.

Throughout the year we continued to recognise the milestones of long-service that our people reach from 10 to 40 years, as well as celebrating retirements and holding passing out ceremonies for newly-qualified staff. In total, 444 people were honoured for their contribution to the Trust.

Charitable work

In 2005/06 we adopted the children's hospices of London to be our first Chief Executive's charities. Over the year, our members of staff have raised thousands of pounds for Richard House in Docklands, the Haven House Foundation in Woodford and Shooting Star in Hampton. They have run in marathons, rode motorbikes to Brighton and even donated media interview fees to help the cause.

In addition, we held a competition inviting the children who attend the hospices to design our official Christmas card. The winning card, designed by three-year old Ashantia, was sent to 2,000 of our stakeholders.

Improved working environments

We unveiled a brand new ambulance station in Streatham in February. Built at a cost of £1.1 million, the new station not only has better facilities that make for a more comfortable working environment, it also has increased capacity which will enable us to meet the rising demand for our service from patients in the local area. We have also refurbished several of our stations such as Newham and Rotherhithe, to upgrade the facilities available to staff.

The handy-work of green-fingered staff at Greenwich ambulance station was given the Royal seal of approval in January when HRH Prince Edward visited their award-winning gardens. It was the Prince's first official engagement as patron to the London Garden Society.

Our Estates Department introduced a new IT-based system for reporting maintenance issues in November. This new reporting mechanism is more reliable and will speed up the process for conducting essential repairs.

Going green

We are taking steps to make the Trust a 'greener' place to work.

We are working with the London Liftshare scheme to encourage our staff to share their car journeys to work. The scheme puts people in touch with others who make similar journeys in their area, with the aim of reducing the number of cars on the roads. We also give staff the opportunity to loan bicycles and offer free cycling courses.

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

In our offices, we provide recycling facilities for paper and printer cartridges and later this year we intend to launch a 'Turn it off' campaign to remind staff to turn off lights, computers and televisions so as not to waste energy.

With regard to vehicles, our new ambulances use diesel rather than petrol but in the future, there are other fuel options that we may consider such as dual fuel or LPG. Our manufacturers are also looking into various emerging technologies such as hydrogen-fuelled vehicles and electric vehicles, but we are not able to make significant changes to our fleet until they prove themselves viable.



Ashantia designed our official Christmas card



The 2005/06 year was our busiest ever, with our control room handling over 77,000 more emergency calls than in the previous 12 months and our frontline staff attending almost 30,000 more incidents.

Meeting our targets

When a 999 call is received in our Emergency Operations Centre, our highly-trained call takers use our call-prioritisation software to ask a series of questions and determine the urgency of the patient's needs. Each incident is categorised as follows:

- Category A - immediately life-threatening incidents
- Category B - serious incidents
- Category C - neither serious nor life-threatening

The Government-set performance targets require us to reach patients within nationally agreed timescales. They stipulate that we must reach 75 per cent of Category A calls within eight minutes and 95 per cent within 14 minutes, and that we must respond to 95 per cent of Category B calls in 14 minutes.

We also respond to urgent calls placed by GPs. In these cases, they specify the urgency of the response required - this could be one, two or three hours from the time they place the call. Our target for getting to these calls is to reach 95 per cent no more than 15 minutes late.

In 2005/06, we responded to:

- 75 per cent of Category A calls within eight minutes, compared to 77 per cent in 2004/05.
- 95 per cent of Category A calls within 14 minutes, compared to 96 per cent in 2004/05.
- 75 per cent of Category B calls within 14 minutes, compared to 80 per cent in 2004/05.
- 51 per cent of urgent calls where we were not more than 15 minutes late, compared to 58 per cent in 2004/05.

During the same period:

- Our Emergency Operations Centre received a total of 1,231,572 emergency calls, compared to 1,153,948 in 2004/05.
- This number resulted in our attending a total of 856,659 emergency incidents (compared to 827,415 in 2004/05) of which 305,300 were classed as Category A, up from 207,106 the previous year.
- We sent 1,103,010 emergency vehicles to these incidents (compared to 1,053,121 in 2004/05).
- We made 47,402 urgent patient journeys as requested by GPs, compared to 54,197 in 2004/05.
- Special/planned patient journeys are pre-booked through us by healthcare professionals and include hospital and hospice transfers. We undertook 375,705, compared to 486,528 in 2004/05.

29 new fast response cars hit the road across the capital



Performance





Improving our A&E performance

It was a difficult year for the Trust and although we met our Category A performance target, we failed to meet those for B and C calls and did not perform as well as in 2004/05.

We faced some periods of particularly high demand, including some of the busiest weeks in our history. In February 2006, we responded to a total of 71,721 incidents, up more than seven per cent on the same month last year, and on 27 May 2005, the UK's hottest day in May for more than 50 years triggered over 950 Category A calls.

We saw a mammoth increase in the number of Category A calls, handling almost 100,000 more in 2005/06 than in the previous 12 months. This increase was, in part, due to the re-categorisation of calls by the Department of Health which has led to more calls being classified as life-threatening.

In December, we took steps to manage this increased demand, introducing our Resourcing Escalation Action Plan (REAP) as part of our Capacity Plan. Under REAP, we regularly monitor how much pressure we are experiencing against five levels, with level one considered routine and level five classed as potential service failure. For each level above one, there are a range of tactical measures invoked to deal with this level of strain on the system.

Between December and April, we were operating at level three of the plan due to a combination of factors, including the deterioration in weather conditions, a high number of vacancies among frontline staff and Category A performance falling below 75 per cent for more than one month. We addressed this situation by taking the following actions:

- We established a Gold command team at our headquarters to manage recovery. This team ensured that ambulances and fast response cars were in the right places and that the workload was being spread as evenly as possible. It was also responsible for closely monitoring demand hour-by-hour so that it could make real-time decisions about staffing and solve issues as they arose each day
- All non-essential meetings for managers were cancelled so that they could concentrate on staffing vehicles and managing performance issues
- We maximised the use of the Patient Transport Service to support A&E
- Team leaders and training officers provided increased operational cover
- We worked with local and regional media to convey messages to Londoners, asking them to use our service wisely over this period.

These measures all helped to ensure that we were able to meet our crucial Category A performance target, without compromising patient care.

Last year also saw the introduction of a new A&E senior management structure designed to provide more support to local complex teams and give our ambulance operations managers more capacity to deliver our service locally to improve the care we provide to patients. Another aspect of the reorganisation was the integration of the newly-formed Urgent Care Service that has been established to deal with non life-threatening calls.

Over 1.2 million calls were received by our Emergency Operations Centre staff

Improving Patient Transport Service performance

The primary role of the Patient Transport Service (PTS) is to provide non-emergency transportation for patients from their home to outpatient appointments. Hospitals now contract out this service and we must compete against other providers such as private organisations, charities and NHS Trusts to secure this work. Like all providers, we must go through the tendering process and submit a proposal that shows we are capable of providing a high-quality service at a reasonable price.

In 2005/06, PTS lost one of its biggest contracts with Hammersmith Hospitals NHS Trust and also contracts with Chase





The Motorcycle Response Unit help us to reach patients quickly in the centre of London

Farm and Barnet Hospitals. We have learnt valuable lessons from this and are reviewing the way we tender for new or existing business.

During the year, we reorganised the structure of PTS so that the commercial aspect of its work is managed by the Finance-Business Development Department. It is hoped that under its leadership, PTS will be better equipped to compete in the patient transport market. We will be reviewing the way we resource our existing contracts, looking to improve the service we provide to our customers and considering how we can reduce the costs of providing this, currently a restricting factor in our ability to win or retain business.

However, PTS did make a substantial gain last year with a contract in the Bromley area. The contract, which commenced in April 2006, involved taking on 45 new staff.

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

Our performance at delivering patients to hospital on time improved to 82 per cent compared to 73 per cent last year, and our performance for departing hospital on time also rose from 83 per cent to 88 per cent.

PTS has developed a much closer working relationship with our A&E side over the past year. Patient Transport Service Central Services is now integrated within the Urgent Care Service and regularly directs PTS ambulance persons on urgent calls when they are not required by their existing contracts.

Staff have also assisted with large-scale events, major incidents and have been responding to alcohol-related incidents as part of the alternative response vehicle trial and the use of mobile-treatment centres as outlined on page 17.

The new Healthcheck

The Healthcare Commission introduced its new annual Healthcheck in April 2005 to measure the performance of NHS organisations in meeting national standards and targets set by the Government. The Healthcheck replaces the star ratings assessment system and looks at a much broader range of issues than the targets used previously. The intention is to measure areas that matter to patients and staff.

We have been working with the Commission, providing information on different aspects of our work against the seven required domains: safety, care environment and amenities, clinical and cost effectiveness, governance, patient focus, accessible and responsive care and public health. The Commission will publish its assessment of our performance in September 2006.

New additions to our fleet

Over the course of the year, we introduced 65 new Mercedes-Benz Sprinter ambulances to replace old vehicles. The new type of ambulances now make up two-thirds of our A&E fleet.

We also introduced 29 fast response cars. Of these, 14 replaced old Vauxhall Astras, 13 are being used by our new emergency care practitioners and to boost

numbers of paramedics in fast response cars, and two will be used as first response cars by our Chemical, Biological, Radiological and Nuclear (CBRN) incident team.

Our Motorcycle Response Unit took delivery of two new motorbikes that will eventually replace the existing bikes when they reach the end of their working lives. The new Honda Pan-European models are lighter, more environmentally friendly, and easier to manoeuvre than the bikes currently in use.

In 2006/07, we will be procuring two emergency control vehicles that can be used in the event of a major incident so that control services staff can manage the co-ordination of ambulances at the scene. We will also be bringing in four emergency support vehicles that carry supplies of essential equipment to the scenes of incidents or large-scale events.

We are also in the process of introducing two specialist ambulances that will be tasked with inter-hospital transfers. These ambulances are wider than our other vehicles and have two generators on board so that they can support equipment that some of our seriously ill patients need.

Expecting the unexpected

As outlined on page 9, our plans for dealing with emergencies in the capital were put to the test on 7 July 2005 and significant lessons have been learnt.

One of the actions we have taken is to upgrade our Incident Control Room so that it is configured to deal with multi-sited simultaneous incidents. Rugby star Lawrence Dallaglio officially opened the refurbished control room in January.

The Emergency Planning Unit has been responsible for updating our Major Incident Plan with new response procedures, such as the need to send a pre-determined number of vehicles when a major incident is declared.

Scenario-planning is vital in testing our major incident plans work. We regularly take part in table-top and live exercises with our emergency services partners and the local authorities. We also work closely with the London airports, Network Rail and London Underground.

In November 2005, we published our new Business Continuity Plan to outline how we will continue to provide our usual level of service in the event of a serious internal or major incident.

We continue to learn from every serious incident that we attend and in 2005/06 after a number of responses involving live rails, we distributed new action cards to all frontline staff reminding them of the procedures for handling such incidents.

We are working with the Department of Health and our London health agency colleagues to develop an operational and command plan that would be adopted in the event of a pandemic flu outbreak.

Following an independent evaluation, changes have been made to the way we respond with the emergency services to potential Chemical, Biological, Radiological or Nuclear (CBRN) incidents. For 16 months, a Multi Agency Initial Assessment Team (MAIAT) acted as a dedicated squad tasked with providing initial assessments at scenes of calls. Although the trial was effective in improving our understanding of the CBRN operational response and encouraging joint multi-agency working, it was felt that it was not the most efficient or fully effective way of providing the type of support required at potential CBRN incidents.

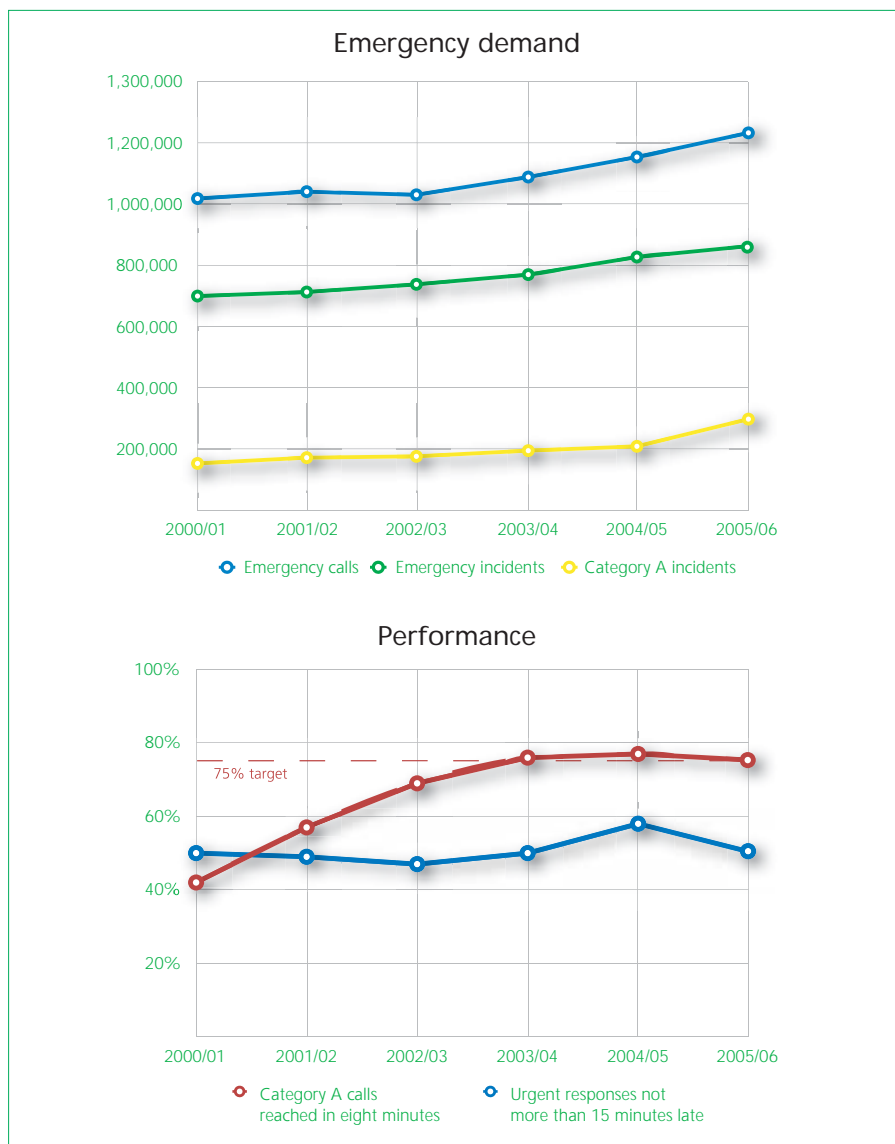
New arrangements have since been introduced which have seen MAIAT members return to their respective organisations and we now maintain a dedicated team. They still come together to provide expert advice at the scenes of incidents and regularly train together.

Handling large-scale events

We dealt with a massive number of emergency 999 calls on New Year's Eve, taking over 1,400 calls between midnight and 4am - up four per cent on the same period last year.

A team of 50 staff worked hard to ensure that concert-goers enjoyed the Live 8 event in Hyde Park in the summer. Supported by the voluntary ambulance services, we treated more than 660 patients at the on-site treatment centres and took a further 50 patients to hospital for more serious illnesses and injuries.

Other events that we have supported



throughout the year include the London Marathon, Notting Hill Carnival and the England Cricket team victory parade. We also manage the many large-scale events that happen on a weekly basis in London, such as football matches and music events.

We are already making preparations for the 2012 Olympic and Paralympic Games. The Games will be the largest inter-agency event ever held in London and the Trust will play its full part with partners including the Olympic Development Agency and the London Organising Committee of the Olympic Games.

Staff from across the organisation attended a brainstorming session in April to consider how the Games will impact on us and how we can prepare for the huge influx of people visiting London to attend them. Subsequently, an Olympic Games project leader has been appointed who will lead on our preparations and a full-time office will be in operation by October 2006.



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 Barry McDonald, Sarah Waller, Colin Douglas and Beryl Magrath and our Risk Management Committee is attended by Barry McDonald, Sarah Waller and Beryl Magrath.

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

Non-executive directors

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

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

Dr Beryl Magrath is a former consultant anaesthetist; she worked latterly at Orpington Hospital in Kent and was a founder of South Bromley HospisCare in 1984. She was Medical Director of Bromley Hospitals NHS Trust between 1992 and 2000 and is now Vice-Chairman of Harris HospisCare.

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

Caroline Silver took up her post as a non-executive director of the Trust in March 2006. A chartered accountant, she is Vice Chairman of the Investment Banking Division at US investment bank, Morgan Stanley. In her 12 years there, she has specialised in advising on international mergers, acquisitions and financings, particularly in the financial services and healthcare sectors. Previously, she worked at Price Waterhouse (now PwC) and at Morgan Grenfell (now Deutsche Bank).

Roy Griffins CB took up his post as a non-executive director of the Trust in March 2006. He is Director General of the Airports Council International (ACI) Europe, having served as UK Director of Civil Aviation between 1999 and 2004. Previously, he worked as Director of Public Affairs at Eurotunnel PLC after a career of nearly 30 years spent in the British civil and diplomatic service, mostly in international, transport and environment posts. Mr Griffins was made a Companion of the Order of Bath (CB) in the 2003 Queen's Birthday Honours list.

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

Colin Douglas left the Trust in March 2006.

Lord Toby Harris left the Trust in November 2005.

Executive Directors

Chief Executive Officer Peter Bradley CBE joined the Trust in May 1996 as Director of Operational Development and was appointed Chief Executive 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. 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. Previously he had worked for 13 years at United Parcel Service Europe in a variety of positions including Group Finance Director for the European logistics business.

Medical Director Fionna Moore was appointed in December 1997 and was made an executive director in September 2000. Dr Moore has over 20 years experience as consultant in emergency medicine, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She is a BASICS Doctor and has recently been awarded 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 ten years. Previous to that, he had worked for Siemens-Nixdorf, GEC in South Africa, and BT.

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

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

The remaining meetings of 2006 will be held on 26 September and 28 November. The meetings of 2007 are scheduled to take place on 30 January, 27 March, 22 May, 31 July, 25 September and 27 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.

2005/06 Financial summary statements

Financial Review

The Trust fulfilled two of its four statutory financial duties in 2005-06:

1. On income and expenditure the Trust reported a surplus of £1,258,000 for the year, and therefore did better than the break even target set for it by the Department of Health for 2005-06.

The financial year 2005-06 was one of growth overall, as the Trust used extra funding from Primary Care Trusts to implement Agenda for Change and improve accident and emergency response time performance. The Trust also received additional funding to meet the additional costs of the 7 July terrorist incidents.

The Trust was able to pay 79 per cent of its invoices within 30 days, which was below the 95 per cent target set for it by the Department of Health.

The Audit Commission were the Trust's external auditors for the year ending 31 March 2006. The Trust paid the Audit Commission £139,000 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 2005-06 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.

Income and Expenditure £000s						
	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Surplus/Deficit(-) in year	101	46	94	89	332	1,258
Cumulative Surplus/Deficit(-)	-486	-440	-346	-257	75	1,333
Cumulative deficit permitted (0.5%)	-618	-678	-804	-843	-963	-1,080

The surplus in 2005/2006 meant that the cumulative position improved for the sixth year running, and remained well within the limit of 0.5% of turnover permitted by the Department of Health.

2. The Trust achieved its EFL (external financing limit) for the year.
3. A return on assets (the capital cost absorption duty) of 4.1 per cent was achieved. This was 0.1 per cent higher than the permitted range of 3.0 per cent to 4.0 per cent. The variance from 3.5 per cent is due to slippage in the capital programme relating to a number of estate projects.
4. In the capital programme £5.4m 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 £1,250,000 against its Capital Resource Limit, which it is permitted to do.

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 individual, market rates and affordability.

Executive directors are subject to normal terms and conditions of employment. They are employed on permanent contracts

which can be terminated by either party with three months' notice.

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

For the purposes of this report, the disclosure of remuneration to senior managers is limited to executive and non-executive directors of the Trust. Details of remuneration, including salaries and pension entitlements, are published on page 36.

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



Chief Executive Officer

3 July 2006

Independent Auditors' Report to the Directors of London Ambulance Service NHS Trust on the Summary Financial Statements

I have examined the summary financial statements set out on pages 30 to 37.

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

Respective responsibilities of directors and auditors

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

Basis of opinion

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

Opinion

In my opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2006 on which I have issued an unqualified opinion.

5 July 2006

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

Related Party Transactions

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

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

	Payments to related party £	Receipts from related party £	Amounts owed to related party £	Amounts due to related party £
Ambulance Service Association	46,899	564,222	840	16,241

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

Richmond & Twickenham PCT;
the NHS Litigation Authority;
the NHS Supplies Authority;
the NHS Pension Agency;
other Primary Care Trusts.

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

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

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

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



Chief Executive Officer

3 July 2006

Statement of Directors' Responsibilities in Respect of the Accounts

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

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

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


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

By order of the Board



Chief Executive Officer

3 July 2006



Finance Director

3 July 2006

Statement on Internal Control 2005-06

1. Scope of responsibility

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

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

A summary of the Risk Management Framework can be found on our website. In addition to this, stakeholder involvement as part of our seven year strategic planning process has been used to define both 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 2006 and up to the date of the approval of the annual report and accounts.

3. Capacity to handle risk

The leadership of risk within the LAS 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. He attends the Audit Committee and chairs the Standards for Better Health Group, overseeing part of the Annual Health Check that includes the healthcare standards. 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 Management Framework, are approved at Risk Compliance and Assurance Group and allocated to an appropriate specialist risk management group for management. The tool has recently been amended to use a numerical scoring system when grading risks. Those of a high priority are monitored by one of the sub-committees of the Board. All significant risks are recorded on the Risk Register which is used to help prioritise and make decisions on spending allocation for service development.

The Trust has recently reviewed its governance arrangements and other infrastructure requirements that are statutory, mandatory or desirable for the organisation. The review considered the strengths and weaknesses of current governance practice within the Trust.

4. The risk and control framework

The Risk Management Framework defines the risk management process which specifies the way risk (or change in risk) is identified, evaluated and controlled. In addition to this an assessment was undertaken against the Risk Management Standard for the Provision of Pre-Hospital Care in the Ambulance Service by the NHSLA which involved a cross section of staff from all areas and levels of the organisation.

The Risk Management Framework also describes responsibilities for embedding risk management in the organisation. On a local level staff report clinical and non-clinical incidents as indicated in the Incident Reporting procedure. All incidents are assessed using the LAS Risk Scoring Matrix and according to grade investigated so that actions can be implemented to prevent a re-occurrence. In addition the Infection Control Steering Group has implemented an infection control audit programme delivered to all complexes, which has been undertaken by trained frontline staff, and produced an Annual Infection Control Report to the Board which provided assurance regarding the implementation of the Make Ready Scheme.

In addition to the Risk Management Framework and the Risk Register, the Assurance Framework enables us to examine how we are managing risks that are threatening the achievement of 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. The Assurance Framework has been scrutinised this year by the SHA on behalf of the Department of Health.

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

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

Human Resources and Organisation Development

- An internal audit reviewed our system for Criminal Records Bureau and Protection of Children Amendment (POCA) checks. The audit has reassured us that we are compliant with the national guidance to check staff who have direct patient contact. We have developed and implemented protection and training guidance for children and vulnerable adults, using existing staff to strengthen controls with the management of child protection.
- We have taken action to introduce ethnicity monitoring in order to meet our responsibilities under the Race Relation Act. The Trust has now received assurances on the effectiveness of its controls under the Race Relations Act from the recent audit conducted by the South West London Strategic Health Authority. Further controls were also achieved with the award made to the Trust of Practice Plus status under the aegis of Improving Working Lives.

Operational Support

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

Clinical

- With the development of clinical performance indicators and electronic recording facilities, the Clinical Audit and Research Group will oversee enhanced audit reports from all operational staff. A three-year plan to reach 100 per cent compliance with Clinical Performance Indicator audits on PRFs has been put in place.

Control Services

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

Information Management and Technology

- Controls to ensure records management have been enhanced now with the appointment of a Head of Records Management. Subsequently, the development of the Trust's Records Management Policy and Records Management strategy has set down systems and processes for the standardisation of records management processes across the Trust. The progress made by the Information Governance Panel has enabled the requirements of the Freedom of Information Act to be managed effectively.

Business Continuity

- A fully integrated business continuity operational plan has been developed and is held under permanent review by the Business Continuity Steering Group.

A&E Operations

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

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

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of 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 Assurance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board is informed of the effectiveness of the system of internal control through its sub-committees. The Audit Committee 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 look at risk management systems and processes.

The Clinical Governance Committee has responsibility for ensuring the provision of high quality clinical care in the Trust. This is achieved through monitoring and making appropriate recommendations on performance in the areas of clinical governance reviewed by the Healthcare Commission. The Risk 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. Another full trust-wide risk assessment was undertaken this year and generated a further four high priority risks to the Trust's risk profile.

The structure is supported by 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 risk and clinical governance, and is a member of the Clinical Governance Committee and Standards for Better Health Group. The Director of IM&T is responsible for all risks arising out of the provision, use, operation and maintenance of the Trust's technology and communication systems and he also chairs the Information Governance Panel. The Director of Communications is chair of the PPI Committee.

To supplement this mechanism, information is provided to the Board through minutes and annual reports on risk management, infection control, PALS and clinical governance in order for the Board to be confident that sufficient progress has been made.

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



Chief Executive Officer
(on behalf of the Board)

3 July 2006

Income and Expenditure Account for the Year Ended
31 March 2006

	2005-06	2004-05
	£000	£000
Income from activities	212,984	189,357
Other operating income	2,963	3,231
Operating expenses	(210,497)	(189,240)
OPERATING SURPLUS	5,450	3,348
Cost of fundamental reorganisation/restructuring	0	0
Profit on disposal of fixed assets	22	4
SURPLUS BEFORE INTEREST	5,472	3,352
Interest receivable	391	508
Interest payable	0	0
Other finance costs – unwinding of discount	(129)	(165)
Other finance costs – change in discount rate on provisions	(743)	0
SURPLUS FOR THE FINANCIAL YEAR	4,991	3,695
Public Dividend Capital dividends payable	(3,733)	(3,363)
RETAINED SURPLUS FOR THE YEAR	1,258	332

All income and expenditure is derived from continuing operations.

BALANCE SHEET as at 31 March 2006

	31 March 2006	31 March 2005
	£000	£000
FIXED ASSETS		
Intangible assets	447	415
Tangible assets	106,257	105,085
	106,704	105,500
CURRENT ASSETS		
Stocks and work in progress	1,916	1,938
Debtors: Amounts falling due:		
after one year	9,543	9,076
within one year	13,437	7,746
Cash at bank and in hand	667	665
	25,563	19,425
CREDITORS:		
Amounts falling due within one year	(9,193)	(14,177)
NET CURRENT ASSETS/(LIABILITIES)	16,370	5,248
TOTAL ASSETS LESS CURRENT LIABILITIES	123,074	110,748
CREDITORS:		
Amounts falling due after more than one year	0	0
PROVISIONS FOR LIABILITIES AND CHARGES	(24,539)	(25,017)
TOTAL ASSETS EMPLOYED	98,535	85,731
FINANCED BY:		
CAPITAL AND RESERVES		
Public dividend capital	49,617	39,977
Revaluation reserve	41,261	40,284
Donated Asset Reserve	508	698
Other reserves	(419)	10
Income and expenditure reserve	7,568	4,762
TOTAL CAPITAL AND RESERVES	98,535	85,731



Chief Executive Officer

3 July 2006

Cash Flow Statement for the Year Ended 31 March 2006

	2005-06 £000	2004-05 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	(558)	21,930
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	391	502
Interest paid	0	0
Interest element of finance leases	0	0
Net cash inflow/ (outflow) from returns on investments and servicing of finance	391	502
CAPITAL EXPENDITURE		
Payments to acquire tangible fixed assets	(5,589)	(5,976)
Receipts from sale of tangible fixed assets	35	73
Payments to acquire intangible fixed assets	(186)	(63)
Net cash (outflow) from capital expenditure	(5,740)	(5,966)
DIVIDENDS PAID	(3,733)	(3,363)
Net cash inflow/(outflow) before financing	(9,640)	13,103
FINANCING		
Public dividend capital received	9,640	0
Public dividend capital repaid (not previously accrued)	0	(12,861)
Public dividend capital repaid (accrued in prior period)	0	0
Capital element of finance leases	0	0
Net cash outflow from financing	9,640	(12,861)
Increase/(Decrease) in cash	0	242

Statement of Total Recognised Gains and Losses for the Year Ended 31 March 2006

	2005-06 £000	2004-05 £000
Surplus for the financial year before dividend payments	4,991	3,695
Unrealised surplus on fixed asset revaluations/indexation	2,540	13,328
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed asset	17	0
Additions/(reductions) in "other reserves"	(429)	0
Total recognised gains and losses for the financial year	7,119	17,023
Prior Period Adjustment	0	0
Total gains and losses recognised in the financial year	7,119	17,023

Salary and Pension entitlements of senior managers

A) Remuneration

Name and title	2005-06			2004-05		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Sigurd Reinton, Chairman	£20,001-£25,000	£0-£5,000		£20,001-£25,000	£0-£5,000	
Colin Douglas, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
*Toby Harris, Non-Executive Director	£0-£5,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
Barry MacDonald, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
Sarah Waller, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
*Roy Griffins, Associate Non-Executive Director	£0-£5,000	£0-£5,000		£0-£5,000	£0-£5,000	
*Ingrid Prescod, Associate Non-Executive Director	£0-£5,000	£0-£5,000		£0-£5,000	£0-£5,000	
*Caroline Silver, Associate Non-Executive Director	£0-£5,000	£0-£5,000		£0-£5,000	£0-£5,000	
Peter Bradley, Chief Executive	£150,001-£155,000	£0-£5,000	£5,000	£135,001-£140,000	£0-£5,000	£4,000
Michael Dinan, Director of Finance	£90,001-£95,000	£0-£5,000		£30,001-£35,000	£0-£5,000	
Martin Flaherty, Director of Operations	£90,001-£95,000	£0-£5,000	£3,000	£0-£5,000	£0-£5,000	£3,000
*Wendy Foers, Director of Human Resources	£20,001-£25,000	£0-£5,000		£90,001-£95,000	£40,001-£45,000	
*Caron Hitchen, Director of Human Resources	£75,001-£80,000	£0-£5,000		£0-£5,000	£0-£5,000	
Fionna Moore, Medical Director	£60,001-£65,000	£0-£5,000		£60,001-£65,000	£0-£5,000	

* Directors who were in post for part of the financial year. Roy Griffins, Ingrid Prescod and Caroline Silver were appointed Associate Non-Executive Directors on 1 March 2006. Toby Harris resigned from the post of Non-Executive Director on 30 November 2005. Wendy Foers resigned from the post of Director of Human Resources on 21 July 2005. Caron Hitchen was appointed Director of Human Resources on 30 May 2005. Martin Flaherty was appointed Director of Operations on 1 April 2005.

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

Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2006 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2006 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2006	Cash Equivalent Transfer Value at 31 March 2005	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Sigurd Reinton, Chairman	**	**	**	**	**	**	**	
Colin Douglas, Non-Executive Director	**	**	**	**	**	**	**	
Toby Harris, Non-Executive Director	**	**	**	**	**	**	**	
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	£132,437	£114,042	£10,881	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£0-£5,000	£0-£5,000	£19,087	£4,874	£9,864	
Martin Flaherty, Director of Operations	£2,501-£5,000	£10,001-£12,500	£25,001-£30,000	£85,001-£90,000	£416,909	£347,229	£42,700	
Wendy Foers, Director of Human Resources	£0-£2,500	£0-£2,500	£25,001-£30,000	£85,001-£90,000	£449,057	£427,178	£2,406	
Caron Hitchen, Director of Human Resources	£0-£2,500	£5,001-£7,500	£15,001-£20,000	£50,001-£55,000	£233,307	£197,417	£18,106	
Fionna Moore, Medical Director	£2,501-£5,000	£7,501-£10,000	£30,001-£35,000	£100,001-£105,000	£584,154	£500,229	£49,993	

** 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

	2005-06	2004-05
	£000	£000
Management costs	12,226	11,079
Income	215,645	192,256

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.

	2005-06	2005-06	2004-05
	Number	£000	£000
Total bills paid in the year	58,453	52,112	45,280
Total bills paid within target	46,215	43,999	39,948
Percentage of bills paid within target	79.06%	84.43%	88.22%

External Financing

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

	2005-06	2004-05
	£000	£000
External financing limit set by the NHS Executive	9,640	(13,103)
External financing requirement	9,640	(13,103)
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

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

The Capital Resourcing Limit (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 CRL. The CRL is accruals based as opposed to the cash-based EFL in NHS Trusts.

Underspends against the CRL can be carried forward (but should not exceed 5 per cent of the CRL). Overspends against the CRL are not permitted.

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

Capital cost absorption duty

The financial regime of NHS Trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. The Trust is required to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, bears to the average relevant net assets of the Trust. To meet this duty the Trust must achieve a rate between 3 per cent and 4 per cent.

Photography:

Andrew McArthur: *page 11 (bottom)*

Communications Directorate, London Ambulance Service NHS Trust: *pages: 4, 5, 8-9 (top), 8 (bottom), 10 (bottom), 11 (middle), 14, 15, 18-19 (bottom), 20, 22 (top and bottom), 25 (bottom), 26*

Elliott Franks: *page 16*

Newscast: *pages 6, 12, 13, 21*

Pan 3Sixty: *pages 10-11, 18-19, 24-25 and cover*

Press Association: *page 9 (bottom)*

Ted Sepple: *page 23*

The People: *page 17*

Vauxhall: *pages 7, 24 (bottom)*

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