

NHS
London Ambulance Service
NHS Trust

Annual Report & Accounts 2018/19

Our vision

Building a world-class ambulance service for a world-class city

London's primary integrator of access to urgent and emergency care

on scene • on phone • online

Our purpose

We exist to:

Provide outstanding care for all of our patients

Be a first class employer, valuing and developing the skills, diversity and quality of life of our people

Provide the best possible value for the tax paying public, who pay for what we do

Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London

Our values & behaviours

Respectful

Caring for our patients and each other with compassion and empathy

Championing equality and diversity

Acting fairly

Professional

Acting with honesty and integrity

Aspiring to clinical, technical and managerial excellence

Leading by example

Being accountable and outcomes orientated

Innovative

Thinking creatively

Driving value and sustainable change

Harnessing technology and new ways of working

Taking courageous decisions

Collaborative

Listening and learning from each other

Working with partners

Being open and transparent

Building trust

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Chair's Foreword



London Ambulance Service is defined by its people and the considerable achievements in this report are a tribute to their hard work and dedication.

In May, NHS Improvement took us out of "special measures" and I am grateful for the resilience and resourcefulness our staff have shown throughout some testing years. They were rightly recognised by CQC inspectors for going "above and beyond".

Londoners also rate us highly. At a time when the public is losing confidence in institutions, people have faith in us and highly value our staff. According to a survey by the London Assembly, nine out of 10 Londoners have trust in London Ambulance Service.

To maintain that trust, it is essential our workforce better reflects the diversity of the patients we serve. We are committed to our Workforce Race Equality Standard action plan and have launched sponsorship and mentoring schemes to help Black and Minority Ethnic staff develop their careers within the Trust.

This year we have met our target of 15 per cent BME representation. But we are far from complacent. I recognise the culture at London Ambulance Service needs to be more inclusive and truly reflect our values which demand we are: respectful, professional, innovative and collaborative. We have commissioned a review to look at how best to engage stakeholders to ensure they are well informed; and that we are meeting patients' needs as we adapt to the changing demands made of us.

This work should enable us to be an integral partner in the development of urgent and emergency care in London. This is crucial now we are working within the context of the NHS Long Term Plan which was published in January 2019. We value the work the Patients' Forum has provided in helping us move forward with our strategy.

As well as looking forward, we have had a chance to reflect on just how far we have come in this milestone year, with the NHS turning 70. We are no longer "ambulance drivers" but a professional and highly skilled organisation. We are pioneering medical and technological innovation with ambitions beyond pre-hospital care. We are not just an emergency response service: we work to make London a better and safer place.

I am particularly proud of the work we do to protect those who are vulnerable and prevent them from coming to harm. Our education team has never been in more demand for the workshops they run teaching schoolchildren and young people about the dangers of carrying a knife. We see first-hand the devastation knife crime causes in our communities.

Chief executive Garrett Emmerson and I were privileged to be invited by HRH the Prince of Wales to Clarence House in December to discuss knife crime with charities and young people who have been affected. This event gave real urgency to my ambition to develop this work further.

Responding to knife crime has also seen us working collaboratively with the rest of the health sector as well as our colleagues in the Metropolitan Police Service and London Fire Brigade. We will draw on these partnerships further as demand grows for our service.

We also owe a real debt of thanks to our team of volunteers. Emergency responders and community responders are clinically trained to respond to 999 calls across London alongside our staff. Beyond that we have trained thousands of people in life-saving skills and how to use a defibrillator and so they can treat patients until we arrive.

I would also like to thank Jessica Cecil and Robert McFarland who have stepped down from their roles on our Trust Board after many years of dedicated service. I am delighted however to welcome two new Non-Executive Board members – Professor Karim Brohi and Dr Mark Spencer – who will bring immense clinical expertise to their roles. One from the perspective of advanced trauma care, the other from urgent care. They join a Board rich in experience and passion who are helping us improve our processes and how we are run.

All the improvements set out in this report have been driven forward by our Chief Executive Garrett Emmerson. He heads a leadership team of people with exceptional skills, knowledge and experience. Among them are Director of Operations Paul Woodrow who was awarded an OBE in the New Year's Honours list while our Head of Emergency Care Pauline Cranmer received the Queen's Ambulance Service Medal.

Looking back at our achievements of the past year helps us to move forward. We can celebrate our successes while learning from our mistakes and reflect on the work we still have to do.

None of it would be possible without the continuing commitment of our staff but also our partners who are working with us to deliver the best care for those who live in, work in and visit our city.

Heather Lawrence

Heather Lawrence OBE

Chair

Chief Executive's Foreword



Following our exit from NHS 'special measures' in May 2018, this has been a year of consolidation for London Ambulance Service, building on an immense amount of work over the last few years by all of our staff, as we continue to face significant challenges.

Like other NHS trusts we are managing increasing public demand while striving to recruit and retain skilled staff. The squeeze on public funding only intensifies the pressure – on our service and the wider NHS.

For our 999 service, December and January have been the two busiest months since our records began, with crews responding to more than 100,000 incidents each month.

Demand for our 111 integrated urgent care services is also at record levels. Calls to our south east London service have gone up by 14 per cent in the last year while our north east service answered 67 per cent more calls in March than when it launched eight months ago.

Within that context though, our performance has been consistently among the best in the country. Compared to other ambulance trusts our response times for our most life-threatening emergencies (category 1) continue to be among the fastest. Our south east London 111 service has the best call answering response times in London and the north east London service, the lowest transfer of calls to 999 ambulance services.

However, not all 999 calls require an ambulance. Reducing unnecessary trips to hospital is already a defining part of our strategy. We have developed pioneer services which will have the potential to reduce the proportion of patients we take to hospital.

These bespoke services for maternity patients, urgent care, mental health patients, elderly fallers and end-of-life care mean we are providing the best possible care for people. They also provide the best possible value for the tax-paying public. With that in mind, we have delivered a balanced budget, meeting our control total of £4.4 million.

Digital innovation will enable us to make further improvements in care and efficiency. Ambulance crews all have iPads to help them access patient records and stay connected to colleagues. Better use and analysis of our data is enabling us to deliver safe, effective and consistent care for our communities. We are investing in our digital strategy and the possibilities for our staff and our patients are both inspiring and exciting.

Equally ambitious is our goal to increase volunteering and we aim to recruit one per cent of Londoners to become "Life Changers" – in the long term this could create around 100,000 new volunteers.

This year we have also agreed a partnership with South Central Ambulance Service (SCAS) to share learning and best practice. The collaboration will enable both organisations to identify and eliminate unwarranted variation to improve efficiency, productivity and performance.

We are moving forward at a great pace – transforming our 999 emergency service into one that meets the changing and complex needs of our communities. The job of my team is to ensure no one is left behind: our services must be well led and staff must be supported in their demanding jobs – whether they are on the road, in our control rooms and call centres, or working to support these frontline teams.

None of the progress we have made could have happened without the extraordinary people who work at London Ambulance Service. I know I speak for the whole leadership team when I say it was a great honour to see the Service recognised by His Royal Highness, The Prince of Wales when he visited in November. He finished his visit by thanking everyone across all departments for the work they do every day.

It is a sentiment I can only echo as we strive towards becoming a world-class ambulance service for this world-class city.



Garrett Emmerson
Chief Executive



3 About Us

At London Ambulance Service, our 999 service answers up to 6,000 calls and attends more than 3,000 emergencies every day – making us the busiest ambulance service in the UK.

We are the only London-wide NHS trust and employ more than 6,000 people, including volunteers across London. Our teams serve more than 8.5 million people who live and work across the city, covering 620 square miles.

Demand for our services increases every year and in 2018/19, we answered nearly 2 million emergency calls and treated more than 1.1 million patients.

We also deliver 24-hour NHS 111 integrated care services in south east and north east London to help patients whose needs are less severe. The combined services are expected to answer around 1.4 million calls next year.

Calls Handled			
	999		CALL 111
Calls	1,937,210	Calls	772,262

Our fleet is constantly being developed. Our staff respond in ambulances, cars, motorbikes, on bicycles or by helicopter.

Working across one of the world's most dynamic and diverse cities presents specific challenges. We therefore work hard to ensure our services are accessible to all Londoners.

Our services are contracted by 32 clinical commissioning groups (CCGs) and NHS England. Our work demands close collaboration with hospitals, mental health trusts and other specialist trusts across London. We also work with the five sustainability and transformation partnerships (STPs) across the city.

In addition we work and plan with the capital's other emergency services, London's Air Ambulance and London's Resilience Forum to ensure we are ready to respond to major incidents and keep our city safe.

We are governed by a Trust Board, which formally every two months. It is made up of 13 voting members: a non-executive chair, seven non-executive directors, and five executive directors (including the chief executive).

The trust board

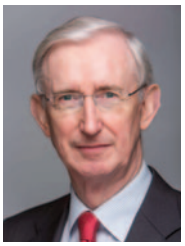
Non-executive directors



Heather Lawrence OBE
Chair



Theo de Pencier
Deputy Chair



Fergus Cass



Sheila Doyle



John Jones



Karim Brohi



Jayne Mee



Mark Spencer



Amit Khutti
Associate

Executive directors



Garrett Emmerson
Chief Executive Officer



Dr Fenella Wrigley
Chief Medical Officer



Paul Woodrow OBE
Director of Operations



Lorraine Bewes OBE
Chief Finance Officer



Dr Trisha Bain
Chief Quality Officer

3.1 Our services

To meet the needs of all Londoners requiring emergency and urgent care we provide the following services:

- Taking and prioritising and allocating 999 calls
- 999 emergency and urgent care response
- 111 integrated urgent care services for south east and north east London – providing help to members of the public with less serious illnesses and injuries
- Dispatching and providing paramedics for London's Air Ambulance
- Non-emergency transport service for patients who do not need clinical intervention during the journey.
- Planning for, and responding to, large-scale events or major incidents.

Our main role as an ambulance service is to respond to 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible. However, many of our patients do not need an ambulance on blue lights and sirens; nor to be taken to hospital. We have a range of clinicians to respond to less critical situations and part of their skill is deciding the most appropriate pathway for their patient.

Frontline services are structured across five sectors of London which gives us the flexibility to respond to local need.

Our 111 integrated care services are changing the way patients can access health services. In line with the NHS Long Term Plan, we have developed our 111 services to give complete care while reducing the pressure on emergency hospital services. Everyone calling the free 111 number will be assessed and can be offered immediate advice or referred to an appropriate clinician. Patients can also get prescriptions or book appointments – ahead of the Long Term plan target to have these facilities in place by 2020.




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3.2 Our vision, purpose and values

We are an ambitious organisation: we want to achieve outstanding care for our patients while providing a rich and supportive workplace for our people. Over the last year, in consultation with our staff, we have developed our vision, purpose and values to give a clear focus to all that we do. They define who we are and set out our direction and standards for transformation.



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Caring for our patients and each other with compassion and empathy

Championing equality and diversity

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Professional

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Aspiring to clinical, technical and managerial excellence

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3.3 Performance summary

Measure	2018/19	2017/18
Total 999 calls	1,937,210	1.892,660
Incidents attended	1,140,980	1,128,348
Average response time Category 1	00:06:28	00:07:17



NHS 111 services		Apr 2017-Mar 2018	Apr 2018-Mar 2019	
Measure	National target	SEL	SEL	NEL**
Total number of calls	-	364,024	415,175	357,087
Average calls per day	-	1,000	1,141	1,380
Calls answered within 60 seconds	95%	322,279 (90%)	337,662 (84%)	252,573 (75.3%)
Calls abandoned after 30 seconds	No more than 5%	3564 (1%)	8217 (1.9%)	15,745 (4.4%)
Calls referred to 999***	<10%	8.20%	9%	7.3%

**NEL went live on August 1, 2018

***Calls referred to 999 – covers data until Feb 24, 2019 (for the period 2018-2019)

Finances	2018/19	2017/18
Total Revenue	£389.3 million	£364.7 million
Total Expenditure	£382.7 million	£359.0 million
Year-end surplus	£6.6 million	£5.7 million

Investment	2018/19	2017/18
Capital Expenditure	£21.5 million	£23.3 million
The surpluses generated in year are used to fund additional capital investment.		

4 Our Patients



4.1 Who we care for

We care for a growing population. The birth rate is high and Londoners are living longer. As the population ages, health needs become increasingly complex and more long-term.

The size, diversity, history and capital status of London brings tremendous opportunities but also creates unique challenges.

Our service has had to adapt to meet the changing demands made of it. As well as providing emergency care, we also respond to urgent care patients. We are supported by partners who make it possible to deliver world-renowned healthcare in an ever-evolving environment.

Many patients who require assistance from us have never contacted the service before and our clinicians have no previous information about the patient they are treating. To address this, all frontline ambulance clinicians have iPads which enable them to access up to date patient information through the Coordinate My Care (CMC) app. This process is in accordance with the wider recommendations made by NHS England and NHS Improvement for information sharing.

We have worked closely with paediatric units to support them using CMC and have received positive feedback. We are now encouraging other providers to adopt this technology to help improve the care provision for all the patients we look after.

Experiences of our emergency and urgent care services are consistently positive with patients having a high level of trust and confidence in the clinicians who treat them.

4.2 Responding to patients with life-threatening and life-changing injuries

Every day, our crews will treat 3,000 patients – nearly 10 per cent of those are people with a life-threatening illness or injury.

Caring for our most critically ill patients is a core priority – in 2018/19 we consistently met the target response time for Category 1 incidents.

We have highly trained and skilled clinicians who prioritise life-saving interventions and make quick decisions to maximise patients' chances of a good recovery.

After appropriate assessment, crews can transfer a patient to hospital or a specialist unit which is best equipped to treat their condition. For specific patients these may include major trauma centres, stroke units and heart attack centres.

Cardiac patients

We have some of the best outcomes for cardiac arrest patients among UK ambulance services with survival rate close to 10 per cent. When an advanced paramedic is dispatched to specific cohorts of cardiac arrest patients, there are higher rates of survival to discharge from hospital and in return of spontaneous circulation (ROSC).

Bystander cardio-pulmonary resuscitation (CPR) rates have increased to a 10-year high which is reflected in the improved outcomes for cardiac arrest patients.

Cardiac arrest patients, who have a ST-elevation Myocardial Infarction (STEMI) and have achieved stable ROSC on-scene, are conveyed to a Heart Attack Centre (HAC) as part of an innovative specialist pathway.

Of the 546 patients conveyed to a HAC, 420 patients had a suspected STEMI. Survival to hospital discharge for patients within this subset of patients remains high at 42.4 per cent.

Heart attack patients

London Ambulance Service continues to maintain a high standard of care for heart attack (STEMI) patients, with a good level of assessment and treatment.

The average call-to-balloon time was 127 minutes – well within the national target of 150 minutes. Over 99 per cent of patients were conveyed to the appropriate destination, a diagnosis of STEMI was confirmed at hospital for 67 per cent of patients with 89 per cent receiving surgical treatment to unblock arteries.

Stroke patients

Ischaemic stroke is the most common type of stroke. It happens when an artery is blocked by a clot, cutting off blood flow to part of the brain. Brain cells can be damaged or destroyed because they may not receive enough oxygen. Symptoms may include numbness or weakness on one side of the body and problems with balance, speech and swallowing. The most severe strokes can lead to coma and death.

Stroke patients are given a comprehensive triage on the telephone as well as on scene assessment and, where clinically appropriate, transported to a specialist destination (HASU).

Patients whose symptom onset falls within the clot-busting (thrombolysis) treatment window of 4.5 hours are conveyed rapidly to a HASU following a pre-alert call to the stroke team. Patients whose symptoms are older than 4.5 hours are transported to a HASU under normal driving conditions in order for the patient to be able to benefit from the clinical expertise at a HASU.

A small number of patients who are diagnosed with stroke are transferred to a tertiary unit for a new treatment which is mechanical clot retrieval called mechanical thrombectomy – this aims to restore normal blood flow to the brain, using a device to remove the blood clot blocking the artery. When used with other medical treatments such as clot-busting drugs, and care on a specialist stroke unit/rehabilitation, mechanical thrombectomy can significantly reduce the severity of disability caused by a stroke. We are supporting the roll out of these pathways to continue to improve patient outcomes for stroke patients.

While the mean time from 999 call to arrival at a HASU was 72 minutes for 2018/19 – which is three minutes slower than the previous year – patients with a symptom onset within 4.5 hours, arrived at HASU 10 minutes faster, enabling definitive assessment and treatment within the optimal time-window.

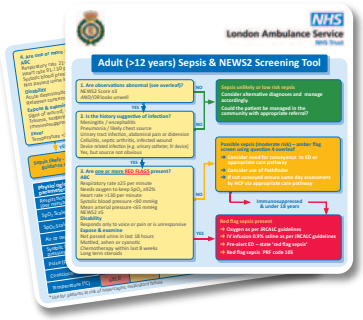
Major trauma patients

Early identification of major trauma patients has helped to improve survival rates and reduce the risk of long-term disability.

Falls make up most of our major trauma cases and the average age of these patients is 60. As London's population is ageing, we have given our clinicians the training to properly assess elderly fallers and recognise trauma.

Knife crime means penetrating injury is common among young people but London has a world-class major trauma system that consistently sees patients survive who would not have done so five years ago.

Early identification of these patients and direct transfer to major trauma centres is crucial in improving survival and minimising long-term disability.



Sepsis patients

We have continued to ensure that both 999 and 111 call handlers remain alert to possible cases of sepsis and frontline clinicians are trained to recognise and manage it appropriately.

In 2018, London Ambulance Service produced a new adult and paediatric Sepsis Card and provided training for all clinicians. The internal clinical performance indicator has consistently scored above 95 per cent through 2018.

Our Clinical Audit and Research team, which is part of the medical directorate, has helped design the new national sepsis Ambulance Quality Indicator which was launched in 2018/19 by NHS England and is reported quarterly.

The sepsis care bundle focuses on adult patients with a National Early Warning score of seven and above and examines observations (specifically respiratory rate, level of consciousness, blood pressure and oxygen saturations), fluid and oxygen administration and the provision of a pre-alert. We are required to supply one month of data from each quarter and have provided three submissions to date.

Our performance is below:

2018-19 sepsis AQI (quarterly)	LAS performance	National average	LAS rank
June	84.9%	68.2%	1
September	91.7%	68.8%	1
December	90.0%	73.3%	1
Ytd total	89.0%	70.6%	1

4.3 Responding to urgent calls

Not all the calls we receive are for life-threatening conditions or emergencies. Urgent care patients now make up a critical mass of our workload. These patients may not be in a life-threatening situation but will often be in a great deal of distress or pain.

We manage these patients through our 111 Integrated Urgent Care Services, 999 Clinical Hub and a range of core and bespoke frontline responses which provide a face-to-face assessment and can then signpost the patient to the right care at the right place in the right time-frame for their clinical need.

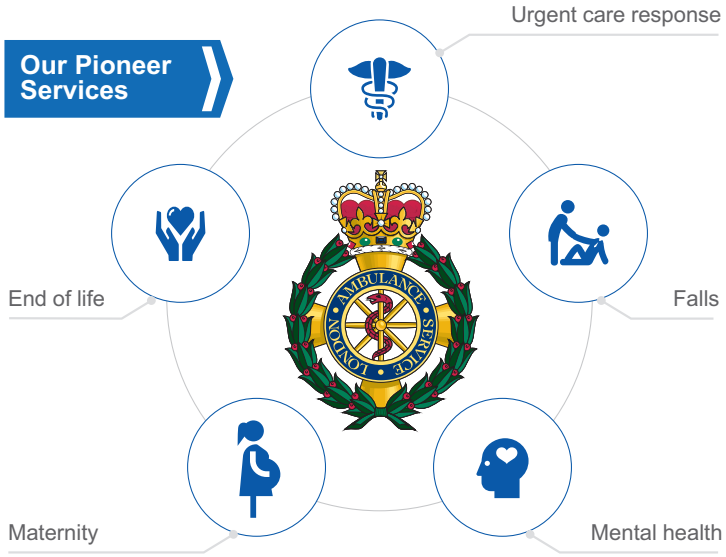
Our 111 telephone assessment services include a multidisciplinary team of General Practitioners, pharmacists, nurses and paramedics. Not only can patients speak to a range of experienced clinicians 24 hours a day, they can also book GP appointments and referrals which is improving outcomes.

Call volumes in our 111 centres have been growing each month, but so is the number of patients who get to speak to a clinician without needing to be transferred elsewhere. Our Consult and Complete rates are high: 27.5 per cent in north east London and 16.7 per cent in south east London (the figure is lower because the service was only fully integrated part way through the year). This means patients' needs are being resolved quickly and there is a high level of satisfaction with the service.

More than seven per cent of 999 calls are handled by the Clinical Hub team, which is one of the highest rates in the country and means thousands of patients are managed without the need to despatch an emergency ambulance and potentially save an unnecessary trip to hospital.

Our advanced paramedic urgent care response pioneer service allows patients to be assessed, diagnosed, treated and referred in their own home or their community. This service is now operational in four STPs with the fifth STP due for roll out in 2019/20.The success of our urgent care response has led to the development of further pioneer services in maternity, elderly falls, mental health and end of life care.

These pioneer services provide a more tailored response and involve a wider mix of skills and professions including advanced paramedics, mental health nurses and midwives.



4.4 Improving care

Clinical strategy refresh

Our organisational strategy sets out how we intend to deliver our ambitions and goals as an NHS Trust. We are refreshing our Clinical Strategy to ensure alignment and enable us to deliver outstanding urgent and emergency care for patients.

At the same time we identified the following drivers:

- The need for a clear clinical career structure for both registered and non-registered clinicians.
- NHSE and College of Paramedic recommendations to establish parity of esteem between urgent and emergency care, including mental health.
- Lord Carter of Coles published a review of 'Operational productivity and performance in English Ambulance Trusts: Unwarranted variations' in September 2018. This identified areas of potential efficiency improvement able to treat and manage more patients with the aim of avoiding conveyance to hospital where possible.
- A need to broaden the workforce to meet patient demands, including greater use of Allied Healthcare Professionals, advanced paramedics and rotational paramedics.
- The opportunity to more fully embrace modern technology, including electronic patients records (EPCR), Skype, artificial intelligence (AI) and remote working.
- The Association of Ambulance Chief Executives 'Vision for the ambulance service: 2020 and beyond', which outlines the steps for ambulance services to 'reposition' themselves at the centre of urgent and emergency care provision.
- The implementation of NHS England's Ambulance Response Programme (ARP) providing a new framework for assessing performance.

Clinical Audit and Research Unit and patient outcomes

Effective clinical audit is vital to the NHS: it enables organisations and clinicians to demonstrate the effectiveness and quality of their service, and work to continually improve patient outcomes.



Our Clinical Audit and Research Unit (CARU) has been recognised nationally for its good practice; the implementation of award-winning initiatives; and a varied programme of research.

The team has written more than 10 publications in peer-reviewed scientific journals, such as The Lancet and New England Journal of Medicine, and contributed textbook chapters on evidence-based practice for paramedics. The unit's work is changing national guidelines, ensuring that innovations in healthcare can be shared across the UK and securing better outcomes for patients.

Changes in clinical guidelines and incidents informed this year's projects which included studies into pain management, drug administration and mental health patients.

Improvement needs are identified and findings are shared with staff through training, infographics and Clinical Update articles. Once recommendations have been implemented, clinical care is re-audited to determine whether patient care has improved. Clinical audit findings were also used to inform the mandatory training for clinicians on medicines and pain management.

London Ambulance Service was part of the Paramedic-2 trial, along with four other ambulance services, looking at the use of adrenaline in cardiac arrest. We treated 2102 patients as part of the trial, with 521 paramedics taking part from North Central and North West sectors.

The results of the trial have now been published in the New England Journal of Medicine (NEJM). The trial found that use of adrenaline results in less than one percent more people leaving hospital alive – but almost doubles the risk of severe brain damage for survivors of cardiac arrest. The research raises important questions about the future use of adrenaline in such cases and has led to debate amongst healthcare professionals, patients and the public.

4.5 Patient and public engagement

The people who we care for – and their families – are at the heart of everything we do. By listening to patients and the public we can improve safety and outcomes. By working in partnership with stakeholders, patient focus groups and wider system partners we can ensure communities are empowered to help shape the future of health services.

Our patients

Our Trust Board meetings are held in public and regularly hear a patient story, usually told directly by the patient involved. This helps to ensure patients feel heard by the organisation and provides an opportunity for Board members to hear about patients' experiences first-hand and for these experiences to provide learning for colleagues across the Service.

The Trust continues to work closely with the Patients' Forum, an independent lay organisation that engages with our work from the perspective of patients and their families. The Forum provides representatives for all our governance committees and its own monthly meetings are hosted at our headquarters, supported by the Patient & Public Involvement Team.



Patients' Forum members meet regularly with our leadership team, our commissioners and other key organisations such as the CQC, to highlight areas of good practice and areas where development is required.

London Assembly

This year the London Assembly Health Committee conducted a nine-month investigation into the work of London Ambulance Service. It also commissioned new research and conducted an online focus group to get the views and perceptions of Londoners' about ambulance services.

Both pieces of work fed into a report which aims to strengthen the partnership between the Greater London Authority and London Ambulance Service.

The report made a series of specific recommendations which highlighted: the importance of aligning our strategic goals; how the Mayor can support our workforce; how we can be supported in the wider urban environment; and how we should better engage with London's diverse communities. It was also recommended that the Mayor should review membership of the Board and invite us to join the London Health Board. We have agreed to report annually to the Health Committee which has suggested ways we can better engage with Londoners, particularly younger people.

Friends and Family Test (FFT)

The Trust continues to be required to record Friends and Family Test (FFT) responses from "see and treat patients", although the response rate remains low. The total number of FFT responses received in the period April 2018 to February 2019 was 31. Almost all patients who responded to the question said they would either be "extremely likely" or "likely" to recommend their friends and family to London Ambulance Service if they needed similar care or treatment.

The National Ambulance Service Patient Experience Group is in discussions with NHS England and NHS Improvement, to highlight the limitations of this methodology and discuss alternative methods of engagement. The requirement to record FFT responses will probably end in 2019/20.


PARAMEDIC
LONDON AMBULANCE SERVICE
NHS

Community engagement events

Paramedics and ambulance staff have a valuable opportunity to improve the health, wellbeing and outcomes among the more vulnerable people in society.

We are leading the way in delivering preventative interventions and commit to a wide range of public events. Our Public Engagement and Education team was asked to attend 763 events in 2018/19. Of these, the team was able to attend 528: that is 69 per cent of all requests made. This is due to the ongoing support of more than 1,300 staff on our database, with more than 300 individuals taking part in multiple events, often in their own time.

We use a closed Facebook group for staff involved in public engagement as another method of communication and engagement with them. Through this group we provide information about the team and forthcoming events, and staff can post their own ideas and questions for members of the team to answer. This has been extremely successful, and the group has over 700 members.

The Public Education Officers focus mostly on activities involving children and young people, such as awareness sessions on the dangers of using alcohol and other legal highs; careers in London Ambulance Service; and multi-agency road safety events such as Safe Drive Stay Alive and Biker Down. Many of these are carried out with partner organisations.

We have delivered our knife crime presentation to tens of thousands of young people including gang members, ex-offenders and pupils in referral units. There is unprecedented demand for our hard-hitting sessions and we regularly visit secondary schools across London to educate children about the grim reality of carrying knives. We also use these opportunities to teach CPR and other life-saving skills.

We have developed some new resources to support all our educational activities: a book for young children ("Brett and Shudi tell you about the ambulance service"), a 360 degree virtual ambulance which can be shown on an iPad or other tablet device, and a recording of a child making a 999 call.

Staff development and training

The Patient and Public Involvement Team ran a four-day course in November 2018 for staff who volunteer to undertake patient engagement work for the Trust. The course is well-established and updated and adapted each year from the feedback received and the Trust's changing public education priorities.



5 Our People




LONDON
AMBULANCE
8462
NO
PARK



2,148 PARAMEDIC

1,405 EMERGENCY AMBULANCE CREW/ MEDICAL TECHNICIAN

500 999 CALL HANDLING SERVICE

OVER 300 111 CALL HANDLING SERVICE

38 NURSING & MIDWIFERY

OVER 150 NON-EMERGENCY TRANSFER SERVICE

We employ more than 5,800 people – our numbers have risen by more than 10 per cent in the last year to keep up with growing demand for our services. With close to 300 volunteer responders, London Ambulance Service has more than 6,000 people helping to keep Londoners safe.

Most of our staff are in direct contact with our patients - whether in ambulances on the road or in our 999 and 111 call centres.

Our frontline crews and call handlers in our 999 and 111 centres could not work without the considerable effort of the people working behind the scenes to support our service. These include those looking after our vehicles, equipment and buildings; IT, finance, education, communications, people and culture and many others.

Our strategy presents opportunities for our employees to extend their skills and experience as well as setting out the need to attract skilled professionals to the service – such as midwives,



mental health nurses, pharmacists, GPs and other allied healthcare professionals.

The average length of service with us is eight years but more than a third of staff have worked for London Ambulance Service for more than 10 years.

5.1 Diversity and inclusion

We are working towards ensuring our workforce reflects the diversity of the population it serves in London. We end 2018/19 achieving the target we set ourselves for 15 per cent of our workforce from Black and Minority Ethnic backgrounds.

We have a bold Workforce Race Equality Action Plan to address our ongoing challenges in this area. We are also developing an action plan which focuses on disability.

Progress during the year 2018/19 includes:

- Co-designing and launching our second Workforce Race Equality Standard Action Plan. This plan goes further than before and we have set out three main themes: Senior Trust Leadership, Workplace Experience and Recruitment and Development.
- We have launched two mentoring schemes – Reverse Mentoring and Sponsorship Mentoring, with the latter scheme specifically targeted to support BME colleagues with their progression through the organisation.
- We have trained a wide range of colleagues in interview skills to ensure that we have appropriately trained people and can field diverse interview panels.
- BME representation on all interview panels for senior posts.
- Improved the diversity of our Trust Board.
- Refreshed the work of the BME Staff Network so that a programme of work can be planned and delivered.
- Launched our Women's Network with the first two events in January and March 2019.
- Developed our plans to establish our base data for the Workforce Disability Equality Scheme.
- Held "big conversations" about race and bullying and harassment with our senior management group (top 500 people) to support our culture development work.
- Engaged with our partner universities to gain their support to improve the diversity of students on paramedic science courses.



Performance against WRES indicators

In 2018/19 we have again reported against eight of the nine WRES indicators and have shown some good progress, with the focus on addressing areas where there is clearly more work to be done:

WRES Indicators		2015/16	2016/17	2017/18	2018/19	Movement
Workforce indicators	**Indicator 1:** Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	BME: 11%	BME 12.7%	BME 13.5%	BME 15%	↑
	Indicator 2: Relative likelihood of staff being appointed from short listing across all posts.	No data	1.7 times more likely to be appointed if white than BME	1.8 times more likely to be appointed if white than BME	2 times more likely to be appointed if white than BME	↔
	Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	No data	BME staff are twice as likely to enter the formal disciplinary process compared to white staff.	BME staff are twice as likely to enter the formal disciplinary process compared to white staff.	BME staff are 1.6 times as likely to enter the formal disciplinary process compared to white staff.	↓
	Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.	No data	No data	No data	White staff 0.99 times more likely	
National staff survey indicators	**Indicator 5:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	White: 56% BME: 35% Difference: 21%	White:56% BME: 34% 22%	White: 57% BME:39% 18%	White: 58% BME:42% 16%	↔
	Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White 38% BME 40% Difference: 2%	White: 32% BME: 32% 0%	White: 31% BME: 38% 7%	White: 28% BME: 32% 4%	↓
	Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progressing and promotion.	White: 63% BME: 42% Difference: 21%	White: 74% BME: 57% 17%	White: 62% BME: 47% 15%	White: 68% BME: 51% 17%	↔
	Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / Team Leader or other colleagues	White: 13% BME: 25% Difference: 12%	White: 9% BME: 18% 15%	White: 11% BME: 19% 8%	White: 10% BME: 17% 7%	↔
Board representation indicator	**Indicator 9:** Percentage difference between the Organisations Board voting membership and its overall workforce. NB. Only voting members of the Board should be included when considering this indicator.	White: 100% BME: 0%	White: 100% BME: 0%	White: 100% BME: 0%	White: 93% BME: 7%	↑

Regular discussions are held at our Equality Group and People and Culture Committee to gain views, input and ideas on how to further improve.

Our gender split is 44 per cent female and 56 per cent male and our gender pay report shows that while the Trust is doing fairly well overall, we need to close the gap at the higher levels of the organisation and over bonus payments. We are working to solve these problems, and have set up a working group to investigate this data and to recommend improvements.

We already have a range of family-friendly policies and our maternity policy is being revised. We are training our staff to help them guard against unconscious bias, particularly for more senior posts. We will do all we can to discover and remove the barriers which stop women.



5.2 Recruiting new people

In 2018/19 we recruited over 850 people across our core front line roles. Our overall vacancy rate on 31 March 2019 was 4.6 per cent; an improvement on our 5.9 per cent vacancy rate last year.

We work closely with our partner universities offering paramedic science degrees and have recruited more than 180 paramedic students this year.

We had a successful recruitment trip to Australia and made 202 offers of employment. We have made similar trips for the last few years and now have more than 500 international paramedics working for the Trust, representing a quarter of our paramedic workforce. We have a very strong partnership with Australian universities, employers and other key stakeholders to continue our work to address the shortage of skills in the UK.

We recruit from Australia because their universities have been offering a degree programme for paramedics for more than a decade which means the quality of graduates is high and reliable.

The level of training meets our requirements and the similarities between our ambulance services makes it an easier transition for the recruit.

We have created extra positions in our 999 control rooms to handle the increasing number of calls we receive. Nearly 170 emergency call handlers have joined our team after an impressive recruitment drive.

We have also completed a restructure across these teams to ensure clarity of role; create clearer career paths; and to improve the terms and conditions of employment on offer.

Progress during 2018/19:

- We have further developed our key workforce planning tool to ensure we managed recruitment in an informed and responsive manner.
- We have collaborated with other ambulance trusts to build a picture of paramedic workforce requirements to inform national discussions on investment required from NHS England and Health Education England.
- We have launched our Strategic Workforce Planning Group to give assurance of a sustainable paramedic-led workforce for Londoners.

5.3 Retaining, developing and supporting our people

We have improved the reporting and analysis of our workforce to understand the nature of turnover across the organisation to design interventions to retain our paramedics and other trained and skilled staff members.

The Trust continues to experience higher than average turnover rates at 11.5 per cent (when compared to other ambulance trusts). Retention efforts have focused on our EOC team including: a restructure to address role clarity and lack of progression; the introduction of a part time roster; a range of well-being initiatives to support employees and improve attendance; and the implementation of professional apprenticeship pathways. Other initiatives to improve, through the introduction of the new electronic staff leavers form and more comprehensive use of exit questionnaires.

It is essential people feel they can enjoy a meaningful career within London Ambulance Service.

The introduction of our pioneer services has made a major contribution to this and we will continue to better define and evolve career pathways to offer options for progression and training to support retention. We recognise that this work will need further investment as the vision for the NHS Long Term Plan offers increasing opportunities for our people outside the traditional ambulance setting.

Appraisal

Appraisals are essential in developing and retaining employees. They allow managers to improve performance and efficiency by ensuring people develop their potential. Appraisals should also identify training needs and can be an opportunity to spot and nurture talent.

Everyone has the opportunity for these career conversations which focus on continuous development. We have ensured that 85 per cent of people are able to engage in their appraisal discussion but now we need to ensure the quality of our appraisals are improved and the process translates into culture and behaviour change for the organisation. This was reflected in our staff survey results.

We are planning to introduce online appraisals which will improve the way we capture training needs and career development activities.



The LAS Academy

We launched our internal academy in 2016 and year on year we increase the number of places available for our staff to pursue a paramedic career. We now offer 108 places each year.

The Trust's bursary programme has resulted in 285 staff enrolled into further education courses, supported by Health Education England investment.

Coaching and mentoring

At London Ambulance Service, we recognise we can boost performance and productivity by empowering our people. Coaching is a proven way to motivate staff and it also leads to increased confidence which in turn increases creativity, learning and knowledge.

We have established a Coaching Steering Group to encourage a coaching style of management and encourage people to develop their leadership style. We have also introduced two mentoring programmes during the year.

The Sponsorship Mentoring Programme is focused on supporting the progression of our BME colleagues to improve representation in senior posts.

The Reverse Mentoring Programme has been designed to become a vehicle of culture change for the Trust. Mentors come from a variety of roles across the organisation and the mentees – executives and senior managers – develop their knowledge or skill in a certain field. This innovative programme is funded by Health Education England.

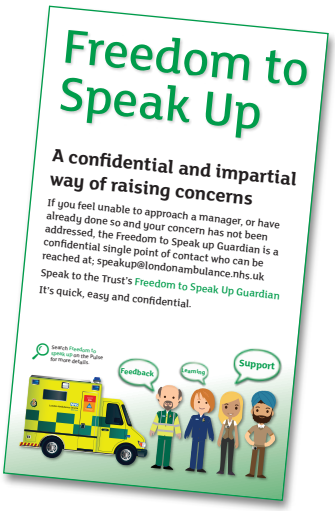
Induction

Integrating new staff into our organisation is fundamental to ensuring the best workplace experience. We aim to welcome all our people through the induction process: setting them up with an understanding of the Trust's vision and values and ensuring they have all they need to succeed at work. Improvements have been made across the year, including combining clinical and non-clinical staff into one induction event. The Trust has commissioned and completed a project to look at this in greater depth and identify key areas for improvement. The actions identified will be delivered during 2019/20.

Emotional and mental wellbeing

Working in a demanding environment like London Ambulance Service can be stressful and challenging. We continue to develop our LINC Peer Support network led by our in-house psychotherapy specialist and work with our external partners to offer support for the physical and mental wellbeing of our staff. This ranges from physiotherapy to counselling interventions to suit the needs of individuals.

Freedom to Speak Up



London Ambulance Service was found to be the most improved NHS trust in England for fostering a positive speaking up culture. When NHS England analysed staff survey results to assess the Freedom to Speak Up (FTSU) culture in trusts, it found our performance indicator score had increased by 18 per cent between 2015 and 2018. We have been asked to document the actions taken to achieve these improvements so other organisations can improve their own speaking up culture.

In 2018/19 some of these actions included:

- Appointing a full-time substantive Freedom to Speak Up Guardian following a competitive recruitment process. The Guardian has monthly 1:1s with the Chief Executive and is able to take an external leadership role as co-chair of the National Ambulance Network of Guardians and part of a supervision research group looking at implementation support for Guardians.
- Ensuring that Trust Board members undertook a self-assessment of leadership and governance arrangements in relation to Freedom to Speak Up using the self-review tool provided by NHS Improvement and the National Guardian's Office.
- Developing a Freedom to Speak Up Strategy, that was approved by the Trust Board in September 2018.
- Appointing a network of 20 Freedom to Speak Up Advocates, ensuring that they have received training from the National Guardian's Office
- Implementing a revised communications plan to improve the visibility of Freedom to Speak Up and the Guardian across the Trust, leading to a significant increase in the number of concerns received.

Developing and implementing a detailed improvement action plan to ensure the delivery of the Trust's Freedom to Speak Up Strategy, evidence the Trust's commitment to embedding speaking up and help oversight bodies to evaluate how healthy its speaking up culture is.

- Continuing quarterly Freedom to Speak Up steering group meetings, which since January 2019 have been expanded to take place alongside quarterly Dignity at Work meetings.
- Continuing to report quarterly to the Trust Board on the progress of FTSU activities within the Trust.

The Trust's Freedom to Speak Up Strategy has the following four themes:

1. Engaging senior leaders to ensure FTSU is given appropriate prominence within the Trust
2. Ensuring that all members of staff know and understand about FTSU and the role of the Guardian
3. Ensuring that the systems/processes/structures are in place to support raising concerns and responding to these and learning from them
4. Facilitating culture change, alongside the People and Culture directorate

The total number of concerns raised in 2018/19 was 118 which is a significant increase to the previous year when we had nine cases.

This increase is largely down to an increase in communications and engagement activity. A FTSU Guardian was appointed in July 2018 in a part-time capacity. The role became full time in December 2019 due to the volume of concerns and 20 FTSU advocates have been recruited across the service.

5.4 Recognising our people



We continue to recognise the great work of our people across the Service – our annual VIP Awards are a clear example of this.

In 2018/19 there were over 360 members of staff recognised through the award nominations process. The annual employee of the year accolade was open to a Service-wide staff vote.

The event was very well attended and feedback continues to suggest that the VIP Awards remain an important element of the way that staff are recognised for the great work they do each and every day.



We hold regular Celebration of Service events including a Long Service & Retirement Ceremony in November with more than 500 staff who had served more than 20 years.



We also continue to recognise the day-to-day contributions of staff through internally publishing the names of all those who receive a letter or message of thanks; or reach long-service milestones.



Paul Woodrow, Director of Operations, was awarded an OBE in the Queen's New Year's Honours List for his services to NHS leadership



Pauline Cranmer, Head of Emergency Services Care, received the Queen's Ambulance Medal for distinguished service

Celebration of Service



Our Service and our people have also been recognised by our peers, partners and the public. Here are some of the awards and nominations we received:

April 2018:

- London Ambulance Service won an Outstanding Emergency Response award at the European Emergency Number Association annual conference. We were honoured alongside London Fire Brigade and the Metropolitan Police Service for our exceptional work in responding to the tragedies of 2017.

May 2018:

- Paramedics James Lafferty and Caroline Appleby and emergency ambulance crew Sherridan Best won the Emergency Lifesavers Award at ITV's NHS Heroes award ceremony for saving the life of Britain's youngest gunshot victim.
- Clinical team leader Jim Bradley from Wimbledon was named VIP Employee of the Year for "going above and beyond" to support his colleagues.

June 2018:

- London Ambulance Service won the award for Best Use of NHS Employee Staff Record (ESR) at the Healthcare People Management Awards.
- Paramedic Natalia Croney was awarded a High Commendation from Metropolitan Police Commissioner Cressida Dick after helping detain an armed man.
- Higher education programme manager Paul Bates received a Fellowship to the College of Paramedics for his outstanding contribution to the professional body and to the education and development of the paramedic profession.

September 2018:

- The Service was shortlisted as NHS Trust of the Year in the HSJ Awards. We were the only ambulance trust to be nominated in this category.

January 2019:

- Director of Operations, Paul Woodrow, was awarded an OBE in the Queen's New Year's Honours List for his services to NHS leadership.
- Pauline Cranmer, Head of Emergency Services Care, received the Queen's Ambulance Medal for distinguished service.

February 2019:

- Dispatcher Amanda Cassidy won the honour for Services to the Public in the APD Control Room Awards for her brave work in educating young people about knife crime.
- London Ambulance Service was shortlisted alongside London South Bank University in this year's Student Nursing Times Awards for Student Placement of the Year: Community.

March 2019

- Board member Jayne Mee was invested into the Order of St John for services to St John Ambulance.

5.5 Staff survey results

We had the highest ever response rate to our 2018 NHS Staff Survey which was sent to everyone to complete online. The number of completed questionnaires was 65 per cent – an 11 per cent increase on last year and significantly higher than any other service in the country but we are aiming for an even higher response rate.

The survey revealed significant improvements including:

- willingness to report incidents of bullying
- effective feedback
- fair treatment of staff after an incident
- senior management communication
- recognition for good work

We have provided a 24-hour telephone number alongside the Datix system to make it easier to report incidents. Through Datix, staff are now receiving feedback on the incidents and team leaders and managers can respond directly.

Over the last year there have been several initiatives to improve communication between senior management and staff as well as empowering more people to be involved in decision-making. This has included regular senior manager meetings, CEO roadshows twice a year, weekly CEO video updates and Facebook live sessions.

However we still have some way to go. Staff Survey Champions are trying to boost engagement through improvement groups, discussion forums and suggestion boxes. Some also produced newsletters and held activities locally to encourage better communication. Recognition for good work has increased through schemes put in place by champions to say thank you and celebrate staff anniversaries on time.

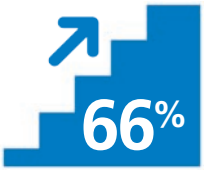
Of the 34 staff survey questions, the top 10 with the highest percentage difference are listed below, as well as the historical data for the last four years.

Most improved from last survey	2014	2015	2016	2017	2018	2017-18 change
Q17d. Staff are given feedback about changes made in response to reported incidents	-	31%	43%	45%	54%	+ 9%
Q17a. Organisation treats staff who are involved in an error, near miss or incident fairly	-	30%	45%	44%	53%	+ 9%
Q21c. Would recommend organisation as a place to work	19%	29%	42%	42%	50%	+ 8%
Q4g. There are enough staff at this organisation	10%	15%	23%	24%	31%	+ 7%
Q5a. Satisfied with recognition for good work	19%	23%	32%	29%	36%	+ 7%
Q9b. Communication between senior management and staff is effective	15%	17%	26%	24%	31%	+7%
Q9c. Senior managers try to involve staff in important decisions	12%	13%	23%	19%	26%	+7%
Q14. Organisation acts fairly: career progression	55%	60%	72%	59%	66%	+7%
Q17c. When incidents are reported, the organisation takes action to ensure that they do not happen again.	-	38%	50%	52%	59%	+ 7%
Q18c. Would feel confident that organisation would address concerns about unsafe clinical practice	33%	34%	49%	49%	56%	+7%

We've made some tangible improvements in some areas:



said they know who senior managers are



said the organisation acts fairly around career progression

But we still clearly have some work to do:



reported their last experience of bullying, abuse or harassment



have experienced musculoskeletal problems as a result of work

Our staff think highly of the care we give, feel increasingly confident that they can raise issues and are becoming more positive about their immediate managers. However only half our staff would recommend London Ambulance Service as a place to work.

Change is not happening fast enough in the areas that matter to our people. We have recognised that managers need to be more consistent in dealing with welfare and wellbeing. Urgent work is being done to improve staff morale; and health and well-being. Every effort is being made to eradicate bullying culture once and for all.

We have made a commitment to ensure we live the visions and values of the Service every day. This means empowering people to challenge behaviour and give honest feedback; we have developed courses to improve communication and given extra training to managers.

Our Dignity At Work week helped to raise awareness of how seriously we take bullying and we have employed experts to develop this further.

London Ambulance Service needs to be an environment where staff feel valued and listened to and crucially, safe. As mentioned earlier, while we have increased the quantity of appraisals, the quality of appraisals must also rise if they are to be meaningful.

Analysis of feedback through 10 key themes shows while we are bottom in one of these indicators, we are above average or average in four areas. The graph below sets out the analysis which shows there is still significant work to do if we want to be an employer of choice in the ambulance sector.

NHS England

2018 NHS Staff Survey Results – Theme results - Overview



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe Environment - Bullying & harassment	Safe Environment - Violence	Safety culture	Staff engagement
Best	8.7	5.3	6.9	5.8	5.3	7.8	7.6	9.0	6.5	6.5
Your org	8.0	4.6	6.3	5.5	4.6	7.2	7.0	8.7	6.3	6.2
Average	8.4	5.0	6.2	5.7	4.6	7.4	7.3	8.8	6.2	6.2
Worst	8.0	4.5	5.3	4.9	3.9	7.0	6.9	8.2	5.8	5.7
No. responses	3,441	3,463	3,492	3,409	2,558	3,261	3,413	3,442	3,442	3,532

5.6 Volunteers

We are grateful to all our volunteer responders who have committed more than 23,000 hours of their own time to support our teams.

We have three different types of volunteer responder:

- **Emergency Responders** – 131 clinically-trained volunteers responding on blue lights alongside ambulances to 999 calls.
- **Community First Responders** – approximately 150 defibrillator-trained St John Ambulance volunteers responding to 999 calls in their own car alongside ambulances.
- **Volunteers at public-access defibrillator sites** – people who work at the 750+ public locations with defibrillators and are trained to respond to emergencies and use the machines while an ambulance is on the way.

Emergency responders

This year Emergency Responders (ERs) were issued the national standard ambulance uniform; a standardisation in their recruitment; and access to the same e-learning opportunities that all members



of London Ambulance Service have. We have also created a monthly ER communications bulletin, rostering system and dedicated intranet pages, ensuring their positions are embedded within our organisation.

We have converted ERs and Community First Responders' training to a FutureQuals Ambulance Service First Responder qualification, increasing their skillset and ability to assess patients with new equipment.

Additional charitable funds have paid for three new replacement response vehicles and training for five ER blue-light drivers.





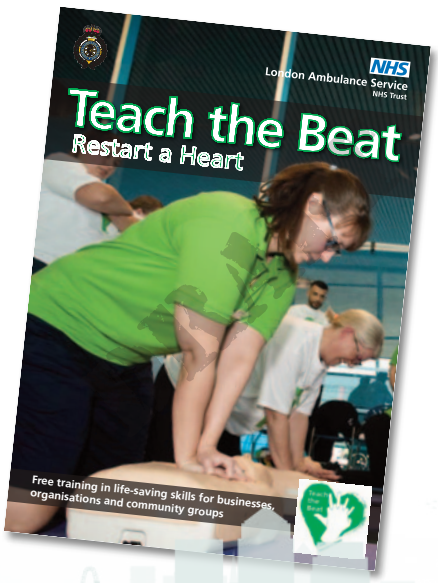
Public defibrillators

Our Cardiac Arrest Report shows the survival rate for patients defibrillated before an ambulance crew arrives dramatically contributes to a patient's successful recovery.

The long-held ambition to have defibrillators available at all London Parkrun sites was finally realised. The individual sites fully funded this project.

We trained London black cab drivers in basic life support skills and fitted vehicles with defibrillators for a pilot scheme we trialled this year.

We developed a scheme, called Teach the Beat, to recruit and train volunteer trainers to deliver our life support skills course. The scheme is a natural extension of the work we do to increase the number of accredited defibrillator sites across the capital.





6 Our Partners



One of three themes in our strategy is: "collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners."

We want to continue to develop collaboration, partnerships and innovation across the full range of public services in London and will support all opportunities to improve patient outcomes and experiences and improve public value.

6.1 Our NHS partners

We work in a complex NHS system where we regularly collaborate with many partners. As the only pan-London NHS provider trust we believe we can be an integral partner in the development of the urgent and emergency care sector in London. We work closely with London's five Sustainability and Transformation Partnerships (STPs) to improve the delivery of care to our patients as the STPs evolve into Integrated Care Systems (ICS).

We continue to work with the 32 Clinical Commissioning Groups (CCGs) in London who commission our 999 services, led by Brent CCG as the lead commissioner. We meet regularly with the CCG representatives to discuss how the different services they commission interact with each other; how we can better use the care pathways available to us; where those pathways work well; and where we struggle to access them.

We are also working increasingly closely with other NHS provider organisations to investigate how we can collaborate to provide the best possible care for our patients. We have started work with mental health trusts to ensure patients with mental health needs are treated in the most appropriate way and in the most appropriate setting. We also work with community healthcare trusts and acute hospital trusts to ensure our plans are aligned and we are all working together on joint initiatives and priorities.



6.2 Working with our emergency services partners

We work closely with the other emergency services to keep Londoners safe and enable us to work efficiently and effectively. While we have a very clear responsibility to respond to major incidents together, we routinely work in collaboration on several initiatives. We have office space at London Fire Brigade's headquarters in Union St and share some space at fire stations. We are investigating whether there are more opportunities to work like this and what the benefits might be.



6.3 Working with London's public services

We have a close relationship with the Mayor of London and the London Assembly and regularly discuss how we can work together for the benefit of the people who live, work and travel in London. We also work with London's local authorities to ensure any developments or plans at a local level include an assessment of the impact that they might have on our ability to respond to patients.

MAYOR OF LONDON

LONDONASSEMBLY

LONDON COUNCILS

6.4 Working with South Central Ambulance Service

London Ambulance Service and South Central Ambulance Service have agreed to formally work together in response to the Carter review into productivity. We have formed an alliance to identify and assess opportunities to improve services, expand capacity, achieve efficiencies, increase value for money and lead the digitisation of healthcare provision in the urgent and emergency care.

Two joint executive team meetings have been held where overviews of the two Trusts' positions have been discussed and challenges identified, allowing directors to identify areas where collaboration will be most beneficial.

These meetings have also allowed the development of Joint Collaboration Principles which set out our intent to share expertise and best practice; and collaborate with a view to reduce costs, accelerate operational/clinical/financial improvements and performance, and maintain/improve the quality of services being provided to patients.

7 Our Public Value



The Trust is committed to providing the best possible value for the tax-paying public, who pay for what we do. We must balance our budget and invest in the service developments necessary to improve our operational productivity. This allows us to play our part in creating a sustainable NHS by reducing our costs per incident each year. This has meant a robust focus on the review of all budgets to ensure they are fit for purpose, and money is directed towards the most valuable activities. We have also developed and prioritised activities which will deliver a positive return on investment in the future – like investing in electric vehicles. This will maximise the public value of our service in the medium term.

In 2018/19, the Trust delivered a strong final performance and improved the efficiency and value of the services we provide. We have delivered a balanced budget, meeting our control total of £4.4 million. This has helped maintain our use of resources rating of 1 – the best rating NHS trusts can achieve. Additionally, we have delivered the entirety of the capital plan, improving on the position of previous years. This has included significant upgrades to our existing fleet, improvement of our estate and laying the foundation for a more technology-driven organisation that will yield significant efficiencies for years to come.

The Trust has also put in greater controls to address agency expenditure and held a major recruitment drive to replace temporary corporate staff with a permanent workforce. We have seen a reduction in the use of agency staff in the last quarter of the year and we should stay within our agency ceiling for 2019/20.

The Trust has also delivered its 2018/19 service development programme to budget.

7.1 Efficiency achievements

To deliver a sustainable NHS, all providers are required to find efficiency savings: to allow the health service's budget to provide more care for more patients each year. The efficiency and productivity programme delivered £12.3 million or 3.2 per cent of overall income.

A Quality Impact Assessment policy was updated and approved by the Executive Leadership Team at the beginning of the year. This provided the necessary assurance to the Trust Board that efficiency savings were made without compromising quality and safety. Most of these schemes involve more efficient deployment of operational staff alongside a focus on improving contract arrangements and better control of clinical consumables.

7.2 Carter Review and recommendations

As referred to in the previous section, Lord Carter of Coles published his review 'Operational productivity and performance in English Ambulance Trusts: Unwarranted variations' in September 2018. The report highlighted the potential opportunity to save £200 million in productivity and efficiency benefits by 2020/21, by reducing variation across the 10 ambulance trusts. The review also proposed that tackling avoidable conveyance to hospital and reducing pressure on emergency departments and wards would save a further £300 million.

The Trust found many of the recommendations in the Carter review matched those set out in our five-year strategy as well as identifying key challenges and actions for the Trust. As well as our collaboration with SCAS, we have embarked upon a range of initiatives which include reducing avoidable conveyances; upskilling the paramedic workforce to increase "see and treat" rates; increasing clinical effectiveness in clinical hubs; and increasing opportunities for patients to be conveyed to alternative care pathways.

8 Quality and Performance



Our focus on the quality of clinical care and patient experiences ensures that we continuously improve our services. Quality drives the direction of our work and puts patients at the centre of everything we do.

We use key performance indicators (KPIs) to measure our quality of care, as well as for response times and finances.

Progress is monitored by our Board, sub-committees and the management team; and findings are published in our board papers which are available at meetings and on our website.

8.1 Quality matters

London Ambulance Service was rated "good" and the care we give to patients was judged to be "outstanding" by Care Quality Commission (CQC) inspectors in May. This gave assurance to our regulators that we could be taken out of special measures.

We are striving to improve our rating. To achieve this, we have delivered a comprehensive action plan based on the CQC inspection findings and established our own quality priorities.

Those priorities focused on patient safety, patient experience and effective care. We set ourselves goals for each of those areas and made significant progress. This has improved outcomes for our patients and staff. We will strive to maintain this through our quality improvement plans for 2019-20 and beyond.

Quality Improvements in 2018/19

- Introduced Sector Senior Clinical Advisors to address quality, clinical effectiveness and supervision and compliance against quality and performance standards.
- Recruited a risk manager to strengthen and embed our risk management systems and processes and ensure staff are trained to understand risk management.
- Implemented the Health Assure system to allow 'real-time' monitoring of quality standards.
- Cut the number of hours lost in handover delays by working closely with emergency departments.
- Implemented secure drug rooms across all sectors.
- Increased the number of defibrillator data downloads from five per cent to 20 per cent to improve management of cardiac arrest patients.
- Completed independent review of training across the organisation.
- Developed new quality indicators which are being reported through performance scorecards
- Agreed our Quality Improvement training programme and have already trained 55 people in this methodology.
- Completed roster review to better meet the organisation's resourcing requirements and enhance the working lives of our staff.

8.2 999 Performance

This is our first full year of working within the Ambulance Response Programme (ARP) which changed the way we categorise our calls in an attempt to improve outcomes by prioritising patients with the greatest need. ARP is about ensuring the right response first time: in practise this means we have more double-crewed ambulances on each shift and fewer solo responders in cars. ARP costs more than the previous way of working.

The main 999 performance indicators measure how quickly we reach patients following a call.

Under ARP, all 999 calls are given categories which are defined as follows:

- Category 1 (Life Threatening): A time critical life-threatening event requiring immediate intervention or resuscitation.
- Category 2 (Emergency): Potentially serious conditions that may require rapid assessment and urgent on-scene intervention and/or urgent transport.
- Category 3 (Urgent): An urgent problem (not immediately life-threatening) that needs treatment to relieve suffering and transport or assessment and management at the scene with referral where needed within a clinically appropriate timeframe.
- Category 4 (Less-Urgent): Problems that are less urgent but require assessment and possibly transport within a clinically appropriate timeframe.
- Category 5 (Non-Urgent): A non-urgent problem which requires home-management advice.
- HCP 1-4 Hours: A referral is received from a healthcare professional who requires an ambulance for a patient at a time to be agreed within the next one to four hours.

999 Performance April 2018 – March 2019

The table below shows, for each category, the number of calls we received and response times we achieved:

Category	National Performance Standards	Apr 2018 - Mar 2019	No. of incidents
Category 1	7 minutes mean response time	00:06:28	128,505
	9 out of 10 people reached in less than 15 minutes	00:10:45	
Category 2	18 minutes mean response time	00:19:16	685,298
	9 out of 10 people reached in less than 40 minutes	00:39:29	
Category 3	60 minutes mean response time	00:53:51	243,942
	9 out of 10 people reached in less than 120 minutes	02:09:47	
Category 4	9 out of 10 people reached in less than 180 minutes	01:19:27	15,972
Category 5	previously known as C4H	no national target	28,305
HCP 1-4 Hours	1-4 hours response is agreed in response to a call from a healthcare professional (HCP)	no national target	39,676
Category O	Other Category – This is an overhang from pre ARP and has now been removed		6
	Face to Face incidents all categories		1,141,704
	Hear and treat incidents		86,607
	Total incidents		1,228,311

Comparison with other ambulance trusts

A national ambulance services balanced scorecard was introduced to monitor how trusts are meeting ARP targets. This scorecard involves weekly reporting of 13 key metrics, including call category response standards; call answering times; time to arrival for Category 1 calls; and the number and nature of serious incidents.

Our performance in 2018/19 has been consistently among the best in the country. The Trust is frequently best in class for the Category 1 mean and 90th centile measures.

Winter planning and performance

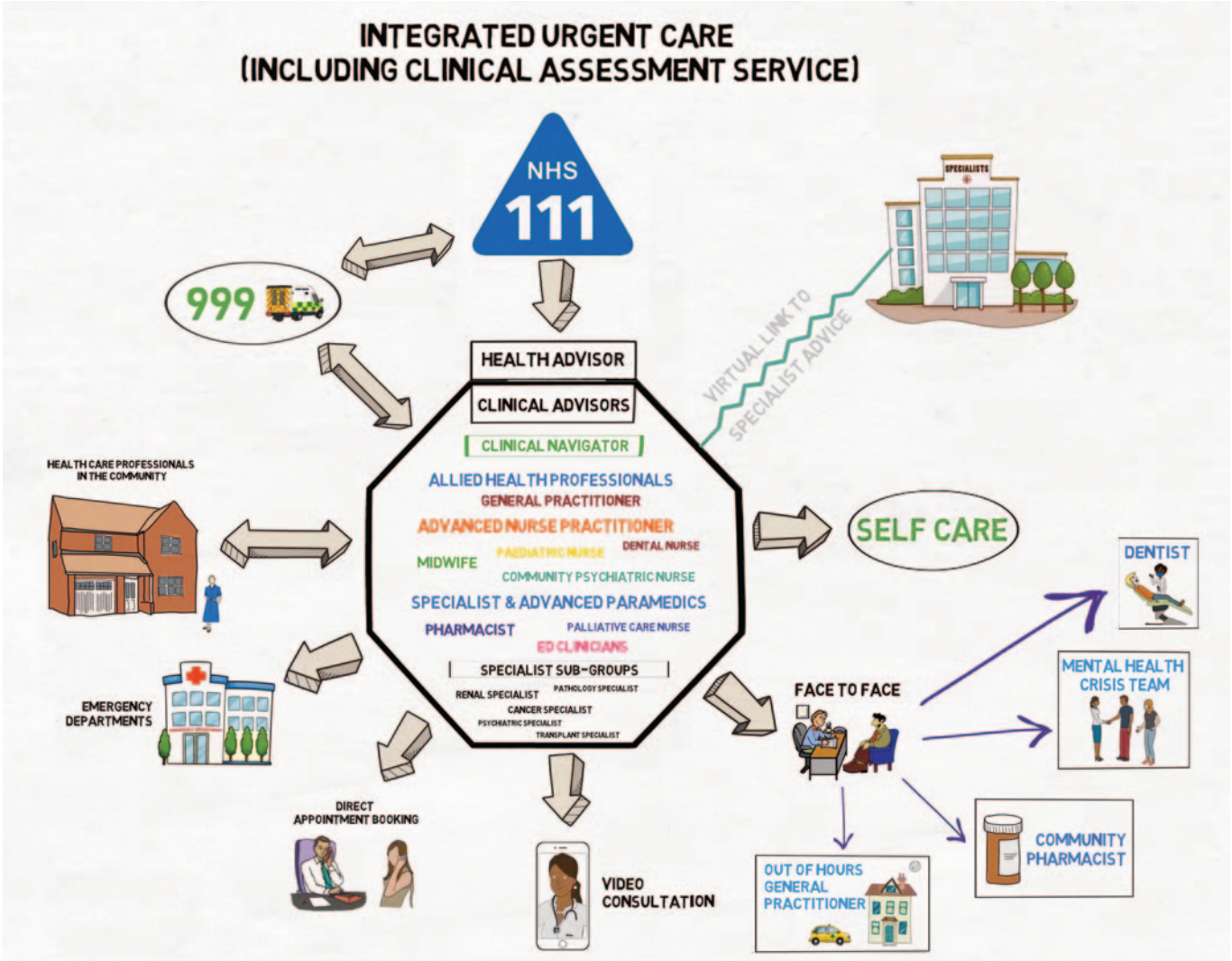
Our preparations for winter pressures in 2018/19 were some of the most detailed we have ever done and helped to ensure that our performance remained strong despite very heavy pressure on our services and the wider NHS. Throughout the winter period we worked closely with NHS England, NHS Improvement, hospitals, clinical commissioning groups and other providers. We worked with hospitals to improve handover times and had a representative in NHS England's "Winter Room" to support planning across the whole of London. December 2018 was the Trust's busiest month on record (responding to over 101,000 face to face patient incidents) however we performed significantly better than the same period last year.

111/Integrated Urgent Care performance

NHS 111 services across England are staffed by fully trained health advisors (non-clinicians) who will advise around 70-80 per cent of patients to contact a clinician, known as signposting. This could be by: calling 999; visiting an Accident & Emergency (A&E) department; speaking to a GP, dentist or pharmacist. Around 20 per cent of callers will be given self-care health advice.

However, in line with the national strategy, we have developed our 111 services to be able to give complete care. Our integrated urgent care (IUC) services – one in north east London (NEL) and the other in south east London (SEL) – are fundamentally changing the way patients can access health services. Patients can be given advice, a prescription, or an appointment for further assessment or treatment. As many calls as possible to NHS 111 will involve consultation with an appropriate clinician within the call centre, reducing the need for referral or additional signposting. This results in more patients being offered self-care advice, fewer ambulance journeys and A&E attendances.

The IUC clinical assessment service (CAS) contains a multidisciplinary clinical team with GPs available 24 hours a day. GPs are supported by advanced practitioners, pharmacists, dental nurses, mental health nurses, palliative care nurses and pathways clinicians. Health advisors are assisted by a triage tool to identify which clinician needs to assess the patient in a timely manner. This call streaming is expected to identify the needs of approximately 75 per cent of patients who need clinical consultation. The other 25 per cent are often calling for simple health information (for example local pharmacy location and opening times) and will not be forwarded to clinicians in line with the "consult and complete" model. Around 34 per cent of the



patients who need clinical consultation can expect to have their needs resolved directly through the IUC CAS service.

The model for an IUC CAS requires access to urgent care via NHS 111, either on a free-to-call telephone number or online, providing:

- triage by a health advisor
- consultation with a clinician using a Clinical Decision Support System (CDSS) or an agreed clinical protocol to complete the episode on the telephone where possible
- direct booking post clinical assessment into a face-to-face service where necessary
- electronic prescription
- self-help information delivered to the patient.

The key performance measures are the percentage of calls which are answered within 60 seconds, calls abandoned after 30 seconds and calls which had to be referred to 999. The table below summarises our IUC performance in 2018/19 however it should be noted that our NEL IUC went live in August 2018 so there is no comparison data for 2017/18. The comparison data is available for SEL as we managed the SEL 111 service in 2017/18 before the SEL IUC went live in February 2019. SEL has seen an increase in calls which has led to a reduction in our call answering performance, but we are continuing to work to improve this.

		Apr 2017-Mar 2018	Apr 2018-Feb 2019	
Measure	**National target**	**SEL**	**SEL**	**NEL****
Total number of calls	-	364,024	376,731	303,920
Average calls per day	-	1,000	1,131	1,440
Calls answered within 60 seconds	95%	322,279 (90%)	310,539 (85%)	211,343 (74%)
Calls abandoned after 30 seconds	No more than 5%	3,564 (1%)	6,870 (1.8%)	14,579 (4.8%)
Calls referred to 999***	<10%	8.20%	9%	8%

**NEL went live on August 1, 2018
***Calls referred to 999 – covers data until Feb 24, 2019 (for the period 2018-2019)

Comparison with other NHS 111 providers in London

There are five providers of 111 services across eight areas in London. We consistently deal with more 111 calls without needing to dispatch an ambulance or recommend A&E. In respect of referrals to 999, NEL is the top performing provider in London in respect of this national standard, indicating the benefits of a CAS. The Trust does however continue to work to make improvements to its call answering times and to reduce the number of abandoned calls.

8.3 Financial performance

Our financial performance in 2018/19 is detailed in the financial statements of this report. Overall, we finish the year in a positive financial position with a surplus of 1.8 per cent of our budget. The surpluses generated are used to fund additional capital investment. During the year we invested £21.5m on capital to modernise our fleet, IM&T systems and Estate.

	2018/19	2017/18
Total Budget	£366.3 million	£364.6 million
Year-end surplus	£6.6 million	£5.7 million

8.4 New vehicles added to our fleet this year



88 double crewed ambulances, 112 being built

20 fully-electric cars for local group managers



29 motorcycles



60 fast response cars



7 advanced paramedic vans being customised



8 logistics vans



8.5 Sustainability

We are committed to making improvements in all aspects of environmental performance, recognising that reducing our carbon impact is critical for the communities we serve, for patients, our finances, our city, and the planet.

The flexibility of our Make Ready system has changed the way we clean our vehicles which has saved water and the amount of chemicals we use.

We have worked hard to improve our supply chain and remove unnecessary deliveries of medical equipment, consumables and medical gases improving resilience, reducing stock and removing waste.

We have developed new vehicle-based medical kit bags which will be packed locally by Make Ready teams, again reducing unnecessary movement of materials across London.

Around 80% of the Trust's carbon footprint is generated by our fleet. In 2018, we worked with external providers to develop a bid to build the first zero emission capable ambulance but unfortunately were unsuccessful. We are now working with NHSI to try to achieve this.

We use around four million litres of diesel every year but reducing this is a priority. We have introduced much cleaner and less polluting ambulances to replace the ageing fleet that was decommissioned. Taking the national ambulance specification, we are in the final stages of defining the specification for the Driver Safety and Security system and this will support a more effective operation and management of our vehicles. This will improve safety for our staff and patients, and also control the speed of vehicles when not responding to an emergency, saving fuel and reducing the most harmful emissions.

ELECTRIC CLEANERAIR FOR LONDON

More than half of our ambulances (52 per cent) meet the standards of the new Ultra-Low Emission Zone (ULEZ). This year that will increase to 72 per cent and we plan to replace all non-compliant ambulances by 2023. From 8 April 2019, all vehicles deployed in the Mayor's new ULEZ zone will comply with the standard. We have a Memorandum of Understanding in place to ensure our response vehicles are not charged under



ULEZ while we upgrade to a fully compliant fleet.

We have been looking at opportunities to introduce electric and hybrid vehicles wherever possible and are currently testing a BMW i3 range extended car for use by specialist staff. Our motor cycle response team have also trialled a zero emissions motor bike.

Our fleet management team have deployed 20 fully electric vehicles into the fleet with Local Group Managers. They managed to finish the blue light conversion on a test vehicle without using an additional power source. Charging infrastructure is being rolled out across the Trust and we are hoping to share this with City Hall, the Metropolitan Police Service, London Fire Brigade and Transport for London.

8.6 EU Exit

We set up a task group to work on EU Exit preparedness and ensure there would be no disruption in our service to patients in the event of no deal.

This involved analysing any potential risk to our suppliers and our workforce. We found no areas of high risk but have continued to monitor the situation.

We have worked with colleagues in the wider NHS to ensure we can continue caring for Londoners under all EU Exit scenarios.



The impact on front line staffing is considered minimal as we only employ 168 people from the EU. The Trust has made arrangements to allow staff special leave to make any necessary applications under the EU Settlement Scheme.

8.7 Risks and continuing challenges

We manage risk through our corporate risk registers, board assurance framework and risk management policy. The board assurance framework and corporate risk register are presented at Trust Board meetings, and further scrutiny is applied at Quality Governance and Audit Committees. The risk register is reviewed in detail by our Executive Leadership Team each month. Risk Management is an integral part of our approach to continuous quality improvement and supports delivery against key performance indicators. Full details can be found in our annual governance statement.

8.8 Anti-bribery/ anti-slavery

The Trust does not tolerate any form of fraud, bribery or corruption by its employees, partners or third parties acting on its behalf. We investigate allegations fully and apply sanctions to those found to have committed a fraud, bribery or corruption offence. The Trust contracted its internal audit provider to provide its local counter-fraud specialist (LCFS) services in accordance with Secretary of State Directions. The Board's Audit and Risk Committee formally approves the counter-fraud annual workplan and progress reports are provided to the committee at each of its meetings.

The Modern Slavery Act 2015 introduced changes in UK law focused on increasing transparency in supply chains, to ensure they are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking). The Trust fully supports the government's objectives to eradicate modern slavery and human trafficking and encourages its staff to pursue training, such as the one developed by Health Education England to train NHS staff, and direct its staff to further resources available.

9 Our Five-year Strategy



This year we carried out our most ambitious and wide-reaching engagement exercise involving patients, staff and partners to devise our five-year strategy. It resulted in a plan which will transform the way we work and allow us to best meet the urgent and emergency care needs of the people who live and work in London and those who visit our city. With demand for our services increasing, it was essential that all our changes and improvements be done in the most cost effective way.

Our vision: To be a world-class ambulance service for a world-class city

We want to be London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line'

Theme 1: comprehensive urgent and emergency care , coordination, access, triage and treatment, with multichannel access for patients

- We want to manage and coordinate the flow of patients through urgent and emergency services, making it as easy as possible for people to access the help that they need
- We will develop an Integrated Clinical Assessment and Triage service (iCAT London), which will sit behind both NHS 111 and 999, providing integrated urgent and emergency care
- Multidisciplinary team working and making best use of technology will provide the best care for patients by providing the right care, first time

Theme 2: A world-class emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital

- We will continue to provide high quality care to everyone who contacts us, especially those most critically ill and injured.
- We will introduce our Pioneer Services; We will introduce specialized and bespoke services for five patient groups:


Urgent care


Mental Health


Fallers


Maternity


End of life care

Theme 3: collaborating with NHS, emergency services and London system partners to provide more consistent and equitable services to Londoners

- We will work with London's other public services and will support every opportunity to improve patient outcomes and experiences whilst improving public value
- We are committed to working with our emergency services partners, supporting Mayor of London's pledge to make "London the safest global city"
- Using our data and unique pan-London position, we can help our NHS partners identify inconsistencies and best practice

Enablers

- Becoming a **fully digital organisation**; utilising modern technology and Artificial intelligence to enhance outcomes
- Making sure our **organisational structure** is fit for now and the future
- Changing our workforce skill-mix to be more flexible and multi-disciplinary
- Having a **strong organisational culture**, supported by new organisational values and behaviours
- Providing the right **clinical and non-clinical training, education and development** to all of our people
- Operating as an **agile commercial organisation**
- Innovating for **continuous improvement** and learning from our experiences
- Involving the public – Launching 'Life Changers': our **volunteer community**
- Ensuring we have the right **estate and fleet** for our future operating model

9.1 Implications of the long term plan

In January 2019, NHS England (NHSE) published its new long term plan which outlines a range of ambitions and commitments covering the next ten years. We have already started working with London's STPs to analyse the key implications and how we can work to deliver the desired changes and improvements over the coming years.

We welcome the plan for its ambition and the focus on improving patient outcomes. We recognise the challenges but are pleased to see it aligns with our own strategy of reducing pressure on acute NHS services. We are working to incorporate its commitments into our own planning and deliver its aims alongside those of our own strategy.

The new model for the NHS – Integrated Care Systems

By April 2021, each STP will have evolved into an Integrated Care System (ICS), which will have overall commissioning responsibility for all services within their locality. We are working with commissioners and STP colleagues to identify the most effective way of commissioning and planning our pan-London urgent and emergency care service within this new setup.

Boosting out-of-hospital care

Improving care while keeping patients out of hospital is a key part of the long term plan. We welcome commitments to improve community based urgent care services and additional support for people living in care homes. Crucially, the long term plan commits to developing Primary Care Networks which will provide a multidisciplinary approach to community care, seeking to improve prevention activities and enhance public health.

Pre-hospital care

The plan puts ambulance services at the centre of the urgent and emergency care system. It focuses on the development of a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, 999 services and GP out-of-hours services. As an existing 111 provider and with an ambition to play an increasingly prominent role in the urgent and emergency care sector, we will be working with commissioners to develop this service.

We also welcome the commitment within the plan to provide more consistent Urgent Treatment Centre provision which will enable our crews to take patients to the most appropriate place for their care.

Mental health provision

Improving care for patients with mental health needs is a priority of the long term plan. London Ambulance Service is already providing many of the services listed for development in the plan. For example, the plan commits to a 24/7 mental health crisis response by 2020/21. We are already working with London's mental health trusts to see how we can work in collaboration to best provide emergency mental health services.

Digital and technology

Digital and technological innovation is at the heart of many of the desired improvements. We are already working with NHS Digital and are continuously looking to improve our digital infrastructure. Ensuring our crews have access to comprehensive patient notes will allow them to make the best decisions and provide the best quality of care for patients.

Next Steps

We will continue to work with STPs and other partners to respond to and implement this new long term plan. Supporting documents and plans will be produced by NHSE over 2019 and we will incorporate all of these into our own planning and strategy.

Accountable Officer:



Garrett Emmerson 23 May 2019

Chief Executive

Accountability report – Section two

10 Annual Governance Statement 2018/19

10.1 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

10.2 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 policies, aims and objectives of London Ambulance Service NHS Trust, to 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 London Ambulance Service NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

10.3 Capacity to handle risk

Leadership

Risk management is a key component of enhancing patient and staff care and is an integral part of the Trust's strategic management. It is the process whereby the Trust methodically addresses the risks related to its activities with the goal of achieving sustained benefits to patient care and to the London Ambulance Service NHS Trust Strategy. The focus of risk management at the Trust is about being aware of potential problems, working through what effect they could have and planning to prevent the worst case scenario. This is achieved through ensuring clear leadership and accountabilities throughout the Trust.

The Chief Executive is accountable to the Board for the quality of risk management arrangements within the Trust. Operationally, responsibility for the implementation of risk management has been delegated to the Chief Quality Officer and the Director of Corporate Governance.

The Director of Corporate Governance supports Executive Committee (ExCo) members and Non-Executive Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Trust Board, for maintaining the Board Assurance Framework (BAF). The BAF defines the principal risks to achieving the Trust's strategic objectives, together with associated controls, sources of assurance and action plans. The Chief Quality Officer is the quality governance lead for the Trust. She is responsible for the Trust's Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. She is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet requirements in relation

to clinical governance and risk, up to and including the Trust's Corporate risk register. The holders of these two positions have continued to drive forward a significant workplan in 2018/19 to strengthen the Trust's risk management processes, at all levels of the organisation, from Board to station-level. This has included an increased focus on strategic risk and the BAF by the Board, ExCo and Board Assurance Committees, the embedding of appropriate Quality Assurance structures and a clearly articulated Quality Assurance Framework. The Trust's focus has continued to be on learning from good practice in this area, both internally and externally.

ExCo members individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to mitigate their associated risks to achieving the Trust's strategic objectives, including compliance with the Trust's licence.

The Trust Board's Assurance Committees have responsibility for providing assurance in respect of the effectiveness of these controls. A system of "key issues" assurance reports to the Trust Board is in place to highlight any risks to compliance. Board Assurance Committees are well attended by ExCo members and Non-Executive Directors as well as by other key Trust staff.

The Quality and Corporate Governance Directorates also have a number of experienced and appropriately qualified staff to lead, support and advise staff at all levels across the organisation with the identification and management of risk.

Training

The Trust provides a comprehensive mandatory and statutory training programme which includes governance and risk management awareness, ensuring that staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

The Trust's Risk Management Strategy and Policy sets out the approach that it takes to the provision of training in relation to risk management. An e-learning package 'Introduction to Risk Management' has been developed and is available to all staff through the Trust intranet. Staff have access to comprehensive risk guidance and advice via the Quality and Corporate Governance Directorates; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities have this provided internally, learning from good practice, as well as being able to access external training courses as appropriate. Leadership development programmes have also been developed for all staff, which address the importance of managing risk. Training compliance is reported to the Trust Board and ExCo by the People and Culture Directorate. The Trust Board receives training every two years, to ensure that the requirements for understanding and discharging duties in relation to risk management at Board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice. The Trust Board last received such training in December 2018.

The Trust's mandatory and statutory training programme is regularly reviewed to ensure that it remains responsive to the needs of Trust staff. There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which includes elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. Despite significant operational pressures, the Trust has been able to achieve target levels of compliance with mandatory and statutory training requirements and this focus continues into 2019/20. Monitoring and escalation arrangements are in place to ensure that the Trust maintains its current good performance and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

10.4 The risk and control framework

Risk management strategy and policy

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

The Risk Management Strategy and Policy provides the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the Trust is able to deliver its objectives by identifying and managing risks, enhancing opportunities and creating an environment that adds value to on-going operational activities. The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical risks. Including but not limited to; strategic, financial, operational, regulatory, environmental and reputational risks.

The Trust's Risk Management Strategy and Policy is an integral part of the Trust's approach to

continuous quality improvement and is intended to support the Trust in delivering the key objectives within the Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements.

Identifying and reporting risk

Risks are identified routinely from a range of reactive & pro-active and internal & external sources including workplace risk assessments, analysis of incidents, complaints / PALS, claims, external safety alerts and other standards, targets and indicators. These are appropriately graded and ranked and included on the Trust's Corporate risk register and Board Assurance Framework (BAF). A Risk, Compliance and Assurance Group (RCAG) exists to review and monitor risks added to the risk register and regular reports from the Corporate risk register and the BAF are submitted to the relevant Board Assurance Committees and Trust Board. The Audit Committee has the delegated authority on behalf of the Trust Board for ensuring these arrangements are in place. The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process. The BAF and risk register have continued to be kept under review and amendment during 2018/19 and the agenda of the Trust Board and Board Assurance Committees are closely aligned to these as a result.

In accordance with the Trust Board's Scheme of Delegation, responsibility for the management / control and funding of a particular risk rests with the directorate / sector / station concerned. However, where action to control a particular risk falls outside the control / responsibility of that domain, where local control measures are considered to be potentially inadequate or require significant financial investment or the risk is 'significant' and simply cannot be dealt with at that level, such issues are escalated to the appropriate Corporate Committee, the RCAG, the ExCo or the Trust Board for a decision to be made.

Managing risk

Risk management is embedded in the activity of the organisation by virtue of robust organisational and committee structures which were reviewed and strengthened during 2017/18 and continued to bed down in 2018/19.

Of fundamental importance to the early identification, escalation and control of risk is the Trust's commitment to the ongoing development of a culture where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong', and a progressively 'risk aware' workforce. In 2018/19 the Trust appointed a substantive full time Freedom to Speak Up Guardian (FTSUG), supported by a 'hub and spoke' model of 20 Freedom to Speak Up Advocates. As a result, the number of concerns raised by members of staff across the Trust during 2018/19 has increased significantly throughout the year. FTSU concerns have been investigated and have led to improvement in processes in a number of different parts of the service. Further information about this can be found in the Annual FTSU report.

Business Planning and Service Development proposals do not proceed without an appropriate assessment of and therefore recognition / acceptance of the risks involved and the involvement of the relevant expertise. The Trust's ExCo reviewed and agreed the approach to be taken to quality impact assessments (including equality and data protection assessments) in December 2017. This has been adopted in the Trust's Business Planning activities for 2018/19.

The Trust's BAF is designed to assist the Trust in the control of risk. The BAF incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Data Protection and Security Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via regular BAF / risk register reports and is supported by a robust Internal Audit Programme.

Key risks facing the organisation in 2018/19, identified in the order in which they were added to the BAF, were:

BAF Risk 45 A cyber-attack could materially disrupt the trust's ability to operate for a prolonged period.		
BAF Risk 47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.		De-escalated January 2019
BAF Risk 49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 2018/19.		De-escalated November 2018
BAF Risk 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room.		
BAF Risk 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice.		De-escalated November 2018
BAF Risk 52 There is a risk that the Trust will not deliver the required control total through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards taking account of cost pressures including agency and potential IT server licence cost pressures.	Added November 2018	
BAF Risk 53 There is a risk that the Trust may not be prepared for potential disruption following the UK's exit from the EU, which may negatively impact on the delivery of services and financial position of the Trust.	Added January 2019	
BAF Risk 54 There is a risk that the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy.	Added March 2019	
BAF Risk 55 The preferred LAS strategy may not be deliverable within the Trust's timeframe due to the scale of investment and resource required and current system contracting arrangements.	Added March 2019	

The Trust Board considered its approach to risk management and its risk appetite at a Board development session in December 2018. The Trust's Risk Appetite Statement was approved by the Board at its meeting on 29 January 2019 and now forms part of the BAF.

The Trust also has in place a range of mechanisms for managing and monitoring risks in respect of quality including:

- The Trust has in place a Quality Strategy which has been approved by the Trust Board. The Trust Board also agrees annual quality objectives.
- The Trust has in place a Quality Assurance Committee (a committee of the Board) which meets bi-monthly and is chaired by a Non-Executive Director. The Quality Assurance Committee is responsible for monitoring performance against the agreed annual quality objectives. The Committee provides a report of each meeting to the Trust Board.
- The Trust publishes an Annual Quality Account.
- Performance against key quality indicators is reported to the Trust Board in the Integrated Quality and Performance Report.
- Quality improvements – including the response to CQC findings and recommendations are progressed through the Trust's Quality Improvement Programme
- As part of its Quality Assurance Framework, a programme of announced and unannounced (Executive and Non-Executive) Director Visits is also in place in order to ensure that there is 'Board to Station' oversight and ownership of quality & safety issues.
- The Trust has identified Non-Executive Directors to lead in respect of specific aspects of governance and risks. These roles are reviewed annually.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient & Public Involvement (PPI) representatives (e.g. Health Watch).
- Patient and Staff Stories are presented respectively to alternate meetings of the Trust Board monthly and actions and lessons learned are widely shared.

In 2018/19, the Trust has taken significant steps to establish and embed Data Quality Assurance, primarily through the following:

- The establishment of a system of systematic reviews by a newly established Data Quality Assurance team, supported by the recruitment of specialist staff.
- The establishment of a new Integrated Performance Report following Trust Board feedback.
- The approval of a new Data Quality Strategy (including a governance structure, policy and implementation plan).

However, there is still further progress to be made with regard to Data Quality Assurance and some elements of this framework are relatively new (such as underpinning KPI confidence reports and the Highlight Report system); therefore time is required to ensure that they are embedded in practice.

With regard to complying with the recommendations of "Developing Workforce Safeguards", the Trust:

- deploys sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- has a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- uses an approach that reflects current legislation and guidance where it is available.

In 2018/19 the Trust retained a focus on the strategic risks associated with workforce, through the BAF and through the People and Culture Committee. The People and Culture Committee has had a specific focus upon the development of a workforce planning model, providing assurance to the Board on this. The ExCo has also agreed to meet as a Strategic Workforce Planning Group in 2019/20, to provide additional oversight in this area.

CQC registration and compliance with the NHS provider licence

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

During 2018/19, the Trust received announced and unannounced visits by the CQC. A Well-Led Review was conducted in March 2018 and the outcome of this inspection was the removal of the trust from special measures and an improved rating of Good overall. The Trust also had an unannounced visit in November 2018 in relation to security arrangements in its Emergency Operations Centre and its Urgent and Emergency Care sites. The report of this visit is on the CQC website. The findings identified concerns relating to safeguarding and security

access issues. A comprehensive action plan was developed and is complete. Medium to long term solutions have been included in the 2019/20 Business Plan and will be implemented over the next year.

The Trust Board has assessed itself in compliance with the relevant aspects of the NHS provider licence at its meeting in May 2019. This assessment was reached following an internal review of the Trust's corporate governance framework.

With respect to condition FT4 (NHS Foundation Trust governance arrangements) the Board reviews the terms of reference of its Assurance Committees on an annual basis to ensure their effectiveness and last did so in March 2019. The Trust has an Audit committee consisting of Non-Executive Directors. The Audit Committee regularly meets with the internal and external auditors without the presence of executive directors or staff. In addition, the Local Counter Fraud specialist presents a report to every meeting of the Audit Committee on measures to tackle Fraud, Bribery and Corruption and also the importance of reporting concerns as appropriate. The Trust also has a Remuneration and Nominations Committee consisting of the Non-Executive Directors, joined when appropriate, by the Chief Executive, the Director of People and Culture and the Director of Corporate Governance. In addition, the Board has established a Quality Assurance Committee, a People and Culture Committee, a Finance and Investment Committee and a Logistics and Infrastructure Committee. Each Committee is chaired by a Non-Executive Director. All Committees and sub Groups undertake an annual self-assessment of their effectiveness, which is reported to the Board (or the appointing Committee in the case of sub groups). The Audit Committee also submits an Annual Report to the Trust Board.

The terms of reference also serve to define the responsibilities, accountabilities and reporting lines of each Assurance Committee. The Board receives a report following each Assurance Committee meeting, written by the Non-Executive Director Chair, and is therefore able to both receive assurance but also challenge any of the decisions made. Each Assurance Committee also has at least one identified lead Executive Director. The responsibilities of the Board and its Directors are defined in the Trust's Standing Orders and Standing Financial Instructions.

The Board has a schedule of business, which is reviewed at each formal meeting of the Board. The schedule defines when reports will be submitted, ensuring that the Board can operate timely and effective scrutiny of its operations. Key performance reports covering corporate, clinical, quality, workforce, finance and operational performance are received at each formal meeting of the Board and are made available on the Trust's website.

The Remuneration and Nominations Committee reviews when necessary the directorate portfolios, and there is a clear organisational structure with staff and managers identified within each directorate, who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. Elsewhere within this report can be found the Trust's duty to operate efficiently, economically and effectively. During 2018/19 the Board and its Assurance Committees received a number of reports on progress against the Lord Carter review to identify efficiencies in ambulance services across the NHS.

The reports submitted to each formal meeting of the Board enables timely and effective scrutiny and oversight by the Board of the Licensee's operations. These are also published on the website. In addition, directors have access to up to date operational information, as well as receiving the details of any serious incidents reported.

The Trust is compliant with health care standards that are binding which is demonstrated by the Trust being rated as "Good" overall following the CQC inspection in 2018. As part of gaining assurance Board and ExCo members are encouraged to visit staff in the sectors with each director allocated to a particular sector. In addition, at each meeting of the Board there is an opportunity to hear either a staff or patient story.

The Quality Assurance Committee receives regular reports from clinical and operational staff and through a number of documents such as the Serious Incident Reports, Quality Oversight Group, and claims and inquests update are able to have oversight and challenge the Trust in relation to the quality of patient care. The Trust's Medical Director, the Chief Quality Officer and the Director of Corporate Governance attend all meetings of the Committee. In addition, the Committee is chaired by a clinician who is a Non-Executive Director of the Trust.

The Board received and approved the Going Concern statement at its meeting in May 2019. This statement is approved on the basis that management has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future with no necessity or plans either to liquidate or cease operations. If this were not the case it would be necessary to prepare the financial statements

with the assumption that the business would not continue beyond a further 12 months after the end of the accounting period. The Trust exercises tight financial control and through reporting to the Board and detailed scrutiny and challenge at meetings of the Finance and Investment Committee, the Board has reasonable assurance over the effectiveness of its financial reporting. In addition, the Trust's Auditors' opinion presented to the Board in May 2019 provided assurance as to the effectiveness of financial reporting and control.

Roles and responsibilities

The Trust Board holds overall responsibility for the management of risks within the Trust. The Board ensures significant risks to the Trust's ability to provide a quality service are identified and managed. They review all significant risks at each formal meeting.

Non-Executive Directors seek assurance in relation to the performance of the ExCo in meeting agreed goals and objectives. They should satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.

The Chief Executive is responsible for ensuring that a system is in place for reporting of all incidents.

All ExCo members hold responsibility for the identification and management of their risks and ensure they are documented, registered and updated in a timely fashion for the relevant forums to review. They are responsible for the risk management process within the Trust and as such ensure:

- the review of risk and risk registers is maintained in accordance with Trust strategy
- all staff have the ability to identify risks and propose they are assessed and entered onto the relevant section of the Trust risk register
- monitoring and timely review of the Risk Management Strategy and associated policies
- provision of expert advice into the incident reporting process
- all Managers within their Directorate are familiar and act in accordance with Trust policies
- incidents are reported and investigated in accordance with the Trust's Incident Reporting Process.

There were a number of changes to the Trust's senior personnel in 2018/19:

- Jamie O'Hara left the role of Director of Strategy and Communications in August 2018
- Jill McGregor left the role of Director of Performance in January 2019
- Mark Spencer and Karim Brohi were appointed as Non-Executive Directors in March 2019
- Jessica Cecil left the role of Associate Director in January 2019
- Robert McFarland left the role of Non-Executive Director in February 2019

The Board Assurance Committees and Executive Groups of the Trust provide a process for escalation of assurance and risk through the trust organisational committee structure which supports delegated risk management systems within the Trust.

The purpose of the ExCo is to lead and manage the performance of the Trust within the strategic framework established by the Trust Board. The ExCo makes proposals to the Trust Board on key policy and service issues for Trust Board decision. The ExCo has established the following sub-groups:

- the Risk Compliance and Assurance Group (RCAG) – to oversee the governance of the risk management process and management of risks rated greater than 15;
- the Information Governance Group (IGG) – to ensure that the London Ambulance Service NHS Trust has clear direction of and management support for the activities required to comply with data quality principles; Caldicott principles; Information Security Management (ISO/IEC 17799 / ISO/IEC 27001); data protection legislation; the Freedom of Information Act 2000; the Data Security and Protection Toolkit; records management as defined by the Care Quality Commission (CQC); the Public Records Act; and the Information Governance Alliance Records Management Code of Practice for Health and Social Care.
- the Preparedness for EU Exit Focus Group – to provide feedback to the ExCo on the actions being taken to manage any risks to the Trust's clinical, quality, operational and financial position identified, as a result of the UK's departure from the EU.

The Audit Committee monitors financial risks and reviews the BAF. It critically reviews and reports on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

The Finance and Investment Committee has responsibility for monitoring and reviewing the adequacy and utilisation of resources to assure the Board upon the risks relating to the efficient and effective delivery of strategic and operational plans and objectives. It monitors financial risks and reviews the BAF advising the Board of any material risks arising.

The Quality Assurance Committee has responsibility for providing the Trust Board with assurance on the achievement of strategic objectives in relation to the provision of a high quality, safe, and effective service. The Trust's definition of quality encompasses three equally important elements:

- Care that is safe – working with patients and their families to reduce avoidable harm and improve outcomes.
- Care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients and their families.
- Care that provides a positive experience – to patients and their families.

The People and Culture Committee has responsibility for providing the Trust Board with assurance on all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks.

The Logistics and Infrastructure Committee has responsibility for providing the Trust Board with assurance on and overseeing strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate.

Public stakeholder involvement

The Trust ensures that its Commissioners are provided with regular reports and review meetings to understand the risks which may impact on the Trust.

The Trust Board meets at least six times a year in public and its papers are available on the Trust website. The Board seeks to have as an item of business on all agenda either 'a patient story' or 'a staff story' that enables members of the public or staff to present their experiences to the Board. There is also the opportunity either through the Trust website or at the meeting on the day to pose questions to the Trust Board on any matter of concern. This is all part of the Board's desire to be as open and transparent as possible. All matters are discussed or determined in public unless the matter would not be disclosed under Freedom of Information regulations.

In addition to the above the Trust engages with the London Assembly and other appropriate Health Overview and Scrutiny Committees (HOSCs), and also local Healthwatch organisations across London.

During consultation of the draft annual Quality Account engagement meetings are set and held around London for various stakeholders to attend for example the public, Commissioners and HOSCs.

The Trust's comprehensive internet website provides the public with ready access to information across all areas of Trust activity and the organisation also uses its newsletter for members to inform the public of new developments and items of interest.

Corporate governance statement

The Trust, under Condition FT4 of its Licence, is required to submit to NHS Improvement a Corporate Governance Statement by and on behalf of the Board of Directors confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. The Statement was drafted and approved by the Trust Board and submitted to the Regulator within the prescribed timescales. The Regulator received the statement and did not require a statement from its auditors either:

- confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or;
- setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

The Trust Board and its Assurance Committees each have an individual schedule of business, which ensures timely performance reporting through the correct governance process.

The Board receives regular reports from its Assurance Committees which provide assurance on detailed review and oversight from its own agenda items and reporting groups. The Board also receives a quality and performance report showing operational, financial, quality, clinical and corporate on trends, themes and key performance indicators.

The reports often show national benchmarking information from the other nine English ambulance trusts e.g. ambulance response targets (ARP), ambulance quality indicators (AQI), finance and workforce.

The Trust has an approved Quality Impact Assessment Framework document. The Board of Directors is responsible for ensuring that transformational programmes designed to provide improved efficiencies do not adversely impact on the quality of the service to patients.

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

NHS Pension Scheme

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

Equality, diversity and human rights

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

In response to its obligations to report on the Workforce Race Equality Standard, the Trust has co-produced with a range of stakeholders an extensive action plan.

Carbon reduction

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

To reduce our carbon emissions and increase efficiency the Trust is investing heavily in replacing a large proportion of its current fleet with new, 'greener' ambulances and cars. It is anticipated that by 2020, the majority of LAS vehicles will meet the Euro IV standard in line with the introduction of the London Ultra Low Emission Zone (ULEZ).

10.5 Review of economy, efficiency and effectiveness of the use of resources

The Trust secures the economic, efficient and effective use of resources through a variety of means:

- A well-established policy framework (including Standing Financial Instructions)
- An organisational structure which ensures accountability and challenge through the committee structure
- A clear planning process
- Effective corporate directorates responsible for workforce, revenue and capital planning and control
- Detailed monthly financial reporting including progress on achievement of Cost Improvement Programmes and year-end forecasting.

The Trust has in place a performance management framework aligned to both the corporate and sector divisional management structure. The framework includes a performance dashboard which includes a series of performance metrics and reflects metrics based on the Carter Report recommendations. The Trust Board reviews the operational, productivity and financial performance, and use of resources both at Trust and Divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the quality and performance report provided to each Board meeting.

The Board's business includes comprehensive reviews of performance against clinical, operational, workforce, corporate and financial indicators through the quality and performance report at each formal meeting. Any emerging issues are identified and mitigating action implemented.

The Finance and Investment Committee which is Chaired by a Non-Executive Director with other Non-Executive Directors also members, provides assurance to the Trust Directors as to the achievement of the Trust's financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. It interfaces with the other Board Assurance Committees, in particular the Logistics and Infrastructure Committee, as appropriate. This Committee also has responsibility for providing assurance with regard to the Trust's procurement policies and procedures.

The Trust's commitment to value for money is strengthened by the effective and focused use of its Internal Audit service. The Trust engages Internal Auditors to provide an independent and objective assurance to the Board that the Trust's risk management, governance and internal control processes are operating effectively.

The Trust has a Local Counter Fraud Specialist (LCFS) supported as required by other qualified LCFS. Any concerns can be directed to the team and, any information is treated in the strictest confidence.

External Auditors, Internal Auditors and Counter Fraud report to each meeting of the Audit Committee, and also meet the members of the Audit Committee without Management present.

10.6 Information governance

The Trust continues to strengthen its arrangements for Information Governance. An executive-led Information Governance Group exists as well as an Information Governance Strategy and Policy, along with a dedicated Information Security Policy.

Information governance incidents are reported on DatixWeb and the Information Governance Manager is alerted by email whenever an incident is reported on the system. These incidents are checked by the Information Governance Manager and, where appropriate, by the Quality Governance and Assurance team. Where there has been an incident such as a loss of information outside the LAS where we are aware, or there is a risk, that personal data has been accessed or disclosed by one or more members of the public, a report is made on the Data Security and Protection Toolkit within 72 hours of the notification of the incident reaching the IG Manager. Each of these reportable incidents is assessed using the 5x5 Breach Assessment Grid in the Guide to the Notification of Data Security and Protection Incidents. This document provides detailed guidance on the reporting of these incidents and should be read by all staff who have reporting rights in the Toolkit before any report is made. The Breach Assessment Grid assesses the Impact and Likelihood that harm as occurred and where the incident is assessed that it is (at least)

likely that some harm has occurred and that the impact is (at least) minor, the incident is reportable and full details will be automatically emailed to the Information Commissioners Office (ICO) and the NHS Digital Data Security Centre (DHSC). The DHSC will also be notified where it is (at least) likely that harm has occurred and the impact is at least serious.

Three information governance incidents were reported to the ICO in 2018/19. No action was taken by the ICO as a result of these.

The Trust was able to submit a fully compliant Data Security and Protection Toolkit.

10.7 Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

In addition to the monthly review of quality data undertaken through the Commissioners' Quality Review Group, the following arrangements are in place to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

Governance & leadership:

- A Board member, the Chief Quality Officer, leads on quality and advises the Trust Board on all matters relating to the preparation of the Trust's Annual Quality Account.
- The Trust's Director of Performance is responsible for providing the information and performance data which informs the Annual Quality Account.
- The Trust's Director of Performance is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs the Annual Quality Account including external testing as appropriate.

Policies & plans in ensuring quality of care provided:

- Policies and procedures are in place in relation to the capture and recording of patient data.
- Clinical coding follows national guidelines in addition to a local policy, as per the Audit Commission's guidelines.

Systems & processes:

- Systems and processes are in place for the audit and validation of performance data both centrally and at operational level.
- The Trust's Datix reporting system has been reviewed in 2018 and restructured, ensuring weekly validation, weekly, prior to submission to national datasets.

Data use & reporting:

- A monthly Integrated Performance Report which outlines the Trust's performance against key quality and other objectives including benchmarking and comparative data, and are the subject of discussion and challenge at every monthly Trust Board meeting and also informs the annual Quality Account.

The Trust has consulted with its commissioners, patients' forum, Healthwatch, CCG and STP leads and Trust staff during 2018/19 in relation to the progress made on the Trust's 2018/19 Quality Strategy and to agree its 2019/20 priorities.

10.8 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and risk/ clinical governance/quality committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of deep dive and internal audit work. The BAF and monthly integrated quality and performance reports provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.

The Trust received the following Head of Internal Audit Opinion for 2018/19:

"Our overall opinion for the period 1 April 2018 to 31 March 2019 is that based on the scope of reviews undertaken and the sample tests completed during the period, significant assurance with some improvements required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control."

Maintenance and review of the effectiveness of the system of internal control has been provided by comprehensive mechanisms already referred to in this statement. Further measures include:

- Regular reports to the Trust Board from the Trust's BAF and risk register including NED review / challenge.
- Regular risk management activity reports to the Trust Board covering incidents, complaints/PALS and claims analysis and including details of lessons learned / changes in practice.
- Receipt by the Trust Board of minutes / reports from key forums including the Audit Committee, Finance & Investment Committee and the Quality Assurance Committee.
- The ongoing development of the BAF
- Consideration of a monthly Quality Improvement Programme report, allowing the Trust Board to monitor improvements in this area.
- The provision and scrutiny of a monthly Integrated Quality and Performance Report to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions. The Trust's performance management arrangements were strengthened during 2017/18 including through the introduction and embedding of Executive Performance Reviews and some changes to Director portfolios.

The validity of the Corporate Governance Statement has been provided to me by the relevant Board Assurance Committees – most notably the Audit Committee, which have considered and commented on this statement, and by the external auditors.

All of the above measures serve to provide ongoing assurance to me, the Executive Committee and the Trust Board of the effectiveness of the system of internal control.

Conclusion

Whilst the Trust continues to work to improve its control environment, as set out above, no significant control issues have been identified.

Signed:



Garrett Emmerson 23 May 2019

Chief Executive

10.9 Chief Executive's statement

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

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

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

Signed:



Garrett Emmerson 23 May 2019

Chief Executive

10.10 Directors' statement

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

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

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

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

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board





Garrett Emmerson
Chief Executive

Lorraine Bewes
Chief Finance Officer

23 May 2019

11. Remuneration report

Our Remuneration and Nominations Committee consists of the Chairman and the six Non-executive Directors. The Chief Executive is usually in attendance but is not present when their own remuneration is discussed.

The Remuneration and Nominations Committee is responsible for advising the Board about appropriate remuneration 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 requirements of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers Pay Framework.

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

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

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 63 to 66.

Banded remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2018/19 was in the range of £210,001 to £215,000 on an annualised basis. The pay multiplier in 2018/19, based on annualised salary, was 5.92 times the median remuneration of the workforce, which was £35,865. In 2017/18, the banded remuneration of the highest paid director £210,001 to £215,000. The pay multiplier in 2017/18, based on annualised salary, was 5.61 times the median remuneration of the workforce, which was £36,504.

In 2018/19, one (2017/18, one) employee received remuneration in excess of the highest-paid director. Remuneration ranged from £285,001 to £290,000 (2017/18 £285,001 to £290,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The change in ratio was due to:

- Increase in pay received by highest paid director in 2018/19 compared with 2017/18.
- The reduction in overtime being worked by frontline staff in 2018/19 compared with 2017/18.

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

The information contained below in the Salary and Pension Entitlement of Senior Managers has been audited by our external auditors.

Salary and pension entitlements of senior managers

A) Remuneration 2018/19

Name and Title	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£00	£'000	£'000	£'000	£'000
Heather Lawrence, Chairman	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Jessica Cecil, Non-Executive Director (from 1st April 2018 to 28Th February 2019)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director (from 1st April 2018 to 28th February 2019)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Sheila Doyle, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Jayne Mee, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Amit Khutti, Associate Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Karim Brohi, Non-Executive Director (from the 1st March 2019)	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Mark Spencer, Non-Executive Director (from the 1st March 2019)	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Garrett Emmerson, Chief Executive	£205,001-£210,000	£0	£5,001-£10,000	£0	£0	£210,001-£215,000
Lorraine Bewes, Director of Finance and Performance	£130,001-£135,000	£0	£0	£0	£0	£130,001-£135,000
Paul Woodrow, Director of Operations	£125,001-£130,000	£7,100	£0	£0	£10,001-£12,500	£135,001-£140,000
Fenella Wrigley, Medical Director	£110,001-£115,000	£4,700	£0	£0	£0	£115,001-£120,000
Patricia Bain, Chief Quality Officer	£120,001-£125,000	£0	£5,001-£10,000	£0	£0	£130,001-£135,000

Salary and pension entitlements of senior managers (continued)

A) Remuneration 2017/18

Name and Title	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£00	£'000	£'000	£'000	£'000
Heather Lawrence, Chairman	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Sheila Doyle, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Jayne Mee, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Amit Khutti, Associate Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Garrett Emmerson, Chief Executive (from 30 May 2017 to 31 March 2018	£170,001-£175,000	£0	£0	£0	£0	£170,001-£175,000
Andrew Grimshaw, Acting Chief Executive (from 1 April 2017 to 29 May 2017) and Finance Director (from 30 May 2017 to 16 June 2017)	£30,001-£35,000	£0	£0	£0	£37,501-£40,000	£70,001-£75,000
Lorraine Bewes, Director of Finance and Performance (from 17 June 2017 to 31 March 2018)	£100,001-£105,000	£0	£0	£0	£0	£100,001-£105,000
Andy Bell, Acting Director of Finance (from 1 April 2017 to 31 May 2017)	£20,001-£25,000	£0	£0	£0	£12,501-£15,000	£30,001-£35,000
Paul Woodrow, Director of Operations	£115,001-£120,000	£7,100	£0	£0	£10,001-£12,500	£135,001-£140,000
Fenella Wrigley, Medical Director	£105,001-£110,000	£4,700	£0	£0	£12,501-£15,000	£125,001-£130,000
Patricia Bain, Chief Quality Officer	£120,001-£125,000	£0	£0	£0	£0	£120,001-£125,000

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 1 April 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
Heather Lawrence, Chairman	**	**	**	**	**	**	**
Jessica Cecil, Non-Executive Director (from 1st April 2018 to 28th February 2019)	**	**	**	**	**	**	**
Robert McFarland, Non-Executive Director (from 1st April 2018 to 28th February 2019)	**	**	**	**	**	**	**
John Jones, Non-Executive Director	**	**	**	**	**	**	**
Fergus Cass, Non-Executive Director	**	**	**	**	**	**	**
Theo de Pencier, Non-Executive Director	**	**	**	**	**	**	**
Sheila Doyle, Non-Executive Director	**	**	**	**	**	**	**
Jayne Mee, Non-Executive Director	**	**	**	**	**	**	**
Amit Khutti, Associate Non-Executive Director	**	**	**	**	**	**	**
Karim Brohi, Non-Executive Director (from 1st March 2019)	**	**	**	**	**	**	**
Mark Spencer, Non-Executive Director (from 1st March 2019)	**	**	**	**	**	**	**
Garrett Emmerson, Chief Executive	*	*	*	*	*	*	*
Lorraine Bewes, Director of Finance and Performance	*	*	*	*	*	*	*
Fenella Wrigley, Medical Director	£0 - £2,500	£0 - £2,500	£35,001 - £40,000	£80,001 - £85,000	£667,855	£0	£660,242
Paul Woodrow, Director of Operations	£0 - £2,500	£0 - £2,500	£40,001 - £45,000	£110,001 - £115,000	£769,518	£96,367	£888,971
Patricia Bain, Chief Quality Officer	*	*	*	*	*	*	*

*Garrett Emmerson, Lorraine Bewes and Patricia Bain are not members of the NHS Pension Scheme.

**Non-executive directors do not receive pensionable remuneration, there are no disclosures in respect of pensions for non-executive directors.

Table 1: Exit packages

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 (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (23).

During the year the methodology used for calculating CETV has changed from the previous year. This means that the opening balances for these figures have been amended from the prior year.

Real increase in CETV 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 scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£s		£s		£s		£s
£150,001 - £200,000	1	160,000						
Totals	1	160,000	Nil	Nil	Nil	Nil	Nil	Nil

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Reporting of other compensation schemes – Exit packages		
	Agreements Number	**Total value of agreements £000s**
Voluntary redundancies including early retirements contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring MHT approval	0	0
Total	**0**	**0**

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

Off-Payroll engagements

Table 1: Off-Payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	0
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	0
No. that have existed for between two and three years at the time of reporting.	0
No. that have existed for between three and four years at the time of reporting.	0
No. that have existed for four or more years at the time of reporting.	0

Table 2: New Off-Payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll.	0
Number of engagements reassessed for consistency/ assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review.	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board member, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year.	0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	16

12. Staff report

Average staff numbers

The average number of staff has increased over the last year to 5,493 (2017/18 5,138) as the Trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	6	3	3
Ambulance Service	2,748	2,708	40
Administration and estates	1,550	1,459	91
Healthcare assistants and other support staff	1,142	1,139	3
Nursing, midwifery and heath visiting staff	45	27	18
Scientific, therapeutic and technical	2	2	0
Total	**5,493**	**5,338**	**155**

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The "contracted hours" method of calculating whole time equivalent number should be used, that is, dividing the contracted hours of each employee by the standard working hours.

Staff composition

At the end of March 2019, we had a workforce of 5,780 staff, made up of 3,049 men and 2,731 women. This was broken down as follows:

	Total	Female	Male
Directors	19	10	9
Senior Managers	220	85	135
Employees	5,541	2,636	2,905
Total	**5,780**	**2,731**	**3,049**

Over the course of the year, a total of 705 people left the service – a turnover rate of 12.4 per cent, compared to 10.8 per cent in 2017/18.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 259 paramedics left during 2018/19.

Staff sickness

The average working days lost in 2018/19 was 11.3 (2017/18 11.7). The data is based on calendar years January 2018 (2017) to December 2018 (2017).

Staff policies

We embrace our obligations under equalities legislation, including the Equality Act 2010. Our aim is to ensure that equality and inclusion is integral to everything we do.

We welcome people to our organisation from any background, who are committed to providing high-quality care that meets the needs of the diverse communities we serve. We aim to provide innovative and responsive healthcare which meets the needs of all these communities, providing better healthcare for all.

Our policy is to treat everyone fairly and without discrimination, and we want to ensure that:

- patients and customers receive fair and equal access to our healthcare service;
- everyone is treated with dignity and respect; and
- staff experience fairness and equality of opportunity and treatment in their workplace.

We want to be an employer of choice, and to attract the best and most talented people from all walks of life to a career where they can develop to their full potential.

As an employer, we are focusing on:

- celebrating and encouraging the diversity of our workforce and creating a working environment where everyone feels included and appreciated for their work;
- promoting and providing training and employment opportunities regardless of age, disability, gender reassignment, marital status, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other aspect of an individual person's background; and
- fostering creativeness and innovation in our working environment, so that all staff can deliver to the best of their ability and help us take forward our equality and inclusion goals.

Expenditure on consultancy

In 2018/19 the trust spent £0.4 million on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer: Garrett Emmerson, Chief Executive

Signed:



Garrett Emmerson 23 May 2019

Chief Executive

Financial report – Section three

13. Financial statements

13.1 2018/19 Introduction to the annual accounts

Financial performance

For the financial year 2018/19 the Trust reported a surplus of £6.6m. The Trust had planned to report a £4.4m surplus. The improvement was due to in year non recurrent sustainability and transformation fund income. The following table summarises the key elements of the financial performance of the Trust in 2018/19.

	Plan £m	Actual £m	Variance £m
Income	370.7	388.9	18.6
Expenditure	(366.3)	(382.3)	(16.4)
Surplus	4.4	6.6	2.2
EBITDA Surplus	24.1	26.3	2.2
Capital Resourcing Limit (CRL)	21.8	21.5	0.3
External Financing Limit (EFL)	20.3	13.2	7.1
Cash	14.6	21.7	7.1

In line with all NHS organisations LAS was required to identify efficiencies. In total £12.3m was identified and delivered in 2018/19.

The Trust continued to invest in new equipment, spending in excess of £21.5m on new vehicles to help improve the age profile of the fleet, IM&T system renewal and improvement, and additional clinical equipment.

	£m
Capital Expenditure	21.53
Less:	
NBV of Disposals	(0.05)
Capital Resourcing Limit (CRL)	21.48

NHS Trusts have a number of financial duties they must adhere to. The following section of the annual report outlines the performance of the Trust against those duties for the financial year ended 31 March 2019. The results outlined in this section relate to the full 12 month period of 1 April 2018 to 31 March 2019. A copy of the full statutory audited accounts is included in this annual report together with a glossary of terms to assist the reader in interpreting the accounts.

Financial duties review

Break-even duty

NHS Trusts have a financial duty to break-even over a three year rolling period. The Trust achieved its break-even duty.

External Financial Limit

The External Financing Limit (EFL) is the means by which the Treasury, via the Department of Health and Social Care and the NHSI, controls public expenditure in NHS Trusts. This is a financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. Exceeding these limits requires prior approval. Trusts are permitted to undershoot their EFL targets.

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

The original planned EFL was £20.3 million. The Trust had an under spend on its EFL of £7.1 million due to higher than planned year-end cash balances. The Trust is permitted to under spend its EFL.

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. Trusts are required to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the average relevant net assets of the Trust. To meet this duty, Trusts must achieve a rate between three per cent and four per cent.

A return on assets (the capital cost absorption duty) of 3.5% was achieved. This was within the permitted range of 3 to 4 per cent.

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 capital resource limit.

A capital resource limit controls the amount of capital expenditure that a NHS body may incur in the financial year. Under spends against the CRL are permitted by the Department of Health and Social Care.

The Trust spent £21.5 million on a range of projects, including ambulances and other vehicles including fast response cars, HART, electric cars and other vehicles, new technology projects and a range of projects to improve clinical equipment and the Trust's estate. Overall, the Trust under spent by £0.3 million against its capital resource limit, which it is permitted to do. The capital programme was primarily funded internally, but was augmented with £4.6 million of external support from the Department of Health and Social Care. The under spend on the capital programme will be carried forward into the 2019-20 financial year's capital programme.

Apply the Better Payment Practice Code

This regulatory duty requires NHS Trusts to pay all supplier invoices within 30 days. The Trust paid 83 per cent of its trade invoices respectively within 30 days. This is below the 95 per cent target set by the Department of Health and Social Care.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 8 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial plan 2019/20

The Trust has formally submitted a plan for the coming financial year, 2019/20 that takes into account planned contracted income levels and expenditure requirements. These plans have been set in line with guidance from the DH, NHSI as well as discussions with clinical commissioning groups across London. The plan is set to deliver a surplus of £0.02 million.

Financial risk

The Trust monitors financial risk through the assurance framework and risk management processes as detailed in the statement of internal control included in the financial statements.

International Financial Reporting Standards (IFRS)

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2019 for all land and buildings. The net gain on revaluation was £0.2 million and the total loss on impairments were £2.0 million.

IAS 19 requires us to accrue for remuneration earned but not yet taken. In this instance, we have made an accrual for annual leave of £4.7 million for the current financial year (£4.6 million in 2017/18).

Subsequent events after the balance sheet date

The Trust has not identified any important event occurring after the financial year end, 31st March 2019, that has a material effect on the 2018/19 financial statements as presented.

Other information

Ernst and Young LLP were the Trust's external auditor for the year ended 31st March 2019. The Trust paid £83,000 (£83,000 in 2017/18) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our Audit Committee. Ernst and Young LLP have not undertaken any non-audit work for the Trust during the year ended 31st March 2019.

The Directors confirm that, as far as they are aware, there is no relevant audit information of which the NHS body's auditors are unaware, and that they have taken all the steps that they should have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

The Trust conforms to the Treasury's guidance on setting charges for information supplied to the public or commercial organisations.

The London Ambulance Service is a NHS Trust established under the National Health Service Act 2006. The Secretary of State for Health has directed that the financial statements of the NHS Trusts will meet the accounting requirements of the NHS Trusts Manual for Accounts, which will be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2018/19 Group Accounting Manual issued by the Department of Health and Social Care.

13.2 Auditor's report

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST

Opinion

We have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2019 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 34. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2018-19 HM Treasury's Financial Reporting Manual (the 2018-19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of London Ambulance Service NHS Trust as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report set out on pages 1 to 73, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in these respects.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 61, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of London Ambulance Service NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those

matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London

The maintenance and integrity of the London Ambulance Service NHS Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.



13.2 Financial statements

London Ambulance Service NHS Trust

Annual accounts for the year ended 31 March 2019



Statement of comprehensive income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	377,005	355,557
Other operating income	4	11,973	9,041
Operating expenses	5, 7	(378,154)	(355,193)
Operating surplus / (deficit) from continuing operations		**10,824**	**9,405**
Finance income	10	173	114
Finance expenses	11	(24)	(27)
PDC dividends payable		(4,482)	(3,780)
Net finance costs		**(4,333)**	**(3,693)**
Other gains / (losses)	12	131	17
Surplus / (deficit) for the year		**6,622**	**5,729**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(2,027)	1,309
Revaluations	14	215	6,333
Total comprehensive income / (expense) for the period		**4,810**	**13,371**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		6,622	5,729
Remove net impairments not scoring to the Departmental expenditure limit		298	(9)
Remove I&E impact of capital grants and donations		38	38
Remove 2016/17 post audit STF reallocation (2017/18 only)		-	(419)
Adjusted financial performance surplus / (deficit)		**6,958**	**5,339**

Statement of financial position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	5,746	4,770
Property, plant and equipment	14	165,304	162,111
Total non-current assets		**171,050**	**166,881**
Current assets			
Inventories	16	2,637	2,746
Receivables	17	27,057	24,098
Non-current assets held for sale / assets in disposal groups	18	-	-
Cash and cash equivalents	19	21,718	30,300
Total current assets		**51,412**	**57,144**
Current liabilities			
Trade and other payables	20	(37,947)	(44,918)
Provisions	23	(5,533)	(8,259)
Other liabilities	21	(218)	(90)
Total current liabilities		**(43,698)**	**(53,267)**
Total assets less current liabilities		**178,764**	**170,758**
Non-current liabilities			
Borrowings	22	(107)	(107)
Provisions	23	(8,110)	(9,576)
Total non-current liabilities		**(8,217)**	**(9,683)**
Total assets employed		**170,547**	**161,075**
Financed by			
Public dividend capital		64,356	59,694
Revaluation reserve		54,070	58,081
Other reserves		(419)	(419)
Income and expenditure reserve		52,540	43,719
Total taxpayers' equity		**170,547**	**161,075**

The notes on pages 84 to 120 form part of these accounts.



Garrett Emmerson 23 May 2019

Chief Executive

Statement of changes in equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Financial assets reserve*	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**59,694**	**58,081**	**-**	**(419)**	**-**	**43,719**	**161,075**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	6,622	**6,622**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-
Other transfers between reserves	-	(2,199)	-	-	-	2,199	-
Impairments	-	(2,027)	-	-	-	-	**(2,027)**
Revaluations	-	215	-	-	-	-	**215**
Public dividend capital received	4,662	-	-	-	-	-	**4,662**
Taxpayers' equity at 31 March 2019	**64,356**	**54,070**	**-**	**(419)**	**-**	**52,540**	**170,547**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of changes in equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**58,016**	**52,217**	**-**	**(419)**	**-**	**36,212**	**146,026**
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	**58,016**	**52,217**	**-**	**(419)**	**-**	**36,212**	**146,026**
Surplus/(deficit) for the year	-	-	-	-	-	5,729	**5,729**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,770)	-	-	-	1,770	**-**
Other transfers between reserves	-	(8)	-	-	-	8	**-**
Impairments	-	1,309	-	-	-	-	**1,309**
Revaluations	-	6,333	-	-	-	-	**6,333**
Public dividend capital received	1,678	-	-	-	-	-	**1,678**
Taxpayers' equity at 31 March 2018	**59,694**	**58,081**	**-**	**(419)**	**-**	**43,719**	**161,075**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves

This reserve was created when London Ambulance Service became a NHS Trust. The negative reserve balance was caused by the legal title of a property not being properly transferred from NHS Estates when the Trust was created. Once the error had been identified, the London Ambulance Service NHS Trust purchased the property from the NHS Estates and this led to a negative reserve being created.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of cash flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		10,824	9,405
Non-cash income and expense:			
Depreciation and amortisation	5.1	15,205	13,054
Net impairments	6	298	(9)
(Increase) / decrease in receivables and other assets		(3,183)	11,798
(Increase) / decrease in inventories		109	369
Increase / (decrease) in payables and other liabilties		(177)	865
Increase / (decrease) in provisions		(4,202)	(804)
Net cash generated from / (used in) operating activities		**18,874**	**34,678**
Cash flows from investing activities			
Interest received		165	103
Purchase of intangible assets		(2,974)	(960)
Purchase of property, plant, equipment and investment property		(25,224)	(19,817)
Sales of property, plant, equipment and investment property		165	130
Net cash generated from / (used in) investing activities		**(27,868)**	**(20,544)**
Cash flows from financing activities			
Public dividend capital received		4,662	1,678
Other interest		(14)	-
PDC dividend (paid) / refunded		(4,236)	(4,149)
Net cash generated from / (used in) financing activities		**412**	**(2,471)**
Increase / (decrease) in cash and cash equivalents		**(8,582)**	**11,663**
Cash and cash equivalents at 1 April - brought forward		**30,300**	**18,637**
Cash and cash equivalents at 31 March	**19.1**	**21,718**	**30,300**

Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. This is based on the expectation that the Trust will be able to maintain a positive cash flow across 2019/20, not require any external financial support to achieve a positive cash flow and be able to pay its creditors across 2019/20 as they fall due. Trust management expect these conditions to be met in and continue beyond 2019/20.

Note 1.3 Revenue

Note 1.3.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations

satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Note 1.3.1 Revenue from contracts with customers cont'd

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations

are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.3.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the

Note 1.3.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or

- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

***Subsequent* expenditure**

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	Max life
Buildings, excluding dwellings	3	99
Plant & machinery	5	10
Transport equipment	2	10
Information technology	3	7
Furniture & fittings	3	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	3	7
Software licences	3	7

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs,

ie, when receipt or delivery of the goods or services is made.

Note 1.10.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.10.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 24 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.17 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.18 Critical judgements in applying accounting policies

There were no critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies.

Note 1.18.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset Valuations

All land and buildings are restated to fair value by way of professional valuations. Full revaluation will be provided every five years. In the intervening years the fair values are updated by way of annual desktop revaluations. For the desktop revaluation the specialised operational values are updated in line with the current Tender Price Index published by the Building Cost Information Service (BCIS). The value of the land, non specialised assets and market values are reviewed by the valuer in line with analysis of market movements during the period.

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. The estimated economic lives are disclosed in note 1.6.5 and the carrying values of property, plant and equipment and intangible assets in notes 14.1 and 13.1 respectively.

Provisions

Provisions are made for liabilities that are uncertain in amount. These include provisions for the cost of pensions relating to other staff, legal claims, restructuring and other provisions. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. The carrying values of provisions are shown in note 23.

Annual Leave Accrual

The accrual is based on management's estimation of untaken leave as at 31 March 2019. The carrying value of the accrual is £4.65m within note 20 under accruals and deferred income.

Injury Cost Recovery Scheme Accrual

The Trust receives income from the NHS injury cost recovery scheme for the recovery of ambulance journey costs relating to road traffic accidents. Accruals are made for receivables that are uncertain in amount. The receivables are based on "management estimates supported by the number of cases" supplied by hospitals. The carrying value of the receivables is £3.53m within note 17 under prepayments and accrued income.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

Accounting Standards issued but not applicable in this financial year include IFRS 16 Leases.

The Trust expects material changes in relation to the implementation of IFRS 16 Leases due to operating leases coming on to the balance sheet. The Trust is currently assessing the impact these changes will have on the financial statements.

Note 2 Operating segments

The Trust Board considers that the Trust has only one segment which is the provision of accident and emergency services.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
A & E income	371,589	352,358
Patient transport services income	42	2,001
Other income	1,447	1,198
Agenda for Change pay award central funding	3,927	-
Total income from activities	**377,005**	**355,557**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	6,766	7,166
Clinical commissioning groups	362,608	342,183
Department of Health and Social Care	3,944	-
Other NHS providers	191	1,472
NHS other	-	653
Local authorities	-	27
Injury cost recovery scheme	1,447	1,198
Non NHS: other	2,049	2,858
Total income from activities	377,005	355,557
Of which:		
Related to continuing operations	377,005	355,557
Related to discontinued operations	-	-

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	205	237
Education and training (excluding notional apprenticeship levy income)	2,167	1,080
Non-patient care services to other bodies	15	66
Provider sustainability / sustainability and transformation fund income (PSF / STF)	9,310	7,514
Income in respect of employee benefits accounted on a gross basis	276	144
Total other operating income	**11,973**	**9,041**
Of which:		
Related to continuing operations	11,973	9,041
Related to discontinued operations	-	-

Note 5 Expenses

Note 5.1 Operating expenses

	2018/19	2017/18
	£000	£000
Staff and executive directors costs	266,604	253,754
Remuneration of non-executive directors	93	89
Supplies and services - clinical (excluding drugs costs)	7,685	7,719
Supplies and services - general	15,625	11,215
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	741	802
Inventories written down	(89)	-
Consultancy costs	436	1,605
Establishment	8,480	9,285
Premises	9,422	9,199
Transport (including patient travel)	28,313	30,065
Depreciation on property, plant and equipment	12,545	10,465
Amortisation on intangible assets	2,660	2,589
Net impairments	298	(9)
Movement in credit loss allowance: contract receivables / contract assets	4,821	
Movement in credit loss allowance: all other receivables and investments	-	2
Increase/(decrease) in other provisions	(626)	149
Change in provisions discount rate(s)	(168)	131
Audit fees payable to the external auditor		
audit services- statutory audit	83	84
other auditor remuneration (external auditor only)	-	-
Internal audit costs	119	156
Clinical negligence	3,621	2,785
Legal fees	662	1,012
Insurance	1,065	1,303
Research and development	771	823
Education and training	8,074	6,651
Rentals under operating leases	4,814	5,211
Redundancy	(198)	535
Car parking & security	282	223
Other	2,021	(650)
Total	**378,154**	**355,193**
Of which:		
Related to continuing operations	378,154	355,193
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

There was no other auditor remuneration in 2018/19 (2017/18 nil).

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 6 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	298	(9)
Total net impairments charged to operating surplus / deficit	**298**	**(9)**
Impairments charged to the revaluation reserve	2,027	(1,309)
Total net impairments	**2,325**	**(1,318)**

Note 7 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	216,011	205,507
Social security costs	24,191	23,130
Apprenticeship levy	1,085	1,025
Employer's contributions to NHS pensions	24,714	22,947
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	(198)	535
Temporary staff (including agency)	10,690	6,698
Total gross staff costs	**276,493**	**259,842**
Recoveries in respect of seconded staff	-	-
Total staff costs	**276,493**	**259,842**
Of which		
Costs capitalised as part of assets	4,104	427

Note 7.1 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £54k (£262k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set

following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 9 Operating leases

Note 9.1 London Ambulance Service NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where London Ambulance Service NHS Trust is the lessee.

The Trust leases ambulances, fast response cars and other vehicles for periods of 3 to 6 years. The Trust leases buildings to provide facilities for ambulance stations, vehicle workshops and other accommodation. These lease terms vary between 1 and 15 years.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	4,814	5,211
Total	**4,814**	**5,211**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	4,032	3,744
- later than one year and not later than five years;	9,520	9,521
- later than five years.	4,027	5,281
Total	**17,579**	**18,546**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	170	96
Interest on other investments / financial assets	-	18
Other finance income	3	-
Total finance income	**173**	**114**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 £000	2017/18 £000
Interest expense:		
Interest on late payment of commercial debt	14	-
Total interest expense	**14**	**-**
Unwinding of discount on provisions	10	27
Total finance costs	**24**	**27**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19 £000	2017/18 £000
Amounts included within interest payable arising from claims under this legislation	14	-

Note 12 Other gains / (losses)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	131	29
Losses on disposal of assets	-	(12)
Total gains / (losses) on disposal of assets	**131**	**17**

Note 13 Intangible Assets

Note 13.1 Intangible assets - 2018/19

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**2,408**	**-**	**-**	**16,536**	**-**	**-**	**-**	**1,698**	**-**	**20,642**
Additions	397	-	-	737	-	-	-	2,155	-	3,289
Reclassifications	325	-	-	539	-	-	-	(517)	-	347
Disposals / derecognition	(146)	-	-	(18)	-	-	-	-	-	(164)
Valuation / gross cost at 31 March 2019	**2,984**	**-**	**-**	**17,794**	**-**	**-**	**-**	**3,336**	**-**	**24,114**
Amortisation at 1 April 2018 - brought forward	**2,298**	**-**	**-**	**13,574**	**-**	**-**	**-**	**-**	**-**	**15,872**
Provided during the year	185	-	-	2,475	-	-	-	-	-	2,660
Reclassifications	-	-	-	-	-	-	-	-	-	-
Disposals / derecognition	(146)	-	-	(18)	-	-	-	-	-	(164)
Amortisation at 31 March 2019	**2,337**	**-**	**-**	**16,031**	**-**	**-**	**-**	**-**	**-**	**18,368**
Net book value at 31 March 2019	**647**	**-**	**-**	**1,763**	**-**	**-**	**-**	**3,336**	**-**	**5,746**
Net book value at 1 April 2018	**110**	**-**	**-**	**2,962**	**-**	**-**	**-**	**1,698**	**-**	**4,770**

Note 13.2 Intangible assets – 2017/18

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**2,643**	**-**	**-**	**16,593**	**-**	**-**	**-**	**990**	**-**	**20,226**
Prior period adjustments	-	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	**2,643**	**-**	**-**	**16,593**	**-**	**-**	**-**	**990**	**-**	**20,226**
Additions	24	-	-	-	-	-	-	758	-	782
Reclassifications	14	-	-	64	-	-	-	(50)	-	28
Disposals / derecognition	(273)	-	-	(121)	-	-	-	-	-	(394)
Valuation / gross cost at 31 March 2018	**2,408**	**-**	**-**	**16,536**	**-**	**-**	**-**	**1,698**	**-**	**20,642**
Amortisation at 1 April 2017 - as previously stated	**2,379**	**-**	**-**	**11,270**	**-**	**-**	**-**	**-**	**-**	**13,649**
Prior period adjustments	-	-	-	-	-	-	-	-	-	-
Amortisation at 1 April 2017 - restated	**2,379**	**-**	**-**	**11,270**	**-**	**-**	**-**	**-**	**-**	**13,649**
Provided during the year	178	-	-	2,411	-	-	-	-	-	2,589
Reclassifications	14	-	-	14	-	-	-	-	-	28
Disposals / derecognition	(273)	-	-	(121)	-	-	-	-	-	(394)
Amortisation at 31 March 2018	**2,298**	**-**	**-**	**13,574**	**-**	**-**	**-**	**-**	**-**	**15,872**
Net book value at 31 March 2018	**110**	**-**	**-**	**2,962**	**-**	**-**	**-**	**1,698**	**-**	**4,770**
Net book value at 1 April 2017	**264**	**-**	**-**	**5,323**	**-**	**-**	**-**	**990**	**-**	**6,577**

Note 14 Property, plant and equipment

Note 14.1 Property, plant and equipment - 2018/19

	Land	Buildings	Dwellings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**52,077**	**64,203**	**-**	**18,708**	**17,539**	**49,897**	**14,204**	**80**	**216,708**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	2,095	-	11,932	461	2,904	703	148	**18,243**
Impairments	-	(4,924)	-	-	-	-	-	-	**(4,924)**
Reversals of impairments	-	(73)	-	-	-	-	-	-	**(73)**
Revaluations	77	(243)	-	-	-	-	-	-	**(166)**
Reclassifications	-	644	-	(14,719)	892	10,481	2,264	91	**(347)**
Disposals / derecognition	-	(89)	-	-	(59)	(8,895)	(455)	-	**(9,498)**
Valuation/gross cost at 31 March 2019	**52,154**	**61,613**	**-**	**15,921**	**18,833**	**54,387**	**16,716**	**319**	**219,943**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**3**	**-**	**-**	**13,381**	**30,695**	**10,455**	**63**	**54,597**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	3,117	-	-	1,521	5,789	2,098	20	**12,545**
Impairments	-	(2,591)	-	-	-	-	-	-	**(2,591)**
Reversals of impairments	-	(81)	-	-	-	-	-	-	**(81)**
Revaluations	-	(381)	-	-	-	-	-	-	**(381)**
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(60)	-	-	(55)	(8,882)	(453)	-	**(9,450)**
Accumulated depreciation at 31 March 2019	**-**	**7**	**-**	**-**	**14,847**	**27,602**	**12,100**	**83**	**54,639**
Net book value at 31 March 2019	**52,154**	**61,606**	**-**	**15,921**	**3,986**	**26,785**	**4,616**	**236**	**165,304**
Net book value at 1 April 2018	**52,077**	**64,200**	**-**	**18,708**	**4,158**	**19,202**	**3,749**	**17**	**162,111**

Note 14.2 Property, plant and equipment - 2017/18

	Land	Buildings	Dwellings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**51,220**	**59,175**	**-**	**9,314**	**16,816**	**42,539**	**13,539**	**74**	**192,677**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	**51,220**	**59,175**	**-**	**9,314**	**16,816**	**42,539**	**13,539**	**74**	**192,677**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	945	-	15,565	163	3,889	2,056	6	**22,624**
Impairments	-	(149)	-	-	-	-	-	-	**(149)**
Reversals of impairments	34	694	-	-	-	-	-	-	**728**
Revaluations	823	3,529	-	-	-	-	-	-	**4,352**
Reclassifications	-	33	-	(6,171)	605	4,782	723	-	**(28)**
Disposals / derecognition	-	(23)	-	-	(45)	(1,313)	(2,114)	-	**(3,495)**
Valuation/gross cost at 31 March 2018	**52,077**	**64,203**	**-**	**18,708**	**17,539**	**49,897**	**14,204**	**80**	**216,708**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**-**	**-**	**-**	**12,025**	**27,030**	**11,193**	**61**	**50,309**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2017 - restated	**-**	**-**	**-**	**-**	**12,025**	**27,030**	**11,193**	**61**	**50,309**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	2,724	-	-	1,401	4,942	1,396	2	**10,465**
Impairments	-	(37)	-	-	-	-	-	-	**(37)**
Reversals of impairments	-	(703)	-	-	-	-	-	-	**(703)**
Revaluations	-	(1,981)	-	-	-	-	-	-	**(1,981)**
Reclassifications	-	-	-	-	-	-	(28)	-	**(28)**
Disposals / derecognition	-	-	-	-	(45)	(1,277)	(2,106)	-	**(3,428)**
Accumulated depreciation at 31 March 2018	**-**	**3**	**-**	**-**	**13,381**	**30,695**	**10,455**	**63**	**54,597**
Net book value at 31 March 2018	**52,077**	**64,200**	**-**	**18,708**	**4,158**	**19,202**	**3,749**	**17**	**162,111**
Net book value at 1 April 2017	**51,220**	**59,175**	**-**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**

Note 14.3 Property, plant and equipment financing - 2018/19

	Land	Buildings	Dwellings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	52,154	61,606	-	15,921	3,986	26,710	4,616	236	**165,229**
Owned - donated	-	-	-	-	-	75	-	-	**75**
NBV total at 31 March 2019	**52,154**	**61,606**	**-**	**15,921**	**3,986**	**26,785**	**4,616**	**236**	**165,304**

Note 14.4 Property, plant and equipment financing - 2017/18

	Land	Buildings	Dwellings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	52,077	64,200	-	18,708	4,158	19,089	3,749	17	**161,998**
Owned - donated	-	-	-	-	-	113	-	-	**113**
NBV total at 31 March 2018	**52,077**	**64,200**	**-**	**18,708**	**4,158**	**19,202**	**3,749**	**17**	**162,111**

Note 15 Revaluations of property, plant and equipment

A professional revaluation was undertaken on all land and buildings at 31 March 2019.

The valuation was carried out by the District Valuers of the Revenue and Customs Government Department. The valuation was carried out in accordance with the terms of the Royal Institution of Chartered Surveyors (RICS), insofar as these terms are consistent with the requirement of HM Treasury, the National Services and the Department of Health.

The market value was used in arriving at fair value for the operational assets subject to the additional special assumptions that:

a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously;

b) in the respect of the Market Value of non-operational asset only the NHS is assumed not to be in the market for the property interest; and

c) regard has been had to appropriate lotting to achieve the best price.

The revaluation model set out in IAS 16 was applied to value the capital assets to fair value.

The following table summarises the gross carrying value of fully depreciated assets that are still in use.

Gross Carrying Value of Assets In Use	2018/19
	£000
Furniture & fittings	56
Transport equipment	9,795
Plant & machinery	9,193
Information technology	8,850
Total	**27,894**

Note 16 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	46	60
Consumables	2,591	2,686
Total inventories	**2,637**	**2,746**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £10,542 (2017/18: £10,757).

Inventories written-down and recognised as expenses for the year were £0k (2017/18: £0k).

Reversals of inventories written-down in prior periods recognised for the year were -£89,000 (2017/18: £0k).

Note 17 Receivables

Note 17.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	27,354	
Contract assets*	-	
Trade receivables*		3,747
Capital receivables	11	-
Accrued income*		14,765
Allowance for impaired contract receivables / assets*	(5,668)	
Allowance for other impaired receivables	-	(853)
Prepayments (non-PFI)	4,561	5,547
Interest receivable	20	12
PDC dividend receivable	174	420
VAT receivable	15	84
Other receivables	590	376
Total current trade and other receivables	**27,057**	**24,098**
Non-current		
Contract receivables*	-	
Contract assets*	-	
Trade receivables*		-
Capital receivables	-	-
Accrued income*		-
Allowance for impaired contract receivables / assets*	-	
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
Interest receivable	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	18,116	14,785
Non-current	-	-

* Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 17.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**853**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	853	(853)
New allowances arising	4,850	-
Reversals of allowances	(29)	-
Utilisation of allowances (write offs)	(6)	-
Allowances as at 31 Mar 2019	**5,668**	**-**

Note 17.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**851**
Prior period adjustments	-
Allowances as at 1 Apr 2017 - restated	**851**
Transfers by absorption	-
Increase in provision	77
Amounts utilised	-
Unused amounts reversed	(75)
Allowances as at 31 Mar 2018	**853**

Note 18 Non-current assets held for sale and assets in disposal groups

	2018/19 £000	2017/18 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**44**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**44**
Transfers by absorption	-	-
Assets classified as available for sale in the year	-	-
Assets sold in year	-	(44)
Impairment of assets held for sale	-	-
Reversal of impairment of assets held for sale	-	-
Assets no longer classified as held for sale, for reasons other than sale	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 19 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19 £000	2017/18 £000
At 1 April	**30,300**	**18,637**
Prior period adjustments	-	-
At 1 April (restated)	**30,300**	**18,637**
Transfers by absorption	-	-
Net change in year	(8,582)	11,663
At 31 March	**21,718**	**30,300**
Broken down into:		
Cash at commercial banks and in hand	7	7
Cash with the Government Banking Service	21,711	30,293
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**21,718**	**30,300**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**21,718**	**30,300**

Note 20 Payables

Note 20.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	7,540	7,445
Capital payables	4,049	10,715
Accruals	16,483	17,719
Social security costs	3,563	3,268
Other taxes payable	2,718	2,428
Other payables	3,594	3,343
Total current trade and other payables	**37,947**	**44,918**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,769	1,839
Non-current	-	-

* Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 22.1. IFRS 9 is applied without restatement therefore comparatives have not been restated. Further detail regarding this change is included in note 28.

Note 21 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	218	90
Total other current liabilities	**218**	**90**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 22 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Bank overdrafts	-	-
Other loans	-	-
Total current borrowings	**-**	**-**
Non-current		
Other loans	107	107
Total non-current borrowings	**107**	**107**

Note 22.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**-**	**107**	**-**	**-**	**107**
Cash movements:					
Financing cash flows - payments and receipts of principal	-	-	-	-	-
Financing cash flows - payments of interest	-	-	-	-	-
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-
Transfers by absorption	-	-	-	-	-
Additions	-	-	-	-	-
Application of effective interest rate	-	-	-	-	-
Change in effective interest rate	-	-	-	-	-
Changes in fair value	-	-	-	-	-
Other changes	-	-	-	-	-
Carrying value at 31 March 2019	**-**	**107**	**-**	**-**	**107**

Note 23 Provisions for liabilities and charges analysis

Note 23.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	**1,370**	**8,816**	**258**	**-**	**-**	**525**	**6,866**	**17,835**
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	(12)	(156)	-	-	-	-	-	(168)
Arising during the year	87	307	416	-	-	-	3,062	3,872
Utilised during the year	(155)	(418)	(125)	-	-	(177)	(1,887)	(2,762)
Reversed unused	-	(1,172)	(177)	-	-	(198)	(3,597)	(5,144)
Unwinding of discount	1	9	-	-	-	-	-	10
At 31 March 2019	**1,291**	**7,386**	**372**	**-**	**-**	**150**	**4,444**	**13,643**
Expected timing of cash flows:								
- not later than one year;	155	412	372	-	-	150	4,444	5,533
- later than one year and not later than five years;	609	1,629	-	-	-	-	-	2,238
- later than five years.	527	5,345	-	-	-	-	-	5,872
Total	**1,291**	**7,386**	**372**	**-**	**-**	**150**	**4,444**	**13,643**

Injury Benefits provision of £7,387k (2017/18 £8,816k) relates to staff injured at work, whilst the Early Departure Costs provision of £1,291k (2017/18 £1,370k) relates to staff who have taken early retirement. Both amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of 0.29% is applied.

The Legal Claims provision of £372k (2017/18 £258k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority. The Redundancy provision of £150k (2017/18 £525k) relates to ongoing management restructures within the Trust.

The other provision of £4,444k (2017/18 £6,866k) includes £3,114k in relation to pending legal cases affecting calculation of holiday pay, £1,003k for pending employment tribunals and £327k relocation costs for recruitment of overseas paramedics.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions and early departure costs.

Note 23.2 Clinical negligence liabilities

At 31 March 2019, £54,231 was included in provisions of NHS Resolution in respect of clinical negligence liabilities of London Ambulance Service NHS Trust (31 March 2018: £59,070).

Note 24 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(156)	(106)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(156)**	**(106)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(156)**	**(106)**
Net value of contingent assets	**-**	**-**

Note 25 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	8,095	3,265
Intangible assets	3	14
Total	**8,098**	**3,279**

Note 26 Financial instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined

formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 26.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	22,304	-	-	22,304
Cash and cash equivalents at bank and in hand	21,718	-	-	21,718
Total at 31 March 2019	**44,022**	**-**	**-**	**44,022**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	18,936	-	-	-	18,936
Cash and cash equivalents at bank and in hand	30,300	-	-	-	30,300
Total at 31 March 2018	**49,236**	**-**	**-**	**-**	**49,236**

Note 26.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Other borrowings	107	-	**107**
Trade and other payables excluding non financial liabilities	31,665	-	**31,665**
Total at 31 March 2019	**31,772**	**-**	**31,772**

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Other borrowings	107	-	**107**
Trade and other payables excluding non financial liabilities	39,318	-	**39,318**
Total at 31 March 2018	**39,425**	**-**	**39,425**

Note 26.4 Fair values of financial assets and liabilities

The book value (carrying value) of financial assest and liabilities is considered to be a reasonable approximation of fair value.

Note 26.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	31,665	**39,318**
In more than one year but not more than two years	-	-
In more than two years but not more than five years	107	**107**
In more than five years	-	-
Total	**31,772**	**39,425**

Note 27 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	11	7	11	4
Stores losses and damage to property	2,366	1,360	2,282	1,533
Total losses	**2,377**	**1,367**	**2,293**	**1,537**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	25	472	41	1,002
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**25**	**472**	**41**	**1,002**
Total losses and special payments	**2,402**	**1,839**	**2,334**	**2,539**

Note 28 New Accounting Standards

Note 28.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 28.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 29 Related parties

The Department of Health and Social Care, as the London Ambulance Service NHS Trust's parent department, is considered to be a related party.

During the year none of the Department of Health and Social Care Ministers, London Ambulance Service NHS Trust board members or members of key management staff, or parties related to any of them, has undertaken any material transactions with the London Ambulance Service NHS Trust.

The London Ambulance Service NHS Trust has had a significant number of material transactions during the year with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below where receipts exceed £10m.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000s	£000s	£000s	£000s
NHS Barnet CCG	187	13,264	-	75
NHS Bexley CCG	130	10,508	-	310
NHS Brent CCG	183	16,824	-	372
NHS Bromley CCG	161	13,667	-	896
NHS Camden CCG	156	10,787	217	-
NHS Central London (Westminster) CCG	173	12,166	-	11
NHS City And Hackney CCG	160	12,528	6	461
NHS Croydon CCG	219	15,906	-	520
NHS Ealing CCG	195	13,881	-	280
NHS Enfield CCG	165	12,450	-	760
NHS England	114	15,368	-	7,965
NHS Greenwich CCG	145	12,465	-	596
NHS Haringey CCG	138	10,191	-	408
NHS Havering CCG	148	12,087	10	392
NHS Hillingdon CCG	185	13,210	-	229
NHS Hounslow CCG	144	10,391	12	241
NHS Lambeth CCG	186	14,974	-	269
NHS Lewisham CCG	156	12,398	-	141
NHS Newham CCG	173	13,602	8	381
NHS Redbridge CCG	147	11,917	9	420
NHS Southwark CCG	187	14,474	-	177
NHS Tower Hamlets CCG	148	12,013	8	608
NHS Waltham Forest CCG	129	10,392	8	317
NHS Wandsworth CCG	144	10,302	46	-

The Trust has a number of staff who also work for St John Ambulance Service. The transactions with St John Ambulance Service during the year comprised expenditure of £1,678k (2017/18 £1,234k), income of £3k (2017/18 nil) and the amount payable by the Trust as at 31 March 2019 was £36k (31 March 2018 £193k).

The London Ambulance Service NHS Trust acts as corporate trustee for the London Ambulance Service Charity. There were no financial transactions with the Charity in 2018/19.

Note 30 Events after the reporting date

There have been no events after the reporting period that need to be disclosed in the financial statements.

Note 31 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	57,760	117,567	55,980	96,013
Total non-NHS trade invoices paid within target	47,952	93,303	47,695	69,177
Percentage of non-NHS trade invoices paid within target	**83.0%**	**79.4%**	**85.2%**	**72.0%**
NHS Payables				
Total NHS trade invoices paid in the year	253	2,455	304	2,488
Total NHS trade invoices paid within target	223	1,404	242	1,073
Percentage of NHS trade invoices paid within target	**88.1%**	**57.2%**	**79.6%**	**43.1%**

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 32 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	13,244	(9,985)
External financing requirement	**13,244**	**(9,985)**
External financing limit (EFL)	20,350	8,696
Under / (over) spend against EFL	**7,106**	**18,681**

Note 33 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	21,532	23,406
Less: Disposals	(48)	(111)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**21,484**	**23,295**
Capital Resource Limit	21,788	24,964
Under / (over) spend against CRL	**304**	**1,669**

Note 34 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,425	1,002	2,751	262	262	6,048	(4,405)	6,143	5,758	6,958
Breakeven duty cumulative position	2,569	3,994	4,996	7,747	8,009	8,271	14,319	9,914	16,057	21,815	28,773
Operating income		279,864	283,617	281,731	303,109	303,827	324,052	319,992	355,507	364,598	388,978
Cumulative breakeven position as a percentage of operating income		**1.4%**	**1.8%**	**2.7%**	**2.6%**	**2.7%**	**4.4%**	**3.1%**	**4.5%**	**6.0%**	**7.4%**

14. Appendix – Glossary of terms

(This glossary does not form a part of the statutory accounts)

STATEMENT OF COMPREHENSIVE INCOME

Statement of comprehensive income

Under UK GAAP used to be called a Profit and Loss account or an Income and Expenditure account. Public sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

Income from patient care activities

Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

Income and expenditure

Often called a Profit and Loss account or an Income and Expenditure account. Public sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

Other operating income

Income from non-patient care services such as commercial training, research funding etc.

Operating surplus

The surplus generated by the normal operations of the Trust before taking into account interest, depreciation and amortisation.

Depreciation

When a fixed asset is purchased, the cost of that asset needs to be charged to the income and expenditure account over the life of the asset to recognise the contribution of that asset to the work of the Trust in each year of ownership. On purchase of a fixed asset, the expected life is assessed and the cost is spread over that life. The value of the asset therefore diminishes, or depreciates, over time.

Amortisation

Where depreciation applies to tangible fixed assets, amortisation is the same process for non-tangible fixed assets such software licences.

Other gains / (Losses)

The difference between the value of an asset in the balance sheet (for example equipment or buildings) and the actual sale price of the item.

Public Dividend Capital (PDC)

PDC originated in NHS Trusts as the difference between the valuation of its assets and liabilities on establishment as an NHS Trust. This originating debt is deemed an asset of the Secretary of State, and equates to taxpayers equity in the organisation. The Trust has to make a return on this capital equivalent to 3.5% per annum, and this amount has to be paid over to the Treasury. The original debt can increase over time due to the allocation of additional capital funds, and is repayable over time.

STATEMENT OF FINANCIAL POSITION

Non-current assets

An asset that has a life that extends beyond the current financial year and that will generate economic benefits in future accounting periods – as opposed to current assets, which are realisable immediately or in the next accounting period. These are categorised as Property, plant and equipment (e.g. equipment or buildings) or Intangible assets (e.g. software).

Current assets

These are assets that are held on the balance sheet of the organisation that have an immediate cash value. These include items such as inventories that could be sold to realise cash quickly, debtors that can be collected quickly to realise cash, or cash held in a bank account.

Inventories

Material held as stock which could be sold to realise cash quickly. Can either be valued at cost where stock is valued in the books at the purchase price or, net realisable value where stock is valued in the books at a value that it could reasonably be expected to fetch if it was sold on open market today.

Receivables

Money owed to the Trust by Commissioners and Customers for services provided, sometimes referred to as debtors.

Payables

Money owed by the Trust to Suppliers for goods and services received, sometimes referred to as creditors.

Total taxpayers' equity

Effectively the value of the taxpayer's investment in the organisation – equal to the difference between the organisation's assets and liabilities. Generally made up of Public Dividend Capital (the initial taxpayer investment plus subsequent specific investments), revaluations reserves (recognising the increase in the value of assets held over time) and Income and expenditure reserves (often referred to as retained earnings which is effectively the sum of all surpluses and deficits achieved by the Trust).

NOTES TO THE ACCOUNTS

Historical cost convention

Representing the value of an asset carried in the Statement of Financial Position (balance sheet) as the amount paid for it on the purchase date.

Accruals basis

Method of accounting whereby the accounts are prepared taking into consideration all income received and receivable, and expenditure paid and payable, wherever they relate to the period in question whether or not cash has been paid or received, as opposed to only recognising transactions based on cash receipts and payments in the period.

Off balance sheet

Refers to assets that are in use by the Trust but which are not technically 'owned' by the organisation, and therefore do not appear in the balance sheet. An example of this would be operating leases, where equipment, such as vehicles, is leased by the organisation but never comes into our ownership, and only the fees paid to use the assets are recognised as expenditure in the Trust accounts.

Liquid Resources

Resources that can be released quickly to enable the organisation to settle debts. Typically these include cash physically held by the Trust or Trust bank deposits in short term accounts.

Prepayments

Where the Trust has paid in advance for goods or services – for example, quarterly payment in advance for telephone rentals.

Deferred income

Income received in the financial year but deferred to a subsequent accounting period because the relevant services will be provided in that future accounting period.

Reserves

Funds set aside in recognition of a future event, project or change, where the need has been recognised but the event has not happened.

TERMINOLOGY

Going concern basis

The accounts are prepared on the basis that the Trust will still be in existence in the next financial year, and that it will therefore be in a position to recover any debtors due to it, and that it will be around to cover its long term liabilities. If it is likely that an organisation will not be in existence beyond this set of accounts, then long term liabilities would become immediately due, and the position of long term debtors would be called into question, resulting in the need to recognise that in the results presented in this set of accounts.

Capital expenditure

The amount expended by the Trust that enhances the value of Trust assets whose useful life extends beyond the current accounting period.

Revenue expenditure

Expenditure on the day to day operations of the Trust whose benefit is used in that accounting period such as pay expenditure, payment for

services etc, as opposed to capital expenditure which generates economic benefits in future accounting periods as the asset created is used over time.

Consumables

Items of inventory that the Trust retains supplies of which have a life of less than one year (and are therefore not fixed assets) such as uniform, stationery, and items of medical and operational equipment that have a short lifespan or are single use.

CCGs – Clinical Commissioning Groups

Clinical Commissioning Groups replaced Primary Care Trusts as the organisations responsible for commissioning care services. They were established from 1st April 2013.

Liability

A liability arises where an organisation has an obligation to pay for something that has already occurred, and around which there is certainty, but is not yet physically paid for.

Provisions

An allowance in the accounts for a known item, but where the value or timing of the event giving rise to it is uncertain. An example may be where a pay award from 1 January in a given year has not yet been agreed, and the settlement date is uncertain. The organisation would typically provide an estimate for inclusion in the accounts to ensure that the relevant charge to Income and Expenditure is made in the correct year.

Contingent liability

A situation where a financial obligation to pay for something that has already happened may arise, but where there is uncertainty or where the final value is difficult to quantify due to dependencies on other things. For example, an outstanding legal claim against the organisation, where if the verdict goes against the organisation, there will be an obligation to pay for an unquantifiable amount. Amounts carried in the accounts under this heading will inevitably be estimates based on the best information available at the time.

Value Added Tax (VAT)

May be in the form of output tax – VAT charged on sales, or input tax – VAT paid on purchases. In the NHS, normal NHS healthcare activity does not attract VAT.

Post balance sheet event

Something that is recognised after the accounts have been finalised, but before publication, which impacts on the results as they are presented, and has a significant impact on how the results should be interpreted.

Risk pooling scheme

A risk pooling scheme is an alternative to commercial; insurance whereby similar organisations join together to finance an exposure to a certain type of liability or risk, sharing the cost. For the Trust, this is essentially the NHS insurance scheme, where an annual premium is paid to cover any claims for certain types of incident that may arise during the year. The scheme covers insurance risks around buildings, equipment and fire, as well as clinical negligence issues.

NHSLA

The NHS Litigation Authority is the body responsible for handling negligence claims against NHS organisations. The NHSLA also advises NHS organisations on risk management.

Losses and special payments

Any payments made in respect of bad debts, stock write offs, insurance excesses or compensation payments that are not considered a part of the normal business of the Trust.

HART

Hazardous Area Response Team – a specialist team to respond to incidents that occur in areas that are hazardous to human health.

RRV

Rapid Response Vehicle – a smaller response vehicle with a single crew member able to respond to incidents more quickly than larger vehicles.

PTS

Patient Transport Service – a non-urgent service to take patients to routine hospital and clinic appointments.



Annual Report & Accounts 2018/19

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