NHS
London Ambulance Service
NHS Trust

Annual Report
2016/17

London Ambulance Service Annual Report 2016/17

Contents

Foreword from Chairman Heather Lawrence and Chief Executive Andrew Grimshaw

As a Trust in special measures, our focus during 2016/17 has been to bring about change to enable us to deliver better care for our patients and make our Service a better place to work. We have achieved this through our quality improvement plan which supports our vision of *Making the LAS great*, and has focused on the actions that each of us can take to improve our Service. While we recognise we remain challenged in some areas, we have made significant progress towards improvement.

Our dedicated and talented staff are critical to our success and we can only deliver excellent care when they have the right support and resources. During 2016/17 we have continued to invest in our workforce, recruiting over 350 frontline staff while implementing a range of measures to improve access to training and development. Ensuring our workforce is as diverse as the population it serves has been a priority, and an action plan has been implemented to ensure progress. Alongside this, significant work has taken place to improve our organisational culture, and make the London Ambulance Service a great place to work. Our recent staff survey results demonstrate progress; of the 88 key questions, 67 are significantly better than in 2015/16.

As part of our improvement plan, we have also strengthened our governance systems, processes and structures, including the way we report and learn from incidents and through the recruitment of a chief quality officer. The roll-out of our digital medicines management system and vehicle 'make ready' schemes has allowed our medics to work more efficiently and spend more time treating patients. The purchase of 140 new ambulances and new hazardous area response team vehicles, to be delivered in the coming year, alongside 60 new cars already on the road, will ensure our staff have the resources they need to care for patients.

Improving the quality of our services remains a key focus and we were delighted to receive a rating of "Good" from the Care Quality Commission (CQC) for our NHS 111 service for South East London in February 2017. During their visit, the CQC observed how our staff treat patients with compassion, dignity and respect, and involve them in decisions about their care and treatment. The report demonstrates our commitment to providing high quality care and the role we can play in the delivery of urgent care in the capital.

Notwithstanding our progress, we recognise there is much more we need to do to improve – our journey of change is a marathon, not a sprint. To transform as an organisation, we must become more consistent, embed improvements to make sure they are sustainable, and continue to innovate. We expect the CQC to highlight the need for further improvement in their follow up inspection report on our 999 service, to be published in the coming months.

Like almost all other ambulance trusts, the unprecedented increase in demand means we remain challenged in meeting national performance targets. During 2016/17 we attended more incidents than ever before. In real terms this means we are now handling nearly 200 more incidents a day across the capital, compared with just last year.

We have worked hard with our commissioners to measure demand and ensure our service is responsive. Yet with our aging population, and an increase in those with complex and long term health needs, we must continue to evolve our Service to ensure it remains efficient, effective and right for our patients. This requires us to work with our partners across the health landscape to ensure our Service is fully integrated into the five sustainability and transformation plans in development across the capital. It also means we must continue to

transform from a Service that delivers emergency care and transportation to hospital, towards a Service that increasingly provides diagnosis, treatment and referral in the community where appropriate. Our new clinical strategy, published in January 2017, sets out the path to achieving this.

In 2016/17 we provided BBC One with unprecedented access to our Service to film *Ambulance*, a TV series which followed our frontline medics and control room staff. We reached 4.5 million viewers and were proud to be able show the country the incredible job our staff undertake day in, day out. Opening our doors was not easy, however the documentary resulted in real benefits for staff and patients; increasing the number of people applying for jobs at our Service, significantly boosting pride among staff and crucially increasing public awareness of the pressures we face each day.

HRH The Duke of Cambridge made a private visit to thank staff for their response to the tragic events which took place in Westminster on the 22 March 2017, as did the Mayor of London Sadiq Khan. We are humbled by the response of our staff, and that of the other emergency services who responded with courage and bravery. We also hosted a visit from HRH Prince Harry who launched 'Time to Talk Day' as part of the Heads Together mental health awareness campaign at our HQ in February 2017. We are proud of the mental health support we provide to our staff and grateful to be recognised in this way.

Our new Chief Executive Garrett Emmerson will join us in May 2017. Garrett brings a wealth of experience in management, leadership and logistics in the capital and we very much look forward to welcoming him to the Service. We would like to pay tribute to Dr Fionna Moore MBE who led our organisation as Chief Executive until December 2016. Fionna's leadership brought our staff together at one of the most difficult times in our Service's history.

As we move forward into 2017/18, we continue to build on our values of care, clinical excellence and commitment. Our priorities for the coming year have been developed in partnership with our staff, including through a series of road shows that provided the opportunity for us to hear the views of over 1,000 staff members. We also continue to work closely with other important stakeholders, including our Patients Forum.

It is only through such strong engagement, and by working together, we will continue to transform our Service. We would like to thank everyone for their hard work this year and their continued commitment to delivering high quality care for Londoners.

Heather Lawrence OBE, Chairman **Andrew Grimshaw, Chief Executive**

1. Performance report

Overview

About Us

London Ambulance Service is the busiest ambulance service in the UK. In 2016/17, we handled over 1.8 million emergency calls from across London and attended more than 1.1 million incidents. We are the only London wide NHS trust; employing over 5,100 staff across 70 sites in London to respond to the health needs of over eight million people who live and work in the capital.

Working across London presents specific challenges: over 150 languages are spoken; we have a transient population with people moving in and out of the city; and there are extremes of wealth and poverty and significant variations in quality and health outcomes. We therefore work hard to engage with the diverse population we serve and to ensure our services are accessible to all Londoners.

The London Ambulance Service in 2016/17:

As an integral part of the NHS, we work closely with partners across London. Commissioned by 32 clinical commissioning groups and NHS England for our specialist services, we also work closely with London's hospital, mental health and specialist trusts, as well as the five sustainability and transformation plans across the city. In addition we work in partnership with the other emergency services and London's Air Ambulance.

We are governed by our Trust Board, which meets monthly. It is made up of 13 members – a non-executive Chairman, five executive directors (including the Chief Executive), and six non-executive directors[1].

[1] As of 31 March 2017.

Our services

Our main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible.

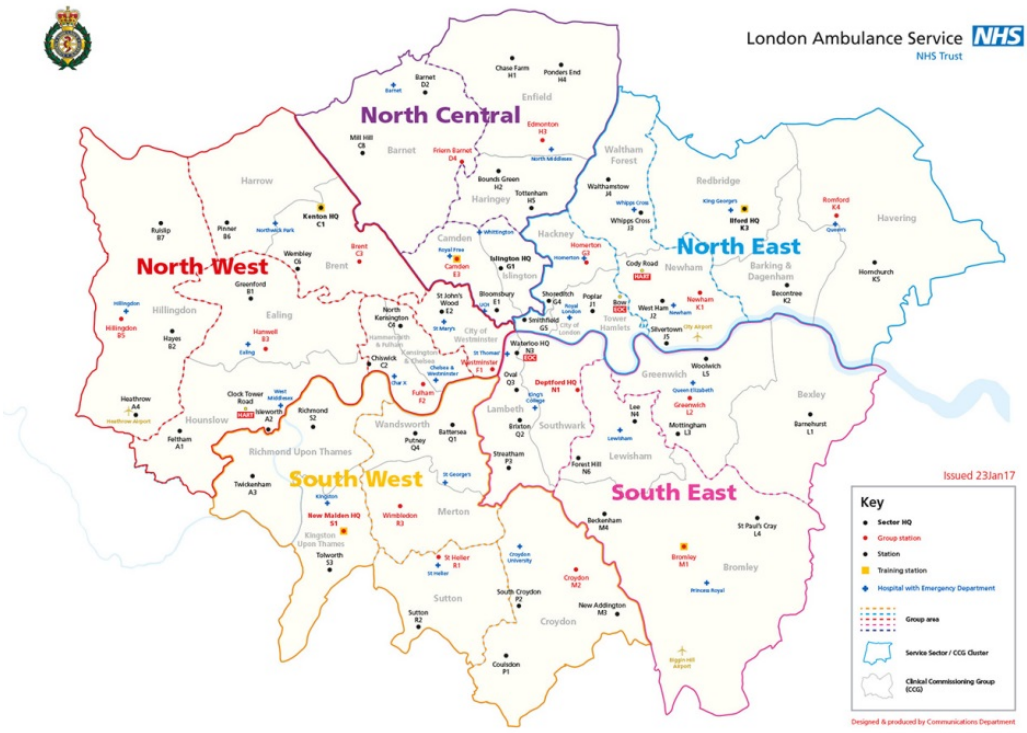
However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. Often these patients will receive more appropriate care somewhere other than at hospital and so we provide a range of care, recognising that many have complex problems or long-term medical conditions.

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

- Call handling – taking and prioritising 999 calls
- 999 emergency and urgent care response
- Clinical telephone advice – providing advice to members of the public with less serious illnesses and injuries that don't need an immediate ambulance response
- Dispatching and providing paramedics for London's Air Ambulance
- 111 Service – we run the 111 service for south east London
- Planning for, and responding to, large-scale events or major incidents in the capital.

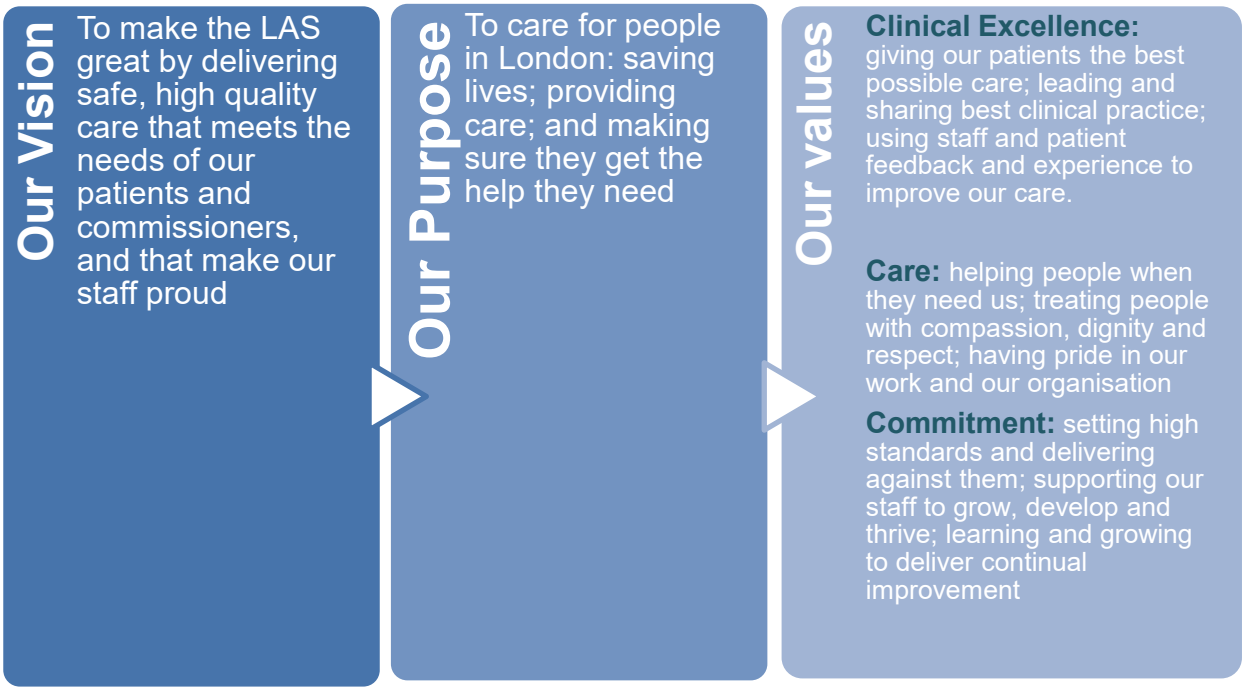
In 2016/17, we received approximately 5,000 emergency calls per day into our emergency operations centres located in Waterloo and Bow.

Our frontline services are structured to support the five sectors of London, ensuring we deliver a pan-London service and the flexibility to respond to local need. Operational and corporate support services are delivered centrally from our Headquarters in Waterloo, and from offices in Pocock Street and Union Street in central London. Our NHS 111 service is delivered from Southern House in Croydon, south London.



Our vision, purpose and values

Our vision, purpose and values shape all that we do. Developed in partnership with staff and stakeholders, these are:



Key issues

Care Quality Commission inspection and our quality improvement plan

In June 2015, we were placed in special measures on the recommendation of the Care Quality Commission (CQC) following a planned inspection.

Following this inspection, we developed our quality improvement programme – a single overarching plan to address quality improvement in our Service, led by the Chair and accountable to our Trust Board. A clear programme of delivery, accountability and governance was established, led by our Director of Transformation, Strategy & Workforce and supported by a programme management office, to ensure oversight and leadership.

Our improvement programme was categorised into five key themes, each with an executive director accountable for delivery:

- Making the London Ambulance Service a great place to work
- Achieving good governance
- Improving patient experience
- Improving environment and resources
- Taking pride and responsibility

By the end of the 2016/17, the vast majority of the projects within our plan were completed, with a number of actions being incorporated into business as usual for directorates. Projects of a more complex nature, which are yet to be completed, are being incorporated into the 2017/18 business plan. Our focus is now on embedding change, to make it consistent

across our organisation. This will be delivered through a transformation programme to begin in 2017/18.

The CQC has conducted two further inspections since June 2015. A focused inspection was carried out in September 2016 and a comprehensive full trust inspection was completed in February 2017.

The three core services listed below were inspected in February 2017:

- Emergency operations centres
- Urgent and emergency care
- Resilience planning including the hazardous area response team

During the inspection we spoke to the CQC about the impact we believe our work over the last year has made on our clinical care, our capacity and performance and our staff morale and culture. Their report is expected to be published in summer 2017.

Risks

Our Trust Board manages risk through our risk management policy, corporate risk registers and board assurance framework.

The board assurance framework and corporate risk register are presented at each meeting of our Trust Board, and further scrutiny is applied through the Quality Governance and Audit Committees. The risk register is reviewed in detail by our Executive Leadership Team each month.

Full details can be found in our governance statement on page 31 of this document.

Going concern statement

Our accounts have been prepared on a going concern basis. This is based on the expectation that we will be able to maintain a positive cashflow across 2017-18, not require any external financial support to achieve a positive cashflow and will be able to pay our creditors across 2017/18 as they fall due. Our management expect these conditions to be met in and continue beyond 2017/18.

Performance Analysis

Our Patients

We aim to provide our patients with the highest quality care and contribute towards Londoners having health outcomes among the best in the world.

Although we were placed in special measures by the CQC in 2015, our overall care of patients was rated as 'good', with the CQC recognising that patients in London receive good clinical care and that our staff are caring and compassionate.

Caring for our most seriously ill and injured patients

Cardiac arrest patients

Patients in cardiac arrest – when their heart stops, and they are clinically dead – are among our highest priority patients.

Our latest cardiac arrest report, published in November 2016, shows that during 2015/16, we attended 10,116 patients in cardiac arrest. Our published survival figures for those patients with the best chance of survival are amongst the highest in the country; just under a third (31.5 per cent) of cardiac arrest patients survived to leave hospital[2].

A defibrillator is a machine that is used to shock a patient's heart to restart it when they are in cardiac arrest. In 2013, we launched a defibrillator accreditation scheme which provides a package of support to shops, gyms, businesses and other organisations across London who purchase a defibrillator. Since its introduction, there has been a huge increase in the number of public access defibrillators across London, from 995 in 2012/13 to 4,486 as of March 2017. We have also been working closely to support our Patients Forum who have an on-going campaign to encourage businesses to install defibrillators.

Where a defibrillator in a public place was used to deliver a shock to patients in shockable heart rhythms, 57.3 per cent of patients survived to leave hospital[3].

Heart attack patients

There are eight specialist centres in London where we take patients who are believed to be having a heart attack, known as an ST-elevation myocardial infarction (STEMI). Taking patients to a specialist centre rather than a local hospital allows quicker access to treatment. This can include primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

Latest provisional data for 2016/17 shows our average response time for STEMI patients was within the national target of eight minutes. During the year, over 3,500 patients were treated by our staff and subsequently transported to an appropriate facility, which for the majority was a specialist heart attack centre.

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[2] These survival figures relate to a specific group of patients who were witnessed to suffer an out-of-hospital cardiac arrest of cardiac cause with an initial shockable rhythm. London Ambulance Service, Cardiac Arrest Annual Report: 2015/16 published November 2016

[3] ibid

Trauma care

Patients with the most serious injuries such as falls from height, stab or gunshot wounds are taken directly to one of four specialist major trauma centres in the capital: The Royal London Hospital, St George's Hospital, King's College Hospital and St Mary's Hospital. Evidence from around the world shows that rapidly conveying these patients to centres with specialist expertise and equipment saves lives and reduces long-term disability.

Our most recent major trauma annual report, published in January 2017[4] shows that 99 per cent of patients who needed to be transported directly to a major trauma centre were identified and taken to the right hospital for their injuries.

Responding to major trauma patients is a vital albeit small part of our work, equating to less than 0.5 per cent of the total workload.

Stroke patients

We take patients we suspect to be having a stroke to one of eight specialist stroke centres in London. Here they have rapid access to life-saving treatment which can increase their chances of survival and cut the risk of long-term disability caused by a stroke.

We attend approximately 1,200 suspected stroke patients every month. Our provisional data for 2016/17 shows that we appropriately convey 99 per cent of patients believed to be having a stroke to a hyper acute stroke unit, with 61 per cent of patients eligible for thrombolysis, a clot-busting treatment, arriving at an appropriate hospital within 60 minutes of the 999 call.

Over the last year, we have represented the UK ambulance services in the development and review of evidence-based national clinical guidelines for the management of stroke in adults and children.

Full details of our performance against the national Ambulance Quality Indicators can be found in our 2016/17 Annual Quality Account.

[4] Major Trauma Annual Report 2015, published in January 2017

Improving urgent and emergency care: Advanced paramedic practitioners

We introduced an advanced paramedic practitioner scheme in 2014 to enhance the level of care provided to our most seriously ill and injured patients, as well as those with complex pre-hospital care needs. Twenty four advanced paramedic practitioners operate out of four sites around London, responding to approximately 600 calls per month.

In January 2017, eight new advanced paramedic practitioners for urgent care were recruited from within the Service to enhance the care provided to patients with complex long-term conditions and less critical illnesses. The scheme is part of a 12-month pilot which aims to treat more patients in their homes without need the need to go to hospital.

The urgent care advanced paramedic practitioners specialise in treating patients with chronic conditions such as chronic obstructive pulmonary disease and back pain, providing treatments and medications which would normally be provided in other settings, such as urgent care centres and primary care.

It is hoped the pilot will help reduce pressure on A&E services, unnecessary conveyances to hospital and lead the way in enabling us to develop urgent care services which are responsive to the needs of our patients.

Caring for patients with urgent care needs

Identifying appropriate care

Whilst our core purpose always has been to save lives, urgent and unscheduled care forms a significant and increasing part of our work.

As such, we are adapting our Service towards staff assessing and treating patients at scene and in community settings, with transport to alternative care settings where appropriate. This can include transferring patients to minor injuries units, urgent care centres and walk-in centres where appropriate.

Our clinical hubs, based in our emergency operations centres and staffed by clinical team leaders, paramedics, nurses and mental health nurses provide a range of services to ensure that patients receive the most appropriate care for their condition.

This includes a hear and treat service where we provide clinical telephone advice for callers who have called 999 but do not have a serious or life threatening condition. Our clinical advisers offer advice on the best course of treatment for the patient—this could be care at home, being referred to a doctor or local pharmacy, or having an ambulance sent to them. We transfer around 10,000 calls a month to our hear and treat service.

During 2016/17, we continued to work closely with our local commissioners, the sustainability and transformation plan partnerships, 111 providers and community services to increase and improve access to services for patients where it’s not necessary for them to go to hospital.

Improving care for mental health patients

999 and NHS 111 are often the first point of care for patients experiencing a mental health crisis, and we continue to see a year-on-year increase in calls to these patients, with a 10.5 per cent increase in incidents[5] in 2016/17 compared to last year.

We recognise the important role that we have in risk reduction, and in signposting these patients to the most appropriate point of care or service. These calls are often complex, and take time to manage well.

Two years ago we introduced specialist mental health nurses into our emergency operations centre, to provide telephone support to ambulance crews and to provide a hear and treat service for patients, with the aim of reducing the need for an ambulance response. This initiative was shortlisted for a national Patient Safety Award in 2016 and the role is continuing to develop.

Through the mental health nurse team we continued to establish links with mental health trusts across London, allowing us to liaise with the crisis teams, develop new pathways and deal with adverse incidents or concerns. We have had a number of very successful joint training events during 2016/17 and are starting to see improved staff confidence in managing this group of patients.

Working in partnership

We continue to maintain a close working relationship with London's blue light services and other organisations. During 2016/17, we developed these relationships further to improve our response to patients. This included:

- Our co-responding trial with the London Fire Brigade, where fire crews in four boroughs are responding to a small number of our highest priority calls alongside our ambulance crews. If fire officers are closer to an incident, they are able to provide emergency life support until our clinicians arrive.
- Working with the Metropolitan Police Service to increase access to defibrillators. A trial in four boroughs has seen 110 defibrillators added to police vehicles, enabling police officers to respond alongside our crews to people in cardiac arrest.
- Working in partnership with the internationally acclaimed GoodSAM app, where clinically trained ambulance staff and members of the public, trained to an approved standard, are able to sign up as volunteers to respond to life-threatening emergency calls, including cardiac arrests. The app automatically alerts the closest two responders to an emergency call.
- Active involvement with the five sustainability and transformation plans across London, with representation from both executive director level and also from senior operational managers

Improving our care

Our clinical strategy

In January 2017, we published our clinical strategy setting out our clinical aims for the next five years and defining how we will deliver urgent care and NHS 111 services as part of the

[5] Data for data for April 2016 to January 2017 in comparison to the same period the previous year.

integrated and emergency care plans for each of the five London sustainability and transformation plan footprints.

The strategy outlines how ambulance clinicians will continue to develop their role in line with the Five Year Forward View, moving from delivering first aid and transportation to hospitals, towards a greater emphasis on decision-making, diagnosis, treatment and referral.

The overarching urgent and emergency care vision for our Service for 2016-2021 is:

- *for adults and children with urgent care needs*, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.
- *for those people with more serious or life-threatening emergency care needs*, we should ensure they are treated at the scene and then in centres with the right expertise and facilities to maximise the prospects of survival and good recovery.

To deliver this strategy, we will continue to develop a professional multi-disciplinary workforce with enhanced clinical capabilities, decision-making skills and leadership who are able to work as an integral part of the wider London healthcare system.

Improving care for bariatric patients

We recognise that we need to do more to respond to the increasing number of bariatric patients in London, and in 2016/17, we set up a working group to review our bariatric requirements. We are currently testing new equipment suitable for moving and assisting patients, and we are also looking at buying specialist vehicles to reduce our dependence on private providers.

Over the coming year, all clinical crews will receive training in managing emergencies for this group of patients.

Palliative care: Coordinate my care

The ambulance service is often the first point of contact for patients nearing the end of their life. This includes planned transfers from an acute care setting to the patient's preferred place of death; unplanned involvement following a sudden crisis, deterioration or worsening symptoms and involvement at, or immediately after, the patient's death.

Our clinicians are often presented with situations in which they have to make decisions about attempting resuscitation. These decisions may need to be made on the basis of limited information and in the context of a distressed family.

We are improving the way we integrate with, and access, specific end-of-life care plans (Coordinate my care records) so that our clinicians have early access to these to enable them to manage these situations better.

We are also investing in a range of different educational opportunities in partnership with the third sector and other providers to ensure that our crews have a clear understanding of the legal and ethical basis for the complex decisions that need to be made in these circumstances.

Improving care for patients with sickle cell disease

We responded to over 4,000 patients in sickle cell crisis in 2016, and of all hospital admissions related to sickle cell disease in the UK each year, 75% are in London. To improve our care for patients in this group we carried out our third sickle cell crisis clinical audit during 2016/17. This analysed both clinical data and patient experiences and found that the care we provide to patients in sickle cell crisis has improved dramatically in recent years and is of a high standard. The audit also made a number of recommendations on how to further improve our service. As a result, managing the care of sickle cell patients was included in the 2016/17 annual training provided to all our clinicians.

Clinical audit and research unit

Our clinical audit and research unit has responsibility for all clinical audit and research within our Service.

We increased the number of projects last year and our external funding also increased. We attracted over £600,000 for research projects that were active during 2016/17, and received a 62 per cent increase in funding from the North West London Clinical Research Network to support activity and build capacity.

Research that we were involved in during the year includes:

- Developing and validating a triage tool (via a smartphone app) to identify potential ruptured abdominal aortic aneurysms. Over 506 of our clinicians used this app on more than 5,000 patients.
- We recruited over 1,500 patients into PARAMEDIC-2 - a ground-breaking randomised controlled trial comparing adrenaline use to a placebo in out-of-hospital cardiac arrest.
- Towards the end of the year, we started the RIGHT-2 trial - a randomised controlled trial to determine whether giving Glyceryl trinitrate (GTN) to suspected stroke patients improves survival and neurological functioning.

- We continue to manage the website for the National Ambulance Research Steering Group which provides a platform for UK ambulance services to promote their research capabilities and activities. This website is also the first point of contact for researcher's wishing to collaborate with ambulance services.

We shared our research findings by publishing eight papers in peer-reviewed journals and presenting our work at six national conferences during the year.

We continued with our comprehensive clinical audit programme to demonstrate clinical quality and inform improvements. During this period, 50 frontline staff were directly involved in working with us on clinical audit projects.

As a direct result of our clinical audit, the 2016 National UK Ambulance Service Clinical Practice Guidelines were updated to clarify the indications for giving IV Paracetamol.

Our work on paediatric sepsis helped inform the development of our paediatric sepsis screening tool, to be introduced in 2017/18.

We continued to monitor the safety and management of patients who were not taken to hospital after a 999 call, but for whom a subsequent re-contact was made (within 24 hours) and the patient had seriously deteriorated or died. Feedback was recommended for nearly 300 members of frontline and control room staff (reflecting both areas for improvement and good practice).

During the year we also developed two new clinical performance indicators (elderly falls and continuous fitting) which will be introduced in 2017/18.

Reporting and learning from incidents

Over the previous 12 months, 495 cases were reviewed and 103 incidents were declared as serious to NHS England (London), with fourteen of these since being de-escalated.

In its follow-up inspection the CQC found that incident reporting had started to increase within our Service with the introduction of the Datix online reporting system, though the system had yet to be fully embedded.

As in previous years, the number of ambulance delay-related serious incidents has remained a consistent theme, although in 2016/17 we have seen a wider range of incidents declared including issues with clinical assessment and call handling.

Our newly appointed Chief Quality Officer will lead an in-depth review of serious incidents in 2017/18, aiming to reduce the time it takes to complete investigations and improve the quality of them.

We have introduced a learning from experience group chaired by an assistant medical director with input from across the organisation. In a bid to increase learning across the organisation, the group has:

- issued two editions of Insight magazine
- provided a series of infographic posters for display in ambulance stations
- informed the content of our core skills refresher programme
- introduced positive incident reporting.

Duty of candour

Duty of Candour requires trusts to inform and involve patients and their families in investigations where there has been severe harm. It is a mandatory requirement under Regulation 20 of the Health and Social Care Act.

We continued to roll out our duty of candour training through last year to all non-clinical staff to ensure there is awareness across the organisation. There have also been a series of duty of candour training sessions as part of the serious incident investigator training that goes into more detail for the benefit of people undertaking the family liaison officer role.

Compliance with the duty is recorded on Datixweb and monitored on a monthly basis. Quality governance and assurance managers have been duty of candour champions across sectors, giving support and advice to frontline staff. Our current compliance with duty of candour is 92 per cent.

Learning from experience: Insight magazine

In November 2016 we launched 'Insight', a new learning from experience magazine which highlights learning that has happened as a result of serious incident reports, incidents, risks and complaints.

It also looks at sharing best practice and highlights the changes that have been made in the Service as a result. The magazine is circulated throughout the organisation and includes clinical and non-clinical learning.

Listening to patients

Our Trust Board approved our new patient engagement strategy in July 2016. Developed in partnership with patient groups, the strategy outlines our commitment to patient and public engagement to 2020, focusing on:

- increasing meaningful engagement with patients so that their views influence service changes and strategic decision-making, as well as decisions about their care
- increasing our commitment to patient engagement across the organisation
- ensuring we are prepared to respond to changes in external requirements in the field of patient engagement
- improving engagement and relationships with partner agencies, patient and community groups and individuals. For example, by providing information, involving patients in our activities, and teaching life-saving skills.

During 2016/17, we launched two leaflets designed to encourage patients to tell us their views of our Service: a 'speaking with us' feedback leaflet available on every ambulance,

and a ‘complaints feedback’ leaflet to ensure that we know how complainants felt they were treated whilst making a complaint.

We also initiated an ‘Insight Project’, designed to bring together staff and specific groups of patients to explore how we could improve our services for particular groups. In addition, we worked with the RNIB to undertake research into the experience of blind and partially-sighted patients using ambulance services, which has led to the production of braille stickers for staff ID badges.

We have an active and engaged Patients’ Forum, who regularly review our work from the point of view of service users, carers and the public. The Patients’ Forum acts as a “critical friend”, and its members represent patients at a range of committees.

Community engagement events

We remain committed to supporting a wide range of patient engagement and public education events, and during 2016/17 we attended 518 events. Our ability to attend so many events is due to the ongoing support of over 1,000 staff on our database with 328 individuals taking part in multiple events, often in their own time.

The range of events we attend is extensive and includes:

- Basic life support and cardiac awareness
- Careers talks
- Junior citizen schemes
- Knife crime awareness
- London Ambulance Service talks
- First aid badges (brownies, cubs etc)
- Road safety initiatives
- Mental health awareness
- Underage drinking talks.

We have two public education officers who focus on delivering awareness sessions on the dangers of carrying knives and legal highs for young people.

Our Performance

Demand on our Service increased again this year, providing challenges for us. Whilst we provided a safe service, we were unable to reach our most seriously ill and injured patients as quickly as we wanted to, and faced with almost 200 more 999 incidents a day, we did not meet our national response time targets.

Our 111 service in south east London was recognised to be providing a good service by the CQC when it visited in September.

Delivering 999 performance

In 2016/17, we received 1,826,808 emergency calls in total - approximately 5,000 calls every day. This is a 1.4 per cent increase on 2015/16.

From these we responded to 1,115,945 emergency incidents, a 6.6 per cent increase on the previous year.

Category A – life-threatening calls:

National performance targets are set by the Department of Health and apply to every ambulance service in England. The targets measure the Service against the percentage of calls responded to in eight or 19 minutes depending on the priority of the call, with Category A calls measured as the highest priority.

Category A calls are subdivided into Red 1 calls and Red 2 Calls as follows:

Red 1 calls are the most time critical, and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. At least 75 per cent of these patients should receive a response within eight minutes.

Red 2 calls are serious, but less immediately time critical, and cover conditions such as stroke and fits. At least 75 per cent of these patients should receive a response within eight minutes.

A target known as A19 is designed to measure the percentage of Red 1 and Red 2 calls where a fully equipped ambulance arrives within 19 minutes. The target is to achieve this in 95 per cent of cases.

Of the total calls we received, 601,556 were treated as life threatening (Category A) - up more than 6.8 per cent from 2015/16 (563, 320 calls).

We attended over half a million Category A incidents last year (548, 896), up nine per cent on the previous year (505, 045 incidents). And we reached 66.4 per cent of these patients within eight minutes.

We arrived at 93.48 per cent of Category A patients within 19 minutes.

TARGET	National Target	2016/17 LAS Performance	2015/16 LAS Performance
RED 1- within 8 minutes	**75%**	69.19%	68.46%
RED 2- within 8 minutes	**75%**	66.31%	63.68%
RED 19-within 19 minutes	**95%**	93.48%	93.40%

Category C – lower priority calls

All other calls we receive fall into one of four C (lower priority) categories. Our target response times for Category C incidents are:

- Category C1 - 45 minutes
- Category C2-C4 - 60 minutes

In 2016/17, we received 1,225,216 Category C calls. We attended 567,020 Cat C incidents compared to 542,314 last year, an increase of 4.5 per cent. And we reached 74.5 per cent of these patients within our target time, compared to 73.9 per cent last year.

All statistics in this section are validated as of 21 April 2017

Delivering NHS 111 performance

Since November 2013, we have provided NHS 111 services for patients in South East London, covering Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark. NHS 111 is a telephone assessment service for people who need urgent medical help and advice but are not in a life-threatening situation. Calls are answered by highly trained advisors, who are supported by healthcare professionals, 24 hours a day, 365 days a year.

On average our 111 service manages around 760 calls a day during the week, up to 1,480 on a Saturday or Sunday and as many as 2,080 calls on bank holidays.

In 2016/17 our 111 service received 316,946 calls. We transferred 7.6 per cent of calls to the 999 system, the lowest proportion across 111 services in London.

Following an inspection in September, the CQC rated our 111 service as 'good', with a rating of good achieved in every one of the five domains. The CQC stated:

'*The London Ambulance Service (LAS) NHS 111 service provided a safe, effective, caring, responsive and well-led service to a diverse population in South East London'*

As part of the report, the CQC made a small number of recommendations on how our service can be improved, which we have already started to address. These include the recruitment of permanent clinical staff, improving our telephony system and increasing opportunities for staff to meet as a team.

Providing patient transport service and non-emergency transport services

Our patient transport service takes patients to and from their pre-arranged hospital or clinic appointments, and during 2016/17, we delivered six patient transport contracts.

We are commissioned through a tender process, and due to the reducing number of contracts we hold, we made the difficult decision in September 2016 to withdraw from the patient transport service market as the service had become financially unviable.

We are currently working with our remaining commissioning trusts to ensure that services are maintained until an appropriate transfer can be made to new providers. We will stop providing our patient transport service during 2017.

Our non-emergency transport service was set up in June 2015 to support our core A&E service in transporting low priority patients to healthcare facilities where there is little or no clinical intervention required en route. As a result we are able to increase the availability of

frontline crews to attend life-threatening calls and ensure lower priority patients receive transport within an agreed timeframe, providing for a better patient experience.

The number of journeys completed by our non-emergency transport service has continued to grow, from approximately 100 journeys a week when the service was set up to approximately 800 journeys a week at the end of this financial year.

Preparing for and managing large-scale events and incidents

We plan for and respond to large scale events in the capital. These include major sporting and cultural events such as the Notting Hill Carnival and the London Marathon where we work alongside St John Ambulance to provide patient care.

During major incidents, we work closely with other emergency services and partner organisations in London to save lives.

Our responsibilities include:

- putting hospitals in London on alert to receive patients
- setting up a system at the scene for prioritising and treating patients based on their medical needs
- treating, stabilising and caring for people who are injured
- taking patients who need further treatment to hospital.

We test our major incident plan on a regular basis, often with our partners. And our planning was put to the test with a number of incidents during the year, most notably the tram crash in Croydon and the terror attack in Westminster.

In early November we responded to a tram derailment in Croydon where we treated a large number of patients, taking 50 of them to hospital with the support of trauma teams from London's Air Ambulance.

Almost 70 frontline staff treated patients at Westminster in March when a man drove into people on the bridge before stabbing a police officer. We took 23 of the patients who we treated to hospital following the attack.

Our hazardous area response teams who attended both incidents are trained to provide emergency medical care in hazardous areas such as confined spaces or where there may be hazardous materials. When the CQC visited our Service in 2015, they raised a number of concerns about these teams, particularly the number of vacancies in the team and low level of shifts that were covered (at 24 per cent). We have since increased our establishment to 98 so that we now have 99 per cent of our hazardous response team shifts covered.

Improving our response

Our vehicles

During 2016/17 we have focused on increasing the availability and efficiency of our vehicles to enable our crews to provide the best possible care to patients. During the year we have:

- Approved a new fleet strategy to ensure our vehicles meet the needs of our patients and clinicians whilst providing value for money and supporting our environmental responsibilities

- Introduced 60 new fast response vehicles into service, carrying sophisticated medical equipment to support the needs of frontline staff. The vehicles have been well received and a second batch of new vehicles will enter service during 2017/18
- Purchased 140 new ambulances to be delivered throughout the coming year
- Replaced all of our hazardous area response team vehicles.

A key focus during the year has been upgrading our process for cleaning, equipping and preparing our vehicles. We are now using an approach where vehicles are ferried in to 14 hub sites across London to go through a robust preparation process, ensuring vehicles are cleaned and equipped in a consistent way across the Service. We introduced the new process through gold (final) and silver (interim) services starting in September 2016. At the end of March 2017, five gold and nine silver sites were rolled out as planned.

We have already seen a significant increase in the number of vehicles available for our crews, rising from an average of 305 vehicles per day in October 2016 to 324 vehicles in March 2017. The number of hours that vehicles are out of service hours due to missing equipment has reduced by 71 per cent between January and March 2017 compared to the same period in 2016. Feedback from gold service hub sites has been encouraging with staff recognising the improved cleanliness and equipping standards of vehicles.

The project remains on track to upgrade the remaining nine silver service sites to the gold service by the end of July 2017.

Managing medicines

Over the last year, we have seen a significant and sustained improvement in medicines management, building on measures put in place in response to the CQC's findings. We have reviewed our processes and procedures so that we are able to trace and account for medicines, from receipt in our logistics support unit to the point at which they are administered to patients. A range of technological solutions have been designed and implemented to support supply, administration and audit of medicines.

In February 2017, we appointed a full-time pharmacist to lead and develop our medicines management programme, and our medicines management group continues to meet regularly and provide advice and support to all areas of the organisation.

Over the last year we also:

- delivered a comprehensive programme of education relating to medicines management for frontline clinical staff
- introduced mobile electronic tablet technology and an associated Perfect Ward app to facilitate paperless medicines management audit and real time upload of audit results
- implemented the kit prep app to enable electronic scanning of drugs packs at stations to allow us to drug pack movements through the system
- developed MedMan an information technology portal to reconcile drugs usage forms with clinical records, providing assurance that drugs removed from packs are administered to patients. This also provides data on trends in drug usage and a means of tracing drugs in the event of batch recall or other concerns.
- introduced an additional 800 new drug packs and agreed minimum numbers to be available at each ambulance station

As a result of increased reporting methods, dedicated quality managers within the operational sectors and a tracking system for the administration of medicines to patients, we

have seen a marked increase in the number of drug errors reported. And we have held round tables where members of the medical directorate have met with staff, providing time for learning, guidance and support.

Information management and technology

Throughout the year we have upgraded some of our core systems and introduced new technologies into the organisation to support the delivery of patient care. These include:

- New airwave radios on all frontline vehicles and the redevelopment of our mobile data terminals to allow new satnavs to be introduced during 2017/18
- The redesign of our digital pocket guide app, which has over 2,300 registered users, so that staff have better access to reference information and local maps for location information.
- The introduction of Surface Pro tablets and smart phones for our incident response officers and roll-out of digital display screens to stations and control rooms where key information can be made available.
- Replacement of computers in both our control rooms alongside an update to our radio control system software. A new telephony system has been installed at our 111 service in Croydon.
- The introduction of new door and gate access cards system across Service to improvement security.
- Working with our logistics and clinical teams to implement our new medicines management systems.

During 2016/17 we experienced some technical difficulties with our Computer Aided Dispatch System which we use to take emergency calls and despatch ambulances. This includes an outage on 1st January 2017 which required our staff to revert to manual processes. As a result, our control room logged emergency calls using a manual back-up system for around five hours.

Our control room staff are fully trained and practised in operating this way and continued to prioritise patients in the same way, using the same assessment process as usual. However, as a manual system is not as efficient as a computer-based one, it took longer to manage calls.

Following the incident we launched a full external investigation, working with NHS Improvement and NHS England alongside an independent IT expert to look at the exact circumstances of what happened and any impact this may have had on our patients. This report is to be published in spring 2017.

Supporting sustainability

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

One of the key aims of our current procurement strategy is to embed sustainability within its supply chain. We are aiming to ensure that social, economic and environmental issues are considered during all stages of our procurement process, and are developing policy and procedures to support this.

Our sustainable procurement aims are to:

- increase awareness of sustainable procurement principles within each departmental spend category
- promote the sustainable purchasing policy, strategy, aims and objectives to key internal stakeholders
- embed good practice in sustainable procurement in day-to-day working and as part of the procurement process. Consider the whole life cycle impacts of the procurement
- undertake sustainability risk/impact assessments of products and services and their supply chains and prioritise
- ensure that environmental, social and economic impacts are appropriately considered in the assessment of value for money when setting up contracts or framework agreements
- manage tendering and lotting strategies that ensure fair access to contracting opportunities for businesses of all sizes and types
- collaborate with other ambulance trusts and other organisations to improve knowledge and understanding of sustainable procurement and to seek shared opportunities and benefits.

To reduce our carbon emissions and increase efficiency we are investing heavily in replacing a large proportion of our current fleet with new, ‘greener’ ambulances and cars. We anticipate that by 2020, the majority of our vehicles will meet the Euro IV standard in line with the introduction of the London Ultra Low Emission Zone (ULEZ).

We continue to work closely and in partnership with the Government’s SALIX programme to procure energy efficient solutions for pipeline projects. During 2016/17, three energy efficient projects were completed, delivering an additional 2,410 tonnes of CO2 savings over the lifetime of the equipment. These projects have an average payback of 3.65 years and financial savings within the region of £23,285.

Our People

We know that to enable us to provide a quality service, our staff need to be highly-skilled, confident and motivated. They should also be representative of the communities we serve.

We continued to work with and listen to our staff to improve our service to patients.

Recruiting staff

We have worked hard to our increase frontline staffing numbers, despite a national shortage of paramedics.

Last year, we recruited 355 frontline staff, increasing our frontline workforce by over 100 whole-time equivalents.

To protect against workforce shortages in the future, we are developing a three-year recruitment plan which takes into account expected leavers from the organisation.

This includes:

- engaging with students and UK paramedic graduates to promote our Service as a prospective employer
- running 'keep in touch sessions' with our four partnership universities, to build relationships with trainee paramedics and ensure that as many as possible make our Service their employer of choice
- holding monthly assessment and interview sessions for paramedic, trainee emergency ambulance crew and emergency medical dispatcher candidates
- attending recruitment fairs and local schools to showcase the career opportunities available
- targeting recruitment campaigns across the capital to attract Londoners to work with us.
- continuing to build relationships with Australian universities to support future recruitment trips

Looking ahead, we aspire to be the employer of choice for UK paramedics and new graduates, and to attract paramedic talent from across the world by offering a depth and breadth of experience, personal development and career progression that is second to none.

So that we have an increasingly self-sufficient pipeline to meet demand, we will promote our organisation and our recruitment opportunities exploring new local recruitment markets to attract applicants for non-registered frontline staff roles; and expanding internal pathways into paramedic education.

Retaining and developing staff

The number of staff leaving our Service fell again last year, from 11.2 per cent in April 2016 to 8.6 per cent in March 2017. We have achieved this through a targeted programme of work which included:

- increasing the number of clinical team leaders and protecting their time to provide support to our frontline staff
- implementing the nationally agreed Band 6 paramedic role; and the newly qualified paramedic role to provide support and mentoring for a two year period. Over 2,000 front-line paramedics moved from Band 5 to Band 6 in 2016/17

- enhancing clinical career structures by:
  - creating our LAS Academy. The Academy provides training to support our non-registered clinical staff to become our paramedics of the future
  - working with Health Education England to pilot new Band 7 urgent care paramedics
  - appointing a consultant paramedic responsible for driving the integrated urgent care agenda, in conjunction with our emergency operations centre and 111 service
- increasing access to training bursaries. We secured £600k with the support of Health Education England to support further education/personal development for our staff. In 2015/16, the same level of funding was invested in development for 338 staff.
- improving our range of non-pay benefits; introducing lease cars and cycle schemes for our staff and providing a new occupational health provider to improve the health and wellbeing of our staff.

A significant development during the year was the introduction of a new appraisal system to ensure staff receive feedback on their performance and are clear about their focus and personal development for the year ahead. Since April 2016, we have completed 3,666 appraisals - equating to 81.3 per cent of our workforce compared with 11 per cent the previous year.

In November 2016, we won a prestigious HSJ Award for our training stations programme, designed to provide new frontline staff with practical support from experienced mentors. The HSJ judges said the initiative made a “real difference to staff morale and patient care in a challenging environment”.

Volunteer Responders

We are extremely grateful for the support of our volunteer lifesavers, who respond to patients in their communities alongside ambulance crews. Our volunteer responders include:

- Emergency responders – clinically-trained volunteers who respond to emergencies on blue lights alongside ambulances, and;
- Community first responders – defibrillator-trained St John Ambulance volunteers attending on call from their homes and responding to 999 calls alongside ambulances in their own car without blue lights

In 2016/17, volunteer responders contributed a total of 28,505 operational hours. They attended 12,193 emergencies, and in 6,996 of these cases, they were first on scene.

Our volunteers are also supported by the London Ambulance Service Voluntary Responder Group charity.

Finding out what staff think

We saw significant improvements in our staff survey last year. Out of the 88 questions that were asked, we scored significantly better in 67 of them compared to the previous year. We are pleased that in 23 questions, we have seen significant improvements of more than 10 per cent, including in:

- appraisals and career progression
- line managers and team working
- use of patient feedback
- error reporting
- training
- managers taking a positive interest in the health and well-being of their staff

- staff looking forward to going to work
- happiness with the standard of care provided by the organisation.

Specifically, we have also seen an improvement in the following metrics in 2016/17 compared to the previous year:

- Enough staff at organisation to do my job properly - an increase of 8 per cent
- Recommend organisation as place to work – up 13 per cent
- If friend/relative needs treatment would you be happy with standard of care provided- 14 per cent increase

Working to improve diversity and culture

Recent analysis of equality and diversity data shows that the black and minority ethnic (BME) population is underrepresented in our workforce, including in senior management. In 2016, 13 per cent of our workforce was from BME backgrounds; in contrast 45 per cent of London's population is from a BME background.

We recognise that the current position for BME staff requires significant improvement and are determined to achieve this, including through implementation of the Workforce Race Equality Standard (WRES) which ensures employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

A new action plan to address race equality issues was agreed by our Trust Board in July 2016 and this is currently being implemented.

We have taken the following actions to improve diversity and equality during 2016/17:

- Employed a lead for equality and diversity.
- Introduced BME staff focus groups and round table events with the Chairman and Director of Operations to understand the issues, barriers and experiences of internal BME staff, for example, barriers to career progression. The equality and diversity lead also provided one to one sessions for staff who wanted to talk in confidence.
- Secured £500,000 from Health Education England in January 2017 to fund:
    - outreach into schools to raise the profile of our Service as an employer and paramedic science as a potential career with BME students (and others)
    - coaching and mentoring for our BME talent
    - supporting and building the BME staff network to give staff a forum for raising issues and a BME 'focus group'.
- Taken positive action advertising to encourage applicants for posts from BME (and other under-represented communities) including taking part in the London Diversity show at Westfield.
- Reviewed the recruitment process to understand challenges facing BME candidates and implemented recruitment and selection training for managers.
- Improved our data on BME staff to ensure our reporting on BME issues is accurate and of high quality, in line with the requirements of the WRES. We are now in a position to report on eight of the nine WRES indicators, with the plan to report on all of the nine indicators in 2017/18.
- Worked closely with the Patient's Forum to better understand the equality and diversity issues that have an implication on patient care.
- Established a BME talent programme to encourage people already working in our Service to encourage career progression to a senior level.

Improving our culture

We have a duty of care to all staff, and are committed to providing a safe working environment that is free from all forms of bullying and harassment in which everyone is treated with dignity and respect.

We have been increasingly active in supporting staff who have reported bullying and/or harassment at work. This has included the introduction of a telephone advice line and the interim appointment of a specialist manager who is delivering training for managers and staff across our Service. In addition, we have:

- delivered bullying and harassment awareness training sessions to 716 staff as well as our executive leadership team
- launched a new dignity at work policy to improve our approach to bullying and harassment allegations and place emphasis on mediation and facilitated conversations to encourage early resolution of concerns
- recruited dignity and respect ambassadors who provide practical guidance on the steps that can be taken to encourage successful working relationships between staff.
- delivered workshops on mediation and having 'courageous conversations' to encourage local resolution of issues prior to entering formal grievance procedures
- facilitated bespoke training/coaching sessions at the request of teams.

We also took part in the London 2016 Pride Parade and network members attended the Stonewall Conference. Lee Hyett-Powell, our LGBT forum chair, won the prestigious NHS Inclusive Leader of the Year Award.

Freedom to speak up

In October 2016, we appointed our Freedom to Speak Up Guardian, a role introduced in each NHS trust as a result of the recommendations in the Francis Report.

Since the role was introduced we have:

- ensured staff are aware of the role and its function, including by attaching a leaflet to staff payslips
- established a Freedom to Speak Up group which will meet quarterly
- agreed reporting arrangements via our Workforce Committee to our Trust Board
- designed a secure recording and reporting module on Datix, our incident reporting software, which is only visible to the Freedom to Speak Up Guardian
- hosted a successful visit by colleagues from the National Guardian’s Office
- commissioned an audit of our Freedom to Speak Up arrangements from KPMG; we are the first NHS organisation to have taken this action.

Since the role has been introduced, a total of 14 concerns have been reported. Half of these have related to a bullying culture across a team or part of the organisation; two have related to our processes; two to patient safety concerns; and the remaining three have been related to infrastructure, to seek advice, or to give ideas about possible improvements.

Feedback has been very positive from staff who have used this method of raising concerns, indicating that is a method of engaging with staff that should be developed further over the coming year.

We are seeing improved impact on staff as demonstrated through the 2016 staff survey compared to the previous year:

- Not experienced bullying & harassment or abuse from managers – up 7 per cent
- Not experiencing discrimination from manager/team leader or other colleagues – an increase of 10 per cent
- My immediate manager values my work – up 14 per cent

Supporting our staff

The Five Year Forward View mental health task force findings 2015 emphasised the importance of responding to the health and well-being needs of NHS and social care staff themselves. And research from Mind[6] shows that emergency service staff are at a high risk of poor mental health, yet are less likely to seek support than others.

Last year, we continued to provide a wide range of internal and external support for our staff, including:

- our LINC (Listening; Informal; Non-Judgemental and Confidential) peer support network which provides psychological and emotional support to any member of staff. LINC workers are volunteers from all levels of our Service and receive specialist training in listening and counselling skills, bereavement, stress, burnout and PTSD. Senior LINC workers staff the dedicated 24-hour emergency on-call line for staff who need urgent support
- mental health awareness training for control room staff (to support patients with mental health conditions) and personal health and wellbeing awareness training
- support and promotion of awareness campaigns, such as mental health awareness week and world mental health day, including signing up to the Mind 'Blue light pledge' to commit to promoting an open and safe environment for our staff to share their emotions and feelings, knowing they will be supported and not judged
- wellbeing events at our HQ for staff to visit and learn about charities and networks available for both patients and themselves
- Access to the Mind Blue Light programme which offers confidential, independent and practical support, advice and signposting around mental health and wellbeing, for emergency service staff, volunteers and their families.

[6] www.mind.org.uk/media/2869026/blue-light-programme-research-briefing-no-one.pdf

Time to Talk Day 2017

His Royal Highness Prince Harry visited the London Ambulance Service control room to launch Time to Talk Day 2017, the annual mental health awareness day run by charity Time to Change.

Prince Harry spent time with staff encouraging them to get talking about mental health and hearing about the support offered to emergency service workers. Speaking to a group of staff outside headquarters at the end of the visit Prince Harry said: “I take my hat off to you and all the staff.”

About being able to cope with the pressures of emergency work, the Prince added: “You need to be able to deal with it, talk about it and so you don’t take your issues home with you. It’s not possible to do the job you do and not talk about it.”

Engaging, valuing and recognising our staff

In June 2016, we launched our vision of *‘Making the LAS Great’*, supported by an internal communications campaign to start hundreds of conversations to engage and motivate staff to deliver improvements within our Service.

Engagement with staff was encouraged through the distribution of conversation packs – including branded mugs, coasters and posters as well as tea and biscuits – to all stations and sites so that managers and their teams could talk about how they could contribute to our quality improvement plan and help us achieve our vision.

We also ran eight internal campaigns throughout the year based on ‘must-dos’ to help us make the London Ambulance Service great. This included ‘Shut it, lock it, prove it’ – a

medicines management campaign to improve compliance across the organisation, advice around keeping information safe, and tips on how to speak up.

To improve engagement and increase the visibility of senior leaders we held a number of staff road shows hosted by members of our executive leadership team during October and November 2016. This provided nearly 1,000 staff members with the opportunity to share their views and ideas, influencing our strategic priorities for 2017/18. In addition, we commissioned the University of Warwick to measure the engagement of patient-facing staff in the different areas of the Service, and are using this learning to inform and improve staff engagement. We will re-run the survey in 2017.

We have a monthly briefing system, Team Talk, which is designed for cascading information through the organisation and gaining feedback, which is then reported back to the executive leadership team for their information and action. This feedback is then made available to all staff – along with details of actions that are being taken as a result. Key themes and topics discussed on our closed staff Facebook site are also included in the Team Talk feedback reports. This group, which now has more than 3,300 members, enables direct communication and engagement with a large part of the workforce, as well as the chance for questions and discussions. Since July 2015, it has been successfully administrated by a group of around 20 peer moderators who volunteer their time to make the group a better forum for staff.

During the year we have strengthened our partnership working with trade union colleagues, rewriting the Partnership Agreement and strengthening our consultation processes via the quarterly Staff Council meetings and the bi-monthly Operational Partnership meetings.

Our VIP Awards scheme recognises the contribution of people across the organisation, and is now in its third year. Nominations are considered by voting panels made up of colleagues from the same staff groups, with the overall winners from each then going forward for a service wide vote to become Employee of the Year.

In the 2016/17 VIP awards cycle, across both rounds of voting, 344 nominations were received for 707 staff and a total of 441 votes were cast for Employee of the Year. We made videos of all the 13 finalists, which were advertised on the intranet and our staff Facebook group. Everyone who is nominated or has made a nomination is invited to the main awards ceremony which takes place in April each year.

We also continued to recognise the day-to-day contributions of staff through marking the achievement of long service milestones, and publishing the names of all those who have received a letter or message of thanks in our weekly bulletin.

In December 2016 our main corporate twitter feed was named best social media account in the Comms2Point0 Unawards 2016. During the year we also provided BBC One unprecedented access to our Service to film *Ambulance* – a three part series which followed our medics and control room staff making life-saving decisions. As well as increasing public awareness of the pressures on the service, the series also improved staff morale; 88 per cent of staff said they were proud to work for the Service following the documentary, compared with 54 per cent prior to broadcast. *Ambulance* was the most watched documentary on the BBC in 2016.

Accountable Officer: **Andrew Grimshaw, Chief Executive**

Organisation: **London Ambulance Service NHS Trust**

Signature: 

Date: **25 May 2017**

2. Accountability Report

London Ambulance Service NHS Trust
Organisation Code: RRU

Governance Statement

Scope of responsibility

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

As Accountable Officer I have overall accountability for having a robust risk management system in place which is supported by a governance structure, processes and monitoring arrangements, and an assurance and risk management framework. These arrangements are documented in the Risk Management Policy which represents a developing and improving approach to risk management achieved by building and sustaining an organisational culture which encourages risk taking, effective performance management, and accountability for organisational learning. The Trust strategy *Caring for the Capital* is the means by which the London Ambulance Service NHS Trust (LAS) will ensure its vision, aims, goals and organisational objectives are continually assessed and managed to ensure appropriate risk taking and effective performance management are in place and part of the organisational culture.

As part of London's health economy we work with our partners to minimise the risks to patient care. To do so we have met routinely with our lead commissioners, NHS Improvement (NHSI) and NHS England (London) in order to progress and maintain the key performance targets set for ambulance services. We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London.

In 2016/17, the demand on the Service continued to increase, with an increase of over 68,000 incidents in comparison with 2015/16. Demand has been particularly high recently, with December 2016 seeing the highest number of Category A (life threatening) incidents the Service has ever seen. With demand increasing we have been mindful of how we respond to 999 calls, ensuring we provide the highest standards of patient care but recognising that conveying patients to hospital is not always the best option. The Trust has worked in partnership with Commissioners, NHSI and NHS England (London) under the oversight of the Regional Oversight Group, to review performance trajectories and has an agreed position going forward in 2017/18.

In 2016/17 the Trust achieved 66.40% for the national performance target of Category A 8 minutes and 93.48% 19 minutes. The Trust Board takes its assurance on the quality and accuracy of the data through the integrated performance report and national reporting of Ambulance Quality Indicators. The LAS is not required to monitor elective waiting time data.

Whilst facing these challenges, our primary concern has been and continues to be the safety

of the service we provide. It is essential as an organisation that we learn from our underperformance and apply that learning to improve services moving forwards. Managing and mitigating against any potential performance impact on patient quality and safety is our fundamental priority. A key mitigation for quality and safety is workforce and the Trust has recruited over 350 front line staff in 2016/17 and has seen a reduction in the frontline vacancy rate down to 6.6%. Paramedic turnover ended the year at an improved figure of 9% and the overall sickness rate for the Trust is down to 5%.

The Trust was placed in Special Measures on the recommendation of the Care Quality Commission (CQC) in October 2015 following the planned inspection under the Chief Inspector of Hospitals Inspection regime in June 2015 and the placement of a Section 29A Warning Notice. The CQC undertook a review of the Warning Notice in August 2016 and this was reduced to a Requirement Notice focussed on medicines management. The CQC then undertook a planned inspection in February 2017. At the time of writing the Trust remains in Special Measures and has the following ratings against the CQC domains:

- Safe – Inadequate
- Effective – Requires Improvement
- Caring – Good
- Responsive – Requires Improvement
- Well-led – Inadequate.

A Quality Improvement Plan (QIP) was implemented in January 2016 to address the recommendations in the full report and warning notice. The QIP had the following five themes:

- Making the LAS a Great Place to Work
- Achieving Good Governance
- Improving Patient Experience
- Improving Environment and Resources
- Taking Pride and Responsibility.

Oversight of the plan has been through the Quality Improvement Programme Board, chaired by the Trust Chair, which has provided assurance to the Trust Board at each formal Board meeting. The Programme Board was dis-established in March 2017, with a formal closure report to be submitted to the Trust Board in May 2017.

By the end of 2016/17, 95% of projects within the programme had been completed and had moved into business as usual. Those projects remaining that required continued focus were taken forward into the 2017/18 business plan and priorities.

The LAS 111 Service was also inspected as part of the General Practice CQC inspection programme in September 2016. The LAS 111 service was subsequently rated as Good, with a rating of good achieved in every of the five domains, with the CQC stating *'The London Ambulance Service (LAS) NHS 111 service provided a safe, effective, caring, responsive and well-led service to a diverse population in South East London'.*

NHSI required the Trust to commission Deloitte LLP in 2016 to undertake an external well-led governance review against the Monitor/NHSI Well-led framework. The Chair and Chief Executive received the report in February 2017 and shared this with the Trust Board. An action plan is being developed to address the recommendations.

The governance framework of the organisation

Heather Lawrence, OBE, joined the Trust as Chair on 1st April 2016. Dr Fionna Moore stepped down as Chief Executive Officer in December 2016 prior to retirement from the Service in March 2017. Andrew Grimshaw took on the role of Acting Chief Executive Officer from January 2017 whilst the Trust recruited to the substantive role.

Nicholas Martin and Jessica Cecil reached the end of their terms of office in 2016/17. Nick remained as an associate non-executive director until 28th February 2017 and Jessica Cecil remains as an associate non-executive director to 31st January 2018. Jayne Mee and Dr Sheila Doyle were appointed by NHSI as non-executive directors on the Trust Board, commencing in January and February 2017 respectively.

Other changes to the Trust Board and executive team included the substantive appointment of Paul Woodrow as Director of Operations. Andrew Grimshaw (Acting Chief Executive) is the substantive Director of Finance so Andy Bell, Deputy Director of Finance, took on the role of Acting Director of Finance from January 2017. Andrew Watson, Chief Information Officer, left the Trust in January 2017, and Steve Bass took on the interim role in March 2017. Zoe Packman left the Trust and the role of Director of Nursing and Quality in May 2016 and Briony Sloper, Deputy Director of Nursing and Quality, acted into the role until Trisha Bain's appointment as Chief Quality Officer in January 2017. Sandra Adams, Director of Corporate Governance/Trust Secretary, left the Trust in April 2017 and an interim arrangement is in place whilst the post is appointed to substantively. The Trust continues to seek to recruit a substantive Director of Human Resources & Organisational Development. Jill Patterson, interim Director of Performance, and Mark Hirst, interim Director of HR, have continued to support the Board and executive team in 2016/17. In addition, as a result of being in Special Measures, the Trust has had the support from NHS Improvement through the role of the Improvement Director since February 2016.

Information on the Trust Board committee structure and the attendance records of members is attached (annexes 1 to 9).

Each Board committee is chaired by a non-executive director. Membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and required.

The Trust Board agreed to establish a Workforce and Organisational Development Committee and the first meeting was held on 18th May 2016. The Committee is a sub-committee of the Trust Board and is chaired by a non-executive director. A Quality Improvement Programme Board was established in January 2016 as a time limited committee of the Board, chaired by the Trust Chair, to provide oversight of the Quality Improvement Plan and board assurance of progress against the plan. The Logistics and Infrastructure Committee was established in January 2017 and its first meeting was held in February, chaired by a non-executive director. The Finance and Investment Committee had a name change and added oversight of performance to its remit. The terms of reference for the above mentioned Board sub-committees and for Audit and the Quality Governance, Remuneration and Nominations, and Charitable Funds Committees were all reviewed and updated with Trust Board sign off in November 2016. Each Board sub-committee provides an assurance report to the next Trust Board meeting held in public, and the minutes of each meeting are available in the private meeting of the Trust Board.

The reporting structure for the Executive Leadership Team was reviewed in early 2016 and the new structure commenced in March 2016. The Risk Compliance and Assurance Group

was re-established, and a Quality Improvement Group, Environment and Resources Group, and Operations Board were also established. Each of the key executive-chaired committees provides assurance to a Board committee. Clinical Safety and Standards, Improving Patient Experience and Risk Compliance and Assurance all provide assurance through the Quality Governance Committee to the Trust Board. The Risk Compliance and Assurance Group also provides assurance to the Audit Committee on the systems and processes for risk management. The Group also reviews and approves changes to the Board Assurance Framework.

The Finance and Investment, Quality Governance, Logistics and Infrastructure, and Workforce and Organisational Development Committees each review the relevant risks for their remit: financial, performance, quality and safety, risks pertaining to the estate, IM&T and fleet & logistics, and to workforce. The Trust Board reviews the corporate risk register and Board Assurance Framework at each meeting held in public.

The Trust Chair and Director of Corporate Governance/Trust Secretary undertake a post-board review each month to ensure the agenda has been covered, sufficient time has been allotted to agenda items and effective contribution and scrutiny given. The Board agenda, papers and practice are continuously reviewed and adapted to ensure that reporting is appropriate and timely. Following the external governance review in early 2016 the processes for Board and committee agendas and papers were strengthened. An action plan has been developed to address the findings of the independent well-led governance (Deloitte) review undertaken in late 2016/17. With the departure of the Director of Corporate Governance/Trust Secretary the Chair took the opportunity to commission a review of the portfolio and some of the governance processes and this has informed some aspects of the portfolio transferring to the Chief Quality Officer. Whilst further thought is given to the role of Director of Corporate Governance/Trust Secretary, the Trust is receiving senior corporate governance support via a secondment from NHS Improvement. The Trust Board will formally meet monthly in 2017/18, either in public or in private, and in addition will meet as a strategy group to ensure there is sufficient time and focus given to this area.

The Board agenda is informed by the forward planner which is reviewed and updated after each meeting and includes an integrated performance report incorporating quality and safety, financial, performance and workforce reporting against key performance indicators, and key business and governance items. This ensures the Trust Board receives quality, financial and performance information that provides assurance on the discharge of statutory responsibilities.

Attendance by board members at Trust Board meetings is recorded in the minutes and included in the annual governance statement. Attendance at key Board Committees is also monitored and recorded by the Committee Secretary and those providing administrative support to each of the Committees.

The Trust Board understands its responsibilities for discharging the statutory functions and takes assurance from the Audit Committee that systems are in place and that these are legally compliant.

The Chair of the Audit Committee provides a report to the next meeting of the Trust Board following each Audit Committee meeting. This report includes a summary of the business discussed and the assurances received from the executive, the internal and external auditors and from local counter fraud. The role of the Audit Committee is to focus on the

controls and related assurance that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The committee undertakes a review of the effectiveness of the corporate risk register at each meeting. The committee met 5 times during the year with the internal and external auditors present and held one meeting without auditors (total of 6 meetings). The Audit Committee met once with auditors only.

At the Trust Board meeting on 25th April 2017 the Audit Committee chair provided assurance to the board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework.

The Quality Governance Committee has oversight of quality governance on behalf of the Trust Board, including review of the annual Quality Account, prior to its publication. The reporting committee structure provides assurance to the Quality Governance Committee on clinical audit, never events and serious incidents including the lessons drawn from these and the action being taken to mitigate future risk. The committee also receives assurance on the Trust's response and actions taken to address coroners' recommendations on preventing future deaths.

The Chair of the Quality Governance Committee provides a report to the following meeting of the Trust Board. This report includes the committee's assessment of quality as taken from the reports and evidence presented to the committee, including the corporate risk register. The committee receives assurance from its reporting committees: Clinical Safety and Standards and Improving Patient Experience. The committee also reviews the cost improvement programme to seek assurance that there is no detrimental impact on patient and staff safety and the quality of services provided as a result of the programme. At the Trust Board meeting the Quality Governance Committee chair provides assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee met 6 times during the year.

The Chair of the Finance and Investment Committee provides a report to the following meeting of the Trust Board. The committee provides assurance on the scrutiny of current finance and investment issues based on the reports and evidence presented to it throughout the year, and oversight on performance reporting. At the Trust Board meeting the chair of the committee reports on the cash position, cash management, liquidity, Cost Improvement Plan progress, and capital expenditure. The committee met 6 times during the year.

The Logistics and Infrastructure Committee was established in January 2017 and has met once. The Chair of the Committee provides an assurance report to the Trust Board on its oversight of issues pertaining to estates, IM&T and fleet and logistics. The first assurance report was presented on 28th March 2017 and referenced high level capital investment plans for the 3 areas and the key performance indicators by which the Committee could take assurance.

The Workforce and Organisation Development Committee was established in 2016 and has met 6 times in 2016/17. The Chair of the Committee provides a report to the following meeting of the Trust Board and this report includes Workforce risks, recruitment and retention, health and wellbeing, strategy and planning.

The Trust Board works within the remit of the standing orders and standing financial

instructions and the scheme of delegation. These were reviewed and approved by the Trust Board on 29th November 2016.

The Trust is registered with the CQC for the provision of the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures.

Risk assessment

The organisation's major risks relate to safety, performance, finance and workforce as described in the Board Assurance Framework.

The Risk Management Policy provides the strategic framework for risk management within the Trust through the specification for risk (or change in risk) identification, assessment, treatment and management controls. It describes the process for embedding risk management throughout the Trust. The corporate risk register is reviewed by the Audit and Quality Governance Committees and by the Trust Board as it contains the highest level of risks facing the organisation. Risks can be escalated to the Risk Compliance and Assurance Group for discussion and addition to the corporate risk register if required. Project and programme management risks are aligned to and incorporated in the corporate risk register.

The Internal Auditors, KPMG, have been reviewing elements of the Trust's risk management arrangements each year. The review in 2016/17 focussed on the risk management processes within the Operations directorate and the outcome concluded with an overall assessment of 'Significant assurance with minor improvement potential'. The Trust implemented a programme of risk management training for all managers in November 2015 and had trained over 300 managers by the end of 2016. The audit process of local risk registers continued throughout the year with key performance indicators developed and monitored through the integrated performance report. The independent well-led governance review and also early feedback from the February 2017 CQC inspection suggests more focus is required to fully embed a consistent approach to risk management. Both also identified that the BAF required a fresh approach and the Acting Chief Executive is leading this development work during the first quarter of 2017/18. In March 2017 the top 3 risks facing the organisation were:

1. BAF risk 37 – there is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.
2. BAF risk 7 – there is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.
3. BAF risk 14 – it is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other cost pressures for the foreseeable future. Failure to identify and deliver CIPs will threaten the ongoing viability and solvency of the Trust.

Patient and staff safety and other incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the safety and risk team, using a risk severity matrix in line with the Risk Management Policy and reported on Datix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the Risk Compliance and

Assurance Group or monitored at a local level. The Serious Incident Group meets weekly to review any serious incidents that need investigating and may need to be formally declared as Serious Incidents. The group monitors the progress of SI investigations and escalates any delays to the Executive Leadership Team. The Trust implemented DatixWeb in May 2016 for reporting and managing incidents, serious incidents, complaints, legal cases and inquests, and safeguarding. Risk registers transferred across to the system during the summer.

New risks with a net severity rating of High (over 15) are added to the corporate risk register and the board assurance framework which are reviewed monthly by the Risk Compliance and Assurance Group and the Executive Leadership Team. In 2016/17 the Trust added 23 new risks to the corporate risk register. A list of the new risks is attached as an annex to this statement (annex 10).

The Trust reported 4 data security incidents to the Information Commissioner and these were declared and investigated as serious incidents.

The Trust achieved 83% against the Information Governance toolkit and is at level 2 overall.

The Trust underwent two further external reviews during 2016/17:

a) Compliance against the NARU specification of the emergency planning response and resilience - the Trust Board received the assurance report on compliance at its November 2016 meeting.

b) Compliance with NHS Protect security management standards for ambulance services – the outcome of this review was one of poor compliance and an action plane was implemented. Assurance was taken through the Audit Committee to the Trust Board in November 2016 of compliance against the standards and this was confirmed by NHS Protect in March 2017.

The risk and control framework

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The format of the board assurance framework shows the key risks facing the Trust during the period, mapped to the key business objectives. The Audit Committee oversees the board assurance framework and corporate risk register and provides assurance to the Trust Board on the effectiveness of the risk and control arrangements. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are met.

The Risk Compliance and Assurance Group manage the corporate risk register whilst the Audit Committee assesses the effectiveness of the corporate risk register at each meeting. The Trust Board and Executive Leadership Team receive an integrated performance report which includes the top risks. The Board sub-committees review the risk registers and significant risks for the areas within their remit and will seek assurance on the controls and assurances in place and any actions being taken to mitigate those risks. Systems in place to deter risk include standing orders, the scheme of delegation and standing financial instructions, NHS counter fraud measures, an anti-bribery policy, and a register for declaring directors' and managers' interests. The Register of Interests was updated in the final quarter of 2016/17.

The local counter fraud specialist (LCFS) attended 5 meetings of the Audit Committee in

2016/17 and regular executive counter fraud meetings. KPMG have provided the local counter fraud service since April 2013 and the contract was extended for a further 2 years within procurement rules.

The internal auditors attended 5 meetings of the Audit Committee during 2016/17 and work closely with the Governance and Assurance team to execute the annual audit work plan which is developed in conjunction with the Trust Executive. KPMG have provided the internal audit service to the Trust since April 2013 and the contract was extended for a further 2 years within procurement rules. Both this contract and the LCFS contract will be re-tendered in 2017/18 for commencement on 1st April 2018.

Ernst Young are the external audit provider. The Trust Board established an Auditor Panel through the Audit Committee to oversee the process for appointment of the external auditor and Ernst Young were approved as the external audit provider with effect from 1st April 2017.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive management team within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the 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 the effectiveness of the system of internal control by the board, the Audit Committee and the Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant Issues

Category A demand for the London Ambulance Service rose by 6.8% in 2016/17 to 1.83 million emergency calls from across London and we responded to more than 1.11 million incidents. This put the Trust under significant pressure and unable to recover performance to agreed contract levels in 2016/17. The Trust is now contracted to achieve 75% Category A8 by October 2017.

The CQC issued a Section 29A Warning Notice and rated the Trust 'Inadequate' in October 2015 following which the NHS TDA (NHSI as of 1st April 2016), in line with the recommendation from the Chief Inspector of Hospitals, placed the Trust in Special Measures. The Trust implemented a Quality Improvement Plan (QIP) in January 2016 which concluded in March 2017. 95% of these projects have been completed and those that remained have been incorporated either into the 2017/18 business plan or business as usual. The QIP was overseen by the Quality Improvement Programme Board which provided regular assurance to the Trust Board. External governance and oversight was provided through the Commissioners' Clinical Quality Review Group and the Regional Oversight Group which comprises membership from commissioners, NHS Improvement, and NHS England.

The Section 29A Warning Notice was lifted in September 2016 following a CQC inspection of the Notice and a Requirement Notice was issued which focussed on medicines

management.

At the time of writing the outcome of the February 2017 CQC Inspection has not been published and the Trust remains in Special Measures.

The Trust Board implemented the recommendations from the 2015 TDA well-led governance review and the independent governance review in 2015/16. Deloitte LLP was commissioned to undertake an independent well-led governance review in 2016/17 with a final report to the Trust Chair and Acting Chief Executive in February 2017. An action plan will be implemented in the 1st quarter of 2017/18 and will include the review and refresh of the BAF and a board development programme.

Internal audit undertook 9 reviews during 2016/17 agreed with management to defer the PRF Management & CQC reviews to future periods. Internal audit raised 35 recommendations, including five high risk recommendations in the period which relate to:

- Committee oversight and reporting in our Clinical Audit review;
- Monitoring and annual timetable in our CIPs review; and,
- Secure storage of medicine and the management of controlled drugs in our Medicines Management review.

Actions will be identified and implemented to address each recommendation.

During 2016/17 we experienced some technical difficulties with our Computer Aided Dispatch System which we use to take emergency calls and despatch ambulances. This includes an outage on 1st January 2017 which required our staff to revert to manual processes. As a result, our control room logged emergency calls using a manual back-up system for around five hours.

Our control room staff are fully trained and practised in operating this way and continued to prioritise patients in the same way, using the same assessment process as usual. However, as a manual system is not as efficient as a computer-based one, it took longer to manage calls.

Following the incident we launched a full external investigation, working with NHS Improvement and NHS England alongside an independent IT expert to look at the exact circumstances of what happened and any impact this may have had on our patients. This report is to be published in spring 2017.

The Head of Internal Audit's opinion is one of:

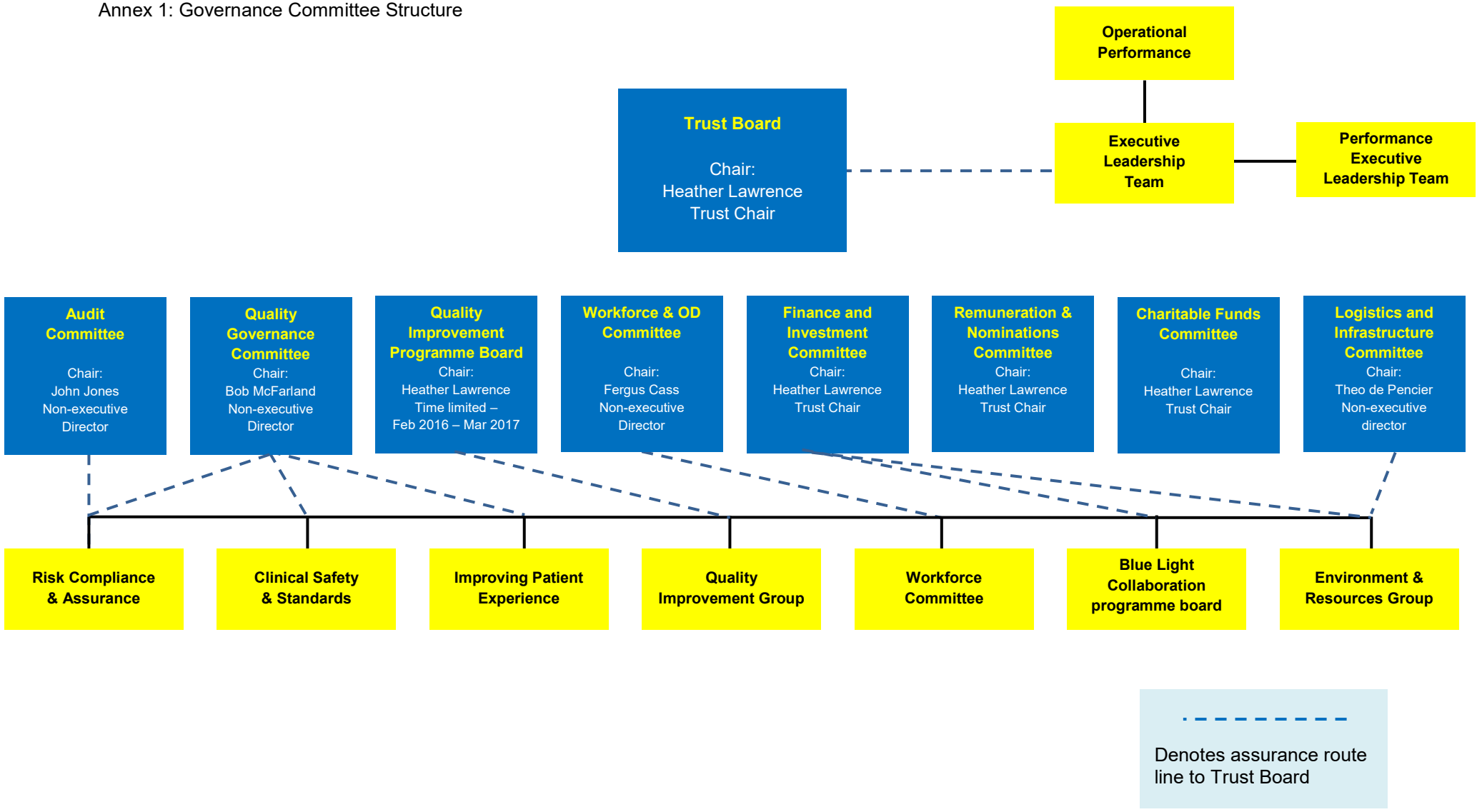
"Significant assurance with minor improvements' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control"

Accountable Officer: Andrew Grimshaw, Chief Executive

Organisation: London Ambulance Service NHS Trust (RRU)

Signature:  **Date: 25 May 2017**

Annex 1: Governance Committee Structure



Annex 2: Committee membership 2016/17

Formal Trust Board committee	Chair	Current members
Audit committee	Non-Executive director, John Jones	Theo de Pencier (Non-Executive director) Fergus Cass (Non-Executive director)
Charitable funds committee	Trust Chair, Heather Lawrence OBE	Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive)
Quality governance committee[7]	Non-Executive director, Bob McFarland	Jessica Cecil (Non-Executive director) Nick Martin (Non-Executive director) to February 2017 Fergus Cass (Non-Executive director) Fenella Wrigley (Medical Director) Zoe Packman (Director of Nursing and Quality) to May 2016 then Briony Sloper (Acting Chief Quality Officer) from June 2016 to January 2017 Trisha Bain (Chief Quality Officer) from January 2017 Sandra Adams (Director of Corporate Governance) Paul Woodrow (Director of Operations)
Finance & investment committee	Non-Executive director, Nick Martin To January 2017 then Heather Lawrence OBE, Trust Chair, from March 2017	John Jones (Non-Executive director) Jessica Cecil (Non-Executive director) Theo de Pencier (Non-Executive director) Andrew Grimshaw (Director of Finance and Performance then Acting Chief Executive) Sandra Adams (Director of Corporate Governance) Andy Bell (Acting Director of Finance)
Remuneration and Nomination committee	Trust Chair, Heather Lawrence OBE	All Non-Executive members of the Trust Board

[7] Terms of reference reviewed and updated in 2016 with membership changes

Quality Improvement Programme Board (time-limited committee with specific assurance role)	Trust Chair Heather Lawrence OBE	Fergus Cass (Non-Executive director) Bob McFarland (Non-Executive director) Fionna Moore (Chief Executive) to December 2016 Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive) Karen Broughton, Director of Transformation, Strategy and Workforce Charlotte Gawne (Director of Strategic Communications) Sandra Adams (Director of Corporate Governance) Trisha Bain (Chief Quality Officer) from January 2017 Fenella Wrigley (Medical Director) Mark Hirst (Interim Director of HR) Paul Woodrow (Director of Operations) Zoe Packman (Director of Nursing and Quality) to May 2016 then Briony Sloper (Acting Chief Quality Officer) from May 2016 to January 2017
Workforce and Organisation Development Committee	Non-Executive Director Fergus Cass	Theo de Pencier (Non-Executive director) to February 2017 Jayne Mee (Non-Executive director) from March 2017 Jessica Cecil (Non-Executive director) Karen Broughton, Director of Transformation, Strategy and Workforce Mark Hirst (Interim Director of HR) Paul Woodrow (Director of Operations) Fenella Wrigley (Medical Director) Briony Sloper (Deputy Director of Nursing and Quality)
Logistics and Infrastructure Committee	Non-Executive Director Theo de Pencier	Sheila Doyle (Non-Executive director) John Jones (Non-Executive director) Andy Bell (Acting Director of Finance) Sandra Adams (director of Corporate Governance)

Annex 3 – Attendance at Trust Board meetings 2016/17

x = attended a = apologies	31st May 2016	26th July 2016	4th October 2016	29th November 2016	31st January 2017	28th March 2017	Comments
Trust Board members (voting)							
Heather Lawrence (Non-Executive Chair)	x	x	x	x	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	a	x	x	x	a	
Theo de Pencier (Non-Executive Director)	x	x	x	x	x	a	
John Jones (Non-Executive Director)	x	x	x	x	x	x	
Bob McFarland (Non-Executive Director)	x	x	x	x	x	x	
Nick Martin (Non-Executive Director)	x	x	x	x	x		Left the Trust in February 2017
Jayne Mee (Non-Executive Director)					x	x	
Sheila Doyle (Non-Executive)						x	
Fiona Moore (Chief Executive)	x	x	x	x			
Fenella Wrigley (Medical Director)	x	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance then Acting Chief Executive)	x	x	x	x	x	x	Appointed to acting Chief Executive in January 2017
Andy Bell (Acting Director of Finance)					x	x	Appointed to acting Director of Finance in January 2017
Paul Woodrow (Director of Operations)	x	x	x	x	x	x	Appointed to substantive role from April 2016.
Trisha Bain (Chief Quality Officer)					x	x	Appointed to substantive role from January 2017
Briony Sloper (Acting Chief Quality Officer)		x	x	a			Appointed to acting Chief Quality Officer in June 2016.
Non-voting							
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	x	x	x	
Karen Broughton (Director of Transformation, Strategy and Workforce)	x	x	x	x	a	x	
Mark Hirst (Interim Director of Human resources)	x	x			x		
Andrew Watson (Chief Information Officer)	x						Left the Trust in February 2017
Jill Patterson (Interim Director of Performance)	x						
Charlotte Gawne (Director of Strategic Communications		x					Attending by invitation

Annex 4 – Attendance at Quality Governance Committee meetings 2016/17

x = attended a = apologies	17th May 2016	12th July 2016	13th September 2016	15th November 2016	10th January 2017	7th March 2017	
Quality Governance Committee members							
Bob McFarland (Non-Executive Chair)	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	x	x	x	x	x	
Nick Martin (Non-Executive Director)	x	x	a	a	x		Left the Trust in February 2017
Fergus Cass (Non-Executive Director)	x	a	x	x	x	x	
Fiona Moore (Chief Executive)		x					Attending by invitation
Sandra Adams (Director of Corporate Governance / Trust Secretary)	x	x	x	x	x	x	
Fenella Wrigley (Medical Director)	x	x	x	x	x	x	
Briony Sloper (Acting Chief Quality Officer)		x	x	a		x	Appointed to acting Chief Quality Officer in June 2016 until January 2017
Trisha Bain (Chief Quality Officer)					x	a	From January 2017
Paul Woodrow (Director of Operations)	a	a	x	a	a	a	
Peter McKenna (Deputy Director of Operations)	x	x		x		x	Attending for Director of Operations
Tina Ivanov (Deputy Director of Clinical Education)	x	x	x	x	x	x	

Annex 5 – Attendance at Audit Committee meetings 2016/17

x = attended a = apologies	18th April 2016	19th May 2016	31st May 2016	5th September 2016	7th November 2016	15th February 2017	Comments
Audit Committee members							
John Jones (Non-Executive Director)	x	x	x	x	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	a	x	a	x	
Attending							
Sandra Adams (Director of Corporate Governance/Trust Secretary)	x	x	x	a	x	x	
Fionna Moore (Chief Executive)	x				x		By invitation
Bob McFarland (Non-Executive)			x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive)	x	x	x	a	x		Appointed to acting Chief Executive in January 2017
Andy Bell (Acting Director of Finance)						x	Appointed to acting Director of Finance in January 2017

Annex 6 – Attendance at Workforce and OD Committee meetings 2016/17

x = attended a = apologies	18th July 2016	26th October 2016	21st November 2016	23rd January 2017	20th March 2017	Comments
Workforce and OD Committee members (voting)						
Fergus Cass (Non-Executive Director)	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	x	x	x	
Jayne Mee (Non-Executive director)					x	From March 2017
Jessica Cecil (Non-Executive director)		x	x		x	
Karen Broughton, Director of Transformation, Strategy and Workforce		x		x	x	
Paul Woodrow (Director of Operations)						
Fenella Wrigley (Medical Director)		x				
Briony Sloper (Deputy Director of Nursing and Quality)						
Mark Hirst (Interim Director of Workforce)	x		x	x	x	

Annex 7 – Attendance at Finance and Investment Committee meetings 2016/17

X = attended a = apologies	26th May 2016	25th July 2016	22nd September 2016	24th November 2016	19th January 2017	23rd March 2017	Comments
Finance and Investment Committee members							
Nick Martin (Non-Executive Director)	x	x	a	x	x	a	Left the Trust in February 2017
Heather Lawrence (Trust Chair)	x	a	a	a	x	x	
John Jones (Non-Executive Director)	x	x	x	x	a	x	
Jessica Cecil (Non-Executive Director)	a	a	x	x	x	x	
Theo de Pencier (Non-Executive Director)	a	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive)	x	x	x	x	x	x	Appointed to acting Chief Executive in January 2017
Andy Bell (Acting Director of Finance)	x	x	a	a	x	x	Appointed to acting Director of Finance in January 2017
Sandra Adams	x	x	a	x	x	a	
Attending							
Jill Patterson	x	a	a	x	x	x	
Michael John	x	x	x	x	a	x	
Graeme Dunn	x	x	x	x	x	x	
Helen Conneally	x	a	a	x	x	a	

Annex 8 – Attendance at Quality Improvement Programme Board meetings in 2016/17

x = attended a = apologies	14th April 2016	17th May 2016	14th June 2016	14th July 2016	30th Augu	11th October 2016	24th November 2016	15th December 2016	19th January 2017	14th February 2017	30th March 2017	Comments
Quality Improvement Programme members												
Andrew Grimshaw (Acting Chief Executive)				x	x	x		x	x	x	a	
Andy Bell (Acting Director of Finance)									x	x	a	
Briony Sloper (Acting Chief Quality Officer)					x			a				
Charlotte Gawne (Director of Strategic Communications)	x	a	x	x	x	x		x	x	a	a	
Fenella Wrigley (Medical Director)				x	x	x	x	x	a	x	x	
Fergus Cass (Non-Executive director)	x	x	x	a	x	x	a	x		x	x	
Fionna Moore (Chief Executive)	x	x	a	x	x	x	x	x				
Heather Lawrence (Trust Chair)	x	x	x	x	x	x	x	x	x	x	x	
Karen Broughton (Director of Trans-formation, Strategy and Workforce)	x	x	x	x	x	x	x	x	x	x	x	
Paul Woodrow (Director of Operations)					x	x	x	a	x	x	a	
Robert McFarland (Non-Executive director)	a	x	x	x	x	x	a	x	x	x	x	
Sandra Adams (Director of Corporate Governance)					x	x	x	a	a	x	a	
Trisha Bain (Chief Quality Officer)									x	x	x	
Attending												
Alex Bass (Communications Manager)										x		
Andrew Watson (Chief Information Officer)						a						
Angie Patton (Communications Manager)		x										
Donna Fong (Programme Manager – PA Consulting)	x	x	x	x	x							
Janet Wint (Programme Manager)					x	a	x	a	x			
Justin Wand (DDO Fleet & Logistics')				x			x					
Lesley Stephen (Improvement Director NHSI)	x	x	x	x	x		x					
Maeve Stevenson (Minutes)	x	x	x	x	x	x	a	x	x	x	a	
Nic Daw (Head of PTS / NEDs)				x								
Nikki Fountain (Project Manager)						x	x	x	x		x	
Peter McKenna (DDO)				x								
Sally Herne (Improvement Director NHSI)									x		a	
Tim Edwards (Consultant Paramedic)							x					
Vic Wynn (Head of IM&T)						x		x	a		a	
Matthew Blow (Deloiites – Observing)									x			

Annex 9 - Attendance at Logistics and Infrastructure meetings in 2016/17

X = attended a = apologies	13th February 2017	Comments
Logistics and Infrastructure Committee members		
Theo de Pencier	x	
John Jones	x	
Sheila Doyle	x	
Andy Bell	x	
Sandra Adams	x	
Attending		
Justin Wand	x	
Martin Nelhams	a	
Vic Wynn	a	
Steve Bass	a	
Kevin Bate	a	
Graeme Dunn	x	

Annex 10 - New Risks Added to the Trust Risk Register in the Period 2016 – 2017

Datix ID	Risk Description
577	There is a risk that operating the LAS CAD system with continued levels of activity above the contract baseline will cause the system to fail and hence impact on patient care
531	There is a risk that the agreed A8 trajectory for 16/17 may be adversely affected by sustained over-activity against contractually agreed growth.
451	There is a risk that staff members who drive on behalf of the trust are not compliant with Trust policy, which states that checks will be undertaken every six months and these do not always occur to the standard or frequency defined.
217	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the on-going viability and solvency of the Trust.
575	Section 19 of the Road Safety Act 2006 is expected to come into force in the near future - the precise date has not been confirmed. This will stipulate a requirement to evidence completion of a driver training course and on-going assessment / competency checks. We cannot currently evidence this for all drivers. The on-going assessment will require a vast increase in the number of driving instructors as we currently would not be able to cope with demand. There is not a sufficient budget to cover this shortfall.
559	There is a risk that on-going delays in ambulance crews handing over their patients at Northwick Park Hospital ED will reduce operational cover in the surrounding area and compromise patient care.
433	Funding proposals for resources or identified costs to deliver the QIP do not align with the outcome of 2016/17 contracting discussions with Commissioners, and therefore unaffordable.
431	The LARP2 project will not deliver its main objectives (of implementing the new ESN based radio system in the control room, all LAS operational vehicles and other key areas before Jan 2020 when the current LAS contract with Airwave Ltd. expires).
428	There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead.
420	There is a risk that Trust systems are vulnerable to cyber-attacks that could defeat industry standard firewalls and virus detection systems, resulting in loss of sensitive personal data and access to critical operational systems.
240	Archiving space for training records is insufficient and now decentralised
116	There is a risk that there may be insufficient emergency ambulances and cars to meet demands.

482	Multiple IM&T incidents negatively affecting the stability of the 111 telephony platform combined with poor achievement of customer requirements has adversely affected 111's service reputation, service provision and overall stability 1. Technical faults to telephony systems causing numerous symptoms affecting 111 operational and support staff - ultimately affecting the quality of service the LAS provides to our patients 2. Telephony system reporting (live and historical) functionality: The new 111 Telephony system does not have the same reporting functionality as the previous system (new system has been place since March 31st), this limits the ability of 111 Management staff to safety and proactively manage their shift and deployment of staff against demand.
445	There is a risk that defibrillation may be delayed by clinical staff in cases where fine ventricular fibrillation (VF) is not recognised.
432	The Quality Improvement Programme fails to achieve tangible outcomes in the first 6-12 months diminishing stakeholder support.
495	Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made and appropriate help and support may not be provided by the local authority or other agencies as a result.
219	Failure to maintain an effective financial control environment could lead to poor decision making and the waste of public funds.
69	There is a risk that the Trust is unable to provide assurance that it is compliant with safeguarding training requirements for clinical and non-clinical staff.
28	There is a risk that voice recordings of 999 calls and radio transmissions more than 2-3 years old cannot be retrieved for the purpose of investigating claims and preparing for inquests. This is contrary to Records Management: NHS Code of Practice which states that the minimum retention period for ambulance records is 10 years. Audio records are covered by the retention schedule.
13	There is a risk that the Board Assurance Framework and/or the Trust Risk Register may not be up to date because of the delays in or lack of response to requested for information. This can have a negative reflection on the LAS when involving external parties e.g. NHS Improvement.
538	There is a risk around the security of personal information that is sent around the Trust without the use of encrypted email (egress). Legal services send call logs and prfs by egress to stations and staff and receive unencrypted emails back from some stations with witness statements containing personal information attached.
308	There is a risk that we will be unable to ensure mentoring of Apprentice Paramedics, as a consequence of insufficient core line capacity, and qualified Paramedics to act as mentors.
76	Industrial Action - There is a risk that patient safety may be compromised during periods of industrial action taken by London Ambulance Service staff as a result of current national ballots.

Remuneration and staff report

Remuneration

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 54 to 56.

Banded Remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2016/17 was in the range of £195,001 to £200,000. The pay multiplier in 2016/17, based on annualised salary, was 5.64 times the median remuneration of the workforce, which was £35,218. In 2015/16, the banded remuneration of the highest paid director £195,001 to £200,000. The pay multiplier in 2015/16, based on annualised salary, was 5.32 times the median remuneration of the workforce, which was £36,930.

In 2016/17, as in the previous year, none of the employees received remuneration in excess of the highest paid director.

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:

- The reduction in overtime being worked by frontline staff in 2016/17 compared with 2015/16.

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 2016/17

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'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
Nicholas Martin, 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	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Jayne Mee, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Fionna Moore, Chief Executive (up to 31 December 2016)	£145,001-£150,000	£3,600	£0	£0	£0	£145,001-£150,000
Andrew Grimshaw, Director of Finance (up to 31 December 2016), Acting Chief Executive (from 1 January 2017)	£130,001-£135,000	£0	£0	£0	£40,001-£42,500	£170,001-£175,000
Andy Bell, Acting Director of Finance (from 1 January 2017)	£20,001-£25,000	£0	£0	£0	£40,001-£42,500	£60,001-£65,000
Paul Woodrow, Director of Operations	£115,001-£120,000	£7,100	£0	£0	£207,501-£210,000	£330,001-£335,000
Fenella Wrigley, Medical Director	£110,001-£115,000	£4,800	£0	£0	£202,501-£205,000	£320,001-£325,000
Zoe Packman, Director of Nursing and Quality (up to 25 May 2016)	£15,001-£20,000	£0	£0	£0	£17,501-£20,000	£35,001-£40,000
Briony Sloper, Acting Director of Nursing (from 6 June 2016 to 31 December 2016)	£45,001-£50,000	£0	£0	£0	£50,001-£52,250	£95,001-£100,000
Patricia Bain, Chief Quality Officer (from 3 January 2017)	£30,001-£35,000	£0	£0	£0	£0	£30,001-£35,000

The figures show under the heading "expenses payments" refer to the provision of lease cars.

* The following directors left the Trust during the year; Nicholas Martin on 28th February 2017, Zoe Packman on 25th May 2016 and Fionna Moore on 31st March 2017.

** The following directors joined the Trust during the year; Sheila Doyle on 6th February 2017, Jayne Mee on 9th January 2017 and Patricia Bain on 3rd January 2017.

Salary and pension entitlements of senior managers

Remuneration 2015/16

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Richard Hunt, Chairman	£20,001-£25,000	£0	£0	£0	£0	£20,001-£25,000
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
Nicholas Martin, 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
Fionna Moore, Medical Director Chief Executive (Acting to 23 July 2015)	£145,001-£150,000	£4,700	£0	£0	£0-£2,500	£150,001-£155,000
Andrew Grimshaw, Finance Director	£125,001-£130,000	£0	£0	£0	£20,001-£22,500	£150,001-£155,000
Jason Killens, Director of Operations (to the 25 September 2015)	£50,001-£55,000	£1,900	£0	£0	£0-£2,500	£55,001-£60,000
Paul Woodrow, Director of Operations (Acting Director of Operations from 28 September 2015)	£50,001-£55,000	£4,900	£0	£0	£22,501-£25,000	£80,001-£85,000
Fenella Wrigley, Medical Director (Acting to February 2016)	£95,001-£100,000	£4,000	£0	£0	£77,501-£80,000	£175,001-£180,000
Zoe Packman, Director of Nursing and Quality (Acting)	£75,001-£80,000	£0	£0	£0	£10,001-£12,500	£85,001-£90,000

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employers contribution to stakeholder pension
Heather Lawrence, Chairman	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Robert McFarland, Non-Executive Director	**	**	**	**	**	**	**	
Nicholas Martin, Non-Executive Director	**	**	**	**	**	**	**	
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	**	**	**	**	**	**	**	
*Fionna Moore, Chief Executive (up to 31 December 2016)	*	*	*	*	*	*	*	
Andrew Grimshaw, Chief Executive (from 1 January 2017)	£2,500-£3,000	£0-£2,500	£35,001-£40,000	£95,001-£100,000	£579,079	£51,154	£630,233	
Andy Bell, Acting Director of Finance (from 1 January 2017)	£0-£2,500	£0-£2,500	£15,001-£20,000	£35,001-£40,000	£163,921	£3,455	£177,933	
Fenella Wrigley, Acting Medical Director (acting to February 2016)	£7,501-£10,000	£22,501-£25,000	£35,001-£40,000	£105,001-£110,000	£454,318	£183,247	£637,565	
Paul Woodrow, Director of Operations	£7,501-£10,000	£22,501-£25,000	£35,001-£40,000	£110,001-£115,000	£527,424	£179,600	£707,024	
Zoe Packman, Director of Nursing and Quality (from 1 April 2016 to 25 May 2016)	£0-£2,500	£0-£2,500	£40,001-£45,000	£130,001-£135,000	£775,034	£7,108	£822,205	
Briony Sloper, Acting Director of Nursing and Quality (from 6 June 2016 to 31 December 2016	£0-£2,500	£0-£2,500	£15,001-£20,000	£35,001-£40,000	£189,692	£25,030	£233,405	
*Patricia Bain, Chief Quality Officer	*	*	*	*	*	*	*	

* Fionna Moore is not an active member of the NHS pension scheme. Trisha Bain has claimed her retirement benefits.

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

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).

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

Table 1: Exit packages

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
Less than £10,000			1	9,262	1	9,262		
£10,000 - £25,000			1	15,531	1	15,531		
Totals			2	24,793	2	24,793		

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	Total value of agreements
	Number	**£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	2	25
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring MHT approval	0	0
Total	**2**	**25**

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

Off-Payroll engagements

Table 1: Off-Payroll engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	0
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: New Off-Payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 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 2016 and 31 March 2017	1
Number of new engagements which include contractual clauses giving the London Ambulance Service NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	1
Number of new engagements for whom assurance has been requested	1
Of which:	
Assurance has been received	1
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	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 2016 and 31 March 2017.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year.	0
both on payroll and off-payroll engagements.	11

Staff report

Average Staff Numbers

The average number of staff has increased over last year 5,054 (2015/16 4,756) as the trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	2	2	0
Ambulance Service	2,597	2,553	44
Administration and estates	1,392	1,288	104
Healthcare assistants and other support staff	1,034	1,034	0
Nursing, midwifery and heath visiting staff	29	14	15
Total	**5,054**	**4,891**	**163**

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 2017, we had a workforce of 5,164 staff, made up of 2,843 men and 2,321 women. This was broken down as follows:

	Total	Female	Male
Directors	25	14	11
Senior Managers	458	169	289
Employees	4,681	2,138	2,543
Total	**5,164**	**2,321**	**2,843**

Over the course of the year, a total of 510 people left the service – a turnover rate of 9.8 per cent, compared to 12.2 per cent in 2015/16.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 174 paramedics left during 2016/17.

Staff Sickness

The average working days lost in 2016/17 was 11.7 (2015/16 12.60). The data is based on calendar years January 2016 (2015) to December 2016 (2015).

Staff Policies

We welcome 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 2016/17 the trust spent £1.5m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer: **Andrew Grimshaw, Chief Executive**

Organisation: **London Ambulance Service NHS Trust**

Signature:  **Date: 25 May 2017**

3. Financial statements

2016/17 Introduction to the Annual Accounts

Financial Performance

2016/17 saw major recurrent investment in the London Ambulance Service by London Clinical Commissioning Groups (CCGs) in support of a programme of quality improvement. This investment was to increase capacity and recruit additional staff for the benefit of patient care. This investment was designed to replace non-recurrent funding that had been made available to the service in previous years.

For the financial year 2016/17 the Trust reported a surplus of £6.0m. The Trust had planned to report a £6.7m deficit. The improvement was due to in year non recurrent income mainly relating to sustainability and transformation funding. The following table summarises the key elements of the financial performance of the Trust in 2016/17

	Plan £m	Actual £m	Variance £m
Income	330.6	355.5	24.9
Expenditure	337.3	349.5	12.2
EBITDA	11.9	23.9	12.0
Deficit	(6.7)	6.0	12.7
Capital Resourcing Limit (CRL)	19.6	12.5	7.1
External Financing Limit (EFL)	1.6	1.6	0.0
Cash	6.7	18.6	11.9

In line with all NHS organisations LAS was required to identify efficiencies. In total £10.5m was identified and delivered in 2016/17.

The Trust continued to invest in new equipment, spending in excess of £12.9m on new vehicles to help improve the age profile of the fleet, IMT system renewal and improvement and additional clinical equipment. The Trust also completed a business case for a further 140 new ambulances for delivery across 2017/18.

	£m
Capital Expenditure	12.9
Less:	
Donated assets	(0.2)
NBV of Disposals, Termination of lease	(0.2)
Capital Resourcing Limit (CRL)	12.5

NHS Trusts have a number of financial duties. This section of the annual report outlines the financial performance of the Trust for the financial year ended 31 March 2017 and the results outlined in this section relate to the full 12 month period of 1 April 2016 to 31 March 2017. 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 regulatory duty to break-even in each and every financial year. The 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 the TDA, controls public expenditure in NHS trusts. This is a statutory 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 £13.5m; during the year the EFL was revised to £1.6m. The trust achieved its EFL target of £1.6m.

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% 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%.

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.

The Trust spent £12.9million on a range of projects, including ambulances (115 procured in year) and fast response cars (60 new cars), new technology projects and a range of projects to improve clinical equipment and the estate. Overall, the Trust under spent by £7.1m against its capital resource limit, which it is permitted to do. The capital programme was funded internally (no loans or external support from the DH). The under spend on the capital programme will be carried forward into the next financial years 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 84% of its NHS trade invoices respectively within 30 days; this is below the 95% target set by the Department of Health.

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 7.3 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial plan 2017/18

The Trust has formally submitted a plan for the coming financial year, 2017/18 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 deficit of £2.5 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)

The Treasury announced that public sector bodies are required to prepare their accounts under International Financial Reporting Statements (IFRS) from 2009/10. That was the first year that we prepared our accounts under IFRS, resulting in the rework of 2008/09 results to act as prior year comparators in the 2009/10 accounts.

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 £4.6 million for the current financial year (£5.4 million in 2015/16).

Subsequent events after the balance sheet date

The Trust has not identified any important event occurring after the financial year end, 31st March 2017, that has a material effect on the 2016/17 financial statements as presented.

Other information

Ernst Young LLP were the Trusts external auditor for the year ended 31st March 2017. The Trust paid £68,000 (£68,000 in 2015/16) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our Audit Committee. Ernst Young LLP carried out some non-audit work during the year ended 31st March 2017. It performed a review of the computer aid despatch system for the Trust at a cost £19,000.

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 2016/17 Group Accounting Manual issued by the Department of Health.

The financial statements for the year follow. A copy can be obtained free of charge from the Head of Financial Services who can be contacted at the address given at the end of this annual report.

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

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury 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.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed:  **Andrew Grimshaw, Chief Executive**

Date: **25 May 2017**

STATEMENT OF THE 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 the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

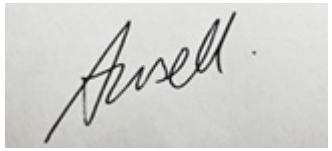
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

By order of the Board

25 May 2017 **Date**  **……Chief Executive**

25 May 2017 **Date**  **……Financial Director**

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

We have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 32. 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 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Manual for Accounts 2016-17 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).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on pages 54-55;
- the table of pension benefits of senior managers and related narrative notes on pages 56
- the tables of exit packages and related notes on pages 57-58;
- the analysis of staff numbers and related notes on pages 61-62 and
- the analysis of pay multiples on page 53.

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 as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. 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.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 69, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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.

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.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST (CONT'D)

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
the reasonableness of significant accounting estimates made by the directors; and
the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our 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 2016, 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 2017.

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.

Opinion on the financial statements

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 2017 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.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST (CONT'D)

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 2017.

We have nothing to report in these respects

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.

Janet Dawson
for and on behalf of Ernst & Young LLP

London Ambulance Service NHS Trust

Annual Accounts for the period

1 April 2016 to 31 March 2017

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits	7.1	**(244,793)**	(230,771)
Other operating costs	5	**(100,732)**	(89,316)
Revenue from patient care activities	3	**340,312**	315,487
Other operating revenue	4	**15,195**	4,505
Operating surplus/(deficit)		**9,982**	(95)
Investment revenue	9	**84**	122
Other gains and (losses)	10	**118**	44
Finance costs	11	**(142)**	(139)
Surplus/(deficit) for the financial year		**10,042**	(68)
Public dividend capital dividends payable		**(4,079)**	(3,966)
Retained surplus/(deficit) for the year		**5,963**	(4,034)

Other Comprehensive Income

	2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	**(2,474)**	87
Net gain/(loss) on revaluation of property, plant & equipment	**667**	10,106
Total comprehensive income for the year	**4,156**	6,159

Financial performance for the year

Retained surplus/(deficit) for the year	**5,963**	(4,034)
Impairments (excluding IFRIC 12 impairments)	**308**	(377)
Adjustments in respect of donated gov't grant asset reserve elimination	**(128)**	6
Adjusted retained surplus/(deficit)	**6,143**	(4,405)

There is a statutory requirement for NHS trusts to break even taking one year with another. Details of the break even duty is given in note 31.1.

A Trust's reported NHS financial performance position is derived from its Retained surplus/ (deficit), but adjusted for the following-

a) impairments to land & buildings due to change in market prices. An impairment charge is not considered part of the organisation's operating position.
b) Donated assets are now shown as income and are not considered part of the organisation's operating poistion.

The notes on pages 79 to 105 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	13	**142,368**	143,403
Intangible assets	14	**6,577**	8,704
Total non-current assets		**148,945**	152,107
Current assets:			
Inventories	17	**3,115**	2,999
Trade and other receivables	18.1	**35,518**	14,461
Cash and cash equivalents	19	**18,637**	20,209
Sub-total current assets		**57,270**	37,669
Non-current assets held for sale	20	**44**	101
Total current assets		**57,314**	37,770
Total assets		**206,259**	189,877
Current liabilities			
Trade and other payables	21	**(41,514)**	(33,495)
Provisions	24	**(8,064)**	(4,609)
Total current liabilities		**(49,578)**	(38,104)
Net current assets/(liabilities)		**7,736**	(334)
Total assets less current liablilities		**156,681**	151,773
Non-current liabilities			
Provisions	24	**(10,548)**	(9,796)
Borrowings	22	**(107)**	(107)
Total non-current liabilities		**(10,655)**	(9,903)
Total assets employed:		**146,026**	141,870
FINANCED BY:			
Public Dividend Capital		**58,016**	58,016
Retained earnings		**36,212**	28,120
Revaluation reserve		**52,217**	56,153
Other reserves		**(419)**	(419)
Total Taxpayers' Equity:		**146,026**	141,870

The notes on pages 79 to 105 form part of this account.

The financial statements on pages 74 to 105 were approved by the Board on 25 May 2017 and signed on its behalf by

Chief Executive: Date: 25 May 2017

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2016	**58,016**	**28,120**	**56,153**	**(419)**	**141,870**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year		5,963			**5,963**
Net gain / (loss) on revaluation of property, plant, equipment			667		**667**
Impairments and reversals			(2,474)		**(2,474)**
Transfers between reserves		2,129	(2,129)	0	**0**
Net recognised revenue/(expense) for the year	**0**	**8,092**	**(3,936)**	**0**	**4,156**
Balance at 31 March 2017	**58,016**	**36,212**	**52,217**	**(419)**	**146,026**
Balance at 1 April 2015	**62,516**	**30,746**	**47,368**	**(419)**	**140,211**
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year		(4,034)			(4,034)
Net gain / (loss) on revaluation of property, plant, equipment			10,106		10,106
Impairments and reversals			87		87
Transfers between reserves		1,408	(1,408)	0	0
Reclassification Adjustments					
PDC repaid in year	(4,500)				(4,500)
Other movements	0	0	0	0	0
Net recognised revenue/(expense) for the year	**(4,500)**	**(2,626)**	**8,785**	**0**	**1,659**
Balance at 31 March 2016	**58,016**	**28,120**	**56,153**	**(419)**	**141,870**

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS trust, is payable to the Department of Health as the public dividend capital dividend.

2 **Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

3 **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.

4 **Other reserves**
This reserve was created when London Ambulance Service became an NHS Trust. The negative reserve balance was caused by the legal title of the 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 thereby created a negative reserve.

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**9,982**	(95)
Depreciation and amortisation	5	**13,784**	12,998
Impairments and reversals	15	**308**	(377)
Donated Assets received credited to revenue but non-cash	4	**(159)**	0
(Increase)/Decrease in Inventories		**(116)**	27
(Increase)/Decrease in Trade and Other Receivables		**(21,062)**	19,183
Increase/(Decrease) in Trade and Other Payables		**1,548**	(1,806)
Provisions utilised		**(2,181)**	(2,098)
Increase/(Decrease) in movement in non cash provisions		**6,388**	(817)
Net Cash Inflow/(Outflow) from Operating Activities		**8,492**	27,015
Cash Flows from Investing Activities			
Interest Received		**93**	121
(Payments) for Property, Plant and Equipment		**(5,949)**	(12,553)
(Payments) for Intangible Assets		**(308)**	(927)
Proceeds of disposal of assets held for sale (PPE)		**329**	46
Net Cash Inflow/(Outflow) from Investing Activities		**(5,835)**	(13,313)
Net Cash Inform / (outflow) before Financing		**2,657**	13,702
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Repaid		**0**	(4,500)
PDC Dividend (paid)/refunded		**(4,229)**	(3,692)
Net Cash Inflow/(Outflow) from Financing Activities		**(4,229)**	(8,192)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(1,572)**	5,510
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**20,209**	14,699
Cash and Cash Equivalents (and Bank Overdraft) at year end	**19**	**18,637**	20,209

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

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 cashflow across 2017-18, not require any external financial support to achieve a positive cashflow and be able to pay its creditors across 2017-18 as they fall due. Trust management expect these conditions to be met in and continue beyond 2017-18.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 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.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing 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 1.11 and the carrying values of property, plant and equipment and intangible assets in notes 13.1 and 14.1 respectively.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

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 24.

Annual Leave Accrual
The accrual is based on management's estimation of untaken leave as at 31 March 2017. The carrying value of the accrual is £4.56m within note 21 under Non-NHS 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 £3.2m within note 18 under Non-NHS prepayments and accrued income.

1.6 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS 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 e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pension Scheme. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
● 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 will be supplied to the NHS trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and either
● the item cost at least £5,000; or
● Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous 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, the components are treated as separate assets and depreciated over their own useful economic lives.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

Valuation
All property, plant and equipment are measured initially at cost, representing the cost 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts 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, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

The estimated lives are as follows:

Medical equipment & engineering plant & equipment	5 to 10
Furniture	10
Set up costs in new buildings	10
Fork lift trucks	10
A&E Ambulances	7
Other vehicles	7
Command point	7
Defibrillators Lifepak 15	7
Defibrillators Lifepak 12	5
Rapid response vehicles	5
Office equipment	5
PTS vehicles	3
Information technology equipment	3
Internally generated software	3 to 7
Second-hand vans	2
Previously leased ambulances	2

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 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.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.17 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 NHS trust's cash management.

1.18 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the NHS trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 24.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.20 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority 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 as and when they become due.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.24 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.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.25 Foreign currencies

The NHS trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (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.

1.27 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 NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.28 Subsidiaries

The Trust Charitable Funds are not considered material and are therefore not consolidated with the Trust financial statements.

1.29 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.30 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.31 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.

2. Operating segments

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

3. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**29**	72
NHS England	**5,975**	1,652
Clinical Commissioning Groups	**329,192**	303,970
Foundation Trusts	**46**	57
Department of Health	**0**	508
NHS Other (including Public Health England and Prop Co)	**2,074**	1,722
Additional income for delivery of healthcare services	**0**	4,500
Non-NHS:		
Local Authorities	**0**	77
Injury costs recovery	**1,235**	1,365
Other Non-NHS patient care income	**1,761**	1,564
Total Revenue from patient care activities	**340,312**	315,487

4. Other operating revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**243**	346
Patient transport services	**2,987**	3,240
Education, training and research	**2,079**	867
Receipt of charitable donations for capital acquisitions	**159**	0
Sustainability & Transformation Fund Income	**9,636**	0
Income generation (Other fees and charges)	**91**	52
Total Other Operating Revenue	**15,195**	4,505
Total operating revenue	**355,507**	319,992

5. Operating expenses

	2016-17 £000s	2015-16 £000s
Trust Chair and Non-executive Directors	**83**	60
Supplies and services - clinical	**7,621**	6,387
Supplies and services - general	**10,692**	2,103
Consultancy services	**1,546**	1,691
Establishment	**8,811**	11,028
Transport	**31,990**	32,380
Business rates paid to local authorities	**2,305**	2205
Premises	**10,190**	14,813
Hospitality	**10**	1
Insurance	**1,250**	980
Legal Fees	**385**	(333)
Impairments and Reversals of Receivables	**72**	(1,279)
Inventories write down	**75**	0
Depreciation	**11,095**	10,329
Amortisation	**2,689**	2,669
Impairments and reversals of property, plant and equipment	**308**	(377)
Internal Audit Fees	**123**	85
Audit fees	**68**	68
Other auditor's remuneration	**19**	0
Clinical negligence	**1,989**	1,413
Research and development (excluding staff costs)	**58**	58
Education and Training	**1,616**	2,438
Change in Discount Rate	**1,243**	(74)
Other	**6,494**	2,671
Total Operating expenses (excluding employee benefits)	**100,732**	89,316

Other includes provisions in relation to contractual performance of £3.6m, occupational health charges of £1.3m and legal claim charges of £0.7m.

Employee Benefits		
Employee benefits excluding Board members	**243,986**	230,083
Board members	**807**	688
Total Employee Benefits	**244,793**	230,771
Total Operating Expenses	**345,525**	320,087

6. Operating Leases

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 office accommodation. The lease term varies between 1 and 15 years.

6.1. London Ambulance Service NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense					
Minimum lease payments				**5,082**	6,720
Total				**5,082**	6,720
Payable:					
No later than one year	4	2,726	2,025	**4,755**	4,463
Between one and five years	2	7,335	2,982	**10,319**	11,009
After five years	0	6,680	0	**6,680**	5,419
Total	**6**	**16,741**	**5,007**	**21,754**	20,891
Total future sublease payments expected to be received:				0	0

7. Employee benefits

7.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**200,528**	195,172
Social security costs	**21,994**	15,837
Employer Contributions to NHS BSA - Pensions Division	**22,479**	21,602
Termination benefits	**0**	(1,697)
Total employee benefits	**245,001**	230,914
Employee costs capitalised	**208**	143
Gross Employee Benefits excluding capitalised costs	**244,793**	230,771

7.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**10**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**750**	439

7.3. 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 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2017. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

8. Better Payment Practice Code

8.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**55,286**	**86,195**	59,493	87,324
Total Non-NHS Trade Invoices Paid Within Target	**46,377**	**69,717**	51,539	69,632
Percentage of NHS Trade Invoices Paid Within Target	**83.89%**	**80.88%**	86.63%	79.74%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**351**	**1,859**	434	**3,563**
Total NHS Trade Invoices Paid Within Target	**294**	**1,218**	310	**2,308**
Percentage of NHS Trade Invoices Paid Within Target	**83.76%**	**65.52%**	71.43%	64.78%

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 a valid invoice, whichever is later.

8.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**0**	1
Total	**0**	1

9. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**65**	105
Other loans and receivables	**19**	17
Subtotal	**84**	122
Total investment revenue	**84**	122

10. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(60)**	44
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**(3)**	0
Gain (Loss) on disposal of assets held for sale	**181**	0
Total	**118**	44

11. Finance Costs

	2016-17 £000s	2015-16 £000s
Provisions - unwinding of discount	**142**	138
Total	**142**	138

12. Auditor Disclosures

12.1. Other auditor remuneration

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	**0**	0
2. Audit-related assurance services	**0**	0
3. Taxation compliance services	**0**	0
4. All taxation advisory services not falling within item 3 above	**0**	0
5. Internal audit services	**0**	0
6. All assurance services not falling within items 1 to 5	**19**	0
7. Corporate finance transaction services not falling within items 1 to 6 above	**0**	0
8. Other non-audit services not falling within items 2 to 7 above	**0**	0
Total	**19**	0

13.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2016	51,758	62,039	0	2,096	16,026	45,189	12,773	74	**189,955**
Additions of Assets Under Construction				8,909					**8,909**
Additions Purchased	0	1,545	0		101	889	717	0	**3,252**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	159	0	0	**159**
Reclassifications	0	2	0	(1,691)	756	292	643	0	**2**
Disposals other than for sale	0	(107)	0	0	(67)	(3,990)	(594)	0	**(4,758)**
Revaluation	348	114	0	0	0	0	0	0	**462**
Impairments/reversals charged to operating expenses	5	(432)	0	0	0	0	0	0	**(427)**
Impairments/reversals charged to reserves	(891)	(3,988)	0	0	0	0	0	0	**(4,879)**
At 31 March 2017	**51,220**	**59,173**	**0**	**9,314**	**16,816**	**42,539**	**13,539**	**74**	**192,675**
Depreciation									
At 1 April 2016	0	4	0		10,080	26,051	10,358	59	**46,552**
Disposals other than for sale	0	0	0		(42)	(3,975)	(594)	0	**(4,611)**
Revaluation	0	(205)	0		0	0	0	0	**(205)**
Impairment/reversals charged to reserves	0	(2,405)	0		0	0	0	0	**(2,405)**
Impairments/reversals charged to operating expenses	0	(119)	0		0	0	0	0	**(119)**
Charged During the Year	0	2,723	0		1,987	4,954	1,429	2	**11,095**
At 31 March 2017	**0**	**(2)**	**0**	**0**	**12,025**	**27,030**	**11,193**	**61**	**50,307**
Net Book Value at 31 March 2017	**51,220**	**59,175**	**0**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**
Asset financing:									
Owned - Purchased	51,220	59,175	0	9,314	4,791	15,358	2,346	13	**142,217**
Owned - Donated	0	0	0	0	0	151	0	0	**151**
Total at 31 March 2017	**51,220**	**59,175**	**0**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	26,671	29,482	0	0	0	0	0	0	**56,153**
Movements (specify)	(551)	(3,385)	0	0	0	0	0	0	**(3,936)**
At 31 March 2017	**26,120**	**26,097**	**0**	**0**	**0**	**0**	**0**	**0**	**52,217**

Additions to Assets Under Construction in 2016-17

Land	0
Buildings excl Dwellings	32
Dwellings	0
Plant & Machinery	8,877
Balance as at YTD	**8,909**

13.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	51,754	53,267	0	3,404	14,657	42,525	12,474	83	**178,164**
Additions of Assets Under Construction				2,017					**2,017**
Additions Purchased	0	536	0		962	4,784	157	0	**6,439**
Reclassifications	0	44	0	(3,325)	407	2,691	187	0	**4**
Disposals other than for sale	0	(109)	0	0	0	(4,811)	(45)	(9)	**(4,974)**
Revaluation	4	8,214	0	0	0	0	0	0	**8,218**
Impairments/reversals charged to operating expenses	0	87	0	0	0	0	0	0	**87**
At 31 March 2016	**51,758**	**62,039**	**0**	**2,096**	**16,026**	**45,189**	**12,773**	**74**	**189,955**
Depreciation									
At 1 April 2015	0	4	0		8,109	26,966	8,351	66	**43,496**
Reclassifications	0	0	0		0	0	(42)	0	**(42)**
Disposals other than for sale	0	(109)	0		0	(4,803)	(45)	(9)	**(4,966)**
Revaluation	0	(1,888)	0		0	0	0	0	**(1,888)**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	(377)	0		0	0	0	0	**(377)**
Charged During the Year	0	2,374	0		1,971	3,888	2,094	2	**10,329**
At 31 March 2016	**0**	**4**	**0**	**0**	**10,080**	**26,051**	**10,358**	**59**	**46,552**
Net Book Value at 31 March 2016	**51,758**	**62,035**	**0**	**2,096**	**5,946**	**19,138**	**2,415**	**15**	**143,403**
Asset financing:									
Owned - Purchased	51,758	62,035	0	2,096	5,946	19,110	2,415	15	**143,375**
Owned - Donated	0	0	0	0	0	28	0	0	**28**
Total at 31 March 2016	**51,758**	**62,035**	**0**	**2,096**	**5,946**	**19,138**	**2,415**	**15**	**143,403**

13.3. (cont). Property, plant and equipment

A professional revaluation was undertaken on all land and buildings at 31 March 2017.

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;

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.

Economic Life of Assets	**Years**
Buildings	3 to 99
Plant and machinery	5 to 15
Transport equipment	2 to 10
Information technology equipment	3 to 5
Furniture and fittings	10

The gross carrying value of fully depreciated assets still in use:	**£m**
Furniture & fittings	0.1
Transport equipment	13.9
Plant and Machinery	7.1
Information technology	8.5
	29.6

14. Intangible non-current assets

14.1. Intangible non-current assets

2016-17	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	**16,510**	**2,511**	**0**	**0**	**0**	**705**	**19,726**
Additions of Assets Under Construction						556	**556**
Additions Purchased	11	0	0	0	0	0	**11**
Reclassifications	131	138	0	0	0	(271)	**(2)**
Disposals other than by sale	(59)	(6)	0	0	0	0	**(65)**
At 31 March 2017	**16,593**	**2,643**	**0**	**0**	**0**	**990**	**20,226**
Amortisation							
At 1 April 2016	**8,897**	**2,125**	**0**	**0**	**0**		**11,022**
Disposals other than by sale	**(59)**	**(3)**	**0**	**0**	**0**		**(62)**
Charged During the Year	**2,432**	**257**	**0**	**0**	**0**		**2,689**
At 31 March 2017	**11,270**	**2,379**	**0**	**0**	**0**	**0**	**13,649**
Net Book Value at 31 March 2017	**5,323**	**264**	**0**	**0**	**0**	**990**	**6,577**
Asset Financing: Net book value at 31 March 2017 comprises:							
Purchased	5,323	264	0	0	0	990	**6,577**
Total at 31 March 2017	**5,323**	**264**	**0**	**0**	**0**	**990**	**6,577**
Revaluation reserve balance for intangible non-current assets							
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	0	0	0	0	0	0	**0**
At 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**

14.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated		Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2015	15,913	2,503	0	0	664	0	**19,080**
Additions - purchased	172	32	0	0	581	0	**785**
Reclassifications	494	42	0	0	(540)	0	**(4)**
Disposals other than by sale	(69)	(66)	0	0	0	0	**(135)**
At 31 March 2016	16,510	2,511	0	0	705	0	19,726
Amortisation							
At 1 April 2015	6,646	1,800	0	0	0	0	**8,446**
Reclassifications	0	42	0	0	0	0	**42**
Disposals other than by sale	(69)	(66)	0	0	0	0	**(135)**
Charged during the year	2,320	349	0	0	0	0	**2,669**
At 31 March 2016	8,897	2,125	0	0	0	0	11,022
Net book value at 31 March 2016	7,613	386	0	0	705	0	**8,704**

14.3. Intangible non-current assets

The Trust does not revalue its intangible assets.

Economic lives of intangible assets

	Years
Software licences	3 to 7
IT: in-house and third party software	3 to 7

14.3 Gross carrying value of fully depreciated intangible assets still in use:

The gross carrying value of fully depreciated intangible assets is £2.8 million.

15. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Total charged to Departmental Expenditure Limit	**0**
Changes in market price	308
Total charged to Annually Managed Expenditure	**308**
Total Impairments of Property, Plant and Equipment changed to SoCI	**308**
Total Impairments charged to SoCI - AME	**308**
Overall Total Impairments	**308**

	Property Plant and Equipment £000s	Intangible Assets £000s	Financial Assets £000s	Non-Current Assets Held for Sale £000s	Total £000s
Impairments and reversals taken to SoCI					
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Changes in market price	308	0	0	0	**308**
Total charged to Annually Managed Expenditure	**308**	**0**	**0**	**0**	**308**
Total Impairments of Property, Plant and Equipment changed	**308**	**0**	**0**	**0**	**308**

16. Commitments

16.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**4,459**	1,003
Intangible assets	**141**	153
Total	**4,600**	1,156

17. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**35**	**2,964**	**0**	**0**	**0**	**0**	**2,999**	0
Additions	957	9,381	0	0	0	0	**10,338**	0
Inventories recognised as an expense in the period	(951)	(9,196)	0	0	0	0	**(10,147)**	0
Write-down of inventories (including losses)	0	(75)	0	0	0	0	**(75)**	0
Balance at 31 March 2017	**41**	**3,074**	**0**	**0**	**0**	**0**	**3,115**	**0**

18.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**6,713**	4,420	**0**	0
NHS prepayments and accrued income	**20,474**	2,037	**0**	0
Non-NHS receivables - revenue	**203**	431	**0**	0
Non-NHS receivables - capital	**2**	6	**0**	0
Non-NHS prepayments and accrued income	**7,844**	7,343	**0**	0
PDC Dividend prepaid to DH	**51**	0	**0**	0
Provision for the impairment of receivables	**(851)**	(782)	**0**	0
VAT	**692**	672	**0**	0
Interest receivables	**1**	11	**0**	0
Other receivables	**389**	323	**0**	0
Total	**35,518**	14,461	**0**	0
Total current and non current	**35,518**	14,461		
Included in NHS receivables are prepaid pension contributions:	**0**			

18.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**2,054**	3,824
By three to six months	**117**	47
By more than six months	**146**	76
Total	**2,317**	3,947

18.3. Provision for impairment of receivables

	2016-17	2015-16
	£000s	£000s
Balance at 1 April 2016	**(782)**	(2,062)
Amount written off during the year	**3**	1
Amount recovered during the year	**25**	0
(Increase)/decrease in receivables impaired	**(97)**	1,279
Balance at 31 March 2017	**(851)**	(782)

19. Cash and Cash Equivalents

	31 March 2017	31 March 2016
	£000s	£000s
Opening balance	**20,209**	14,699
Net change in year	**(1,572)**	5,510
Closing balance	**18,637**	20,209
Made up of		
Cash with Government Banking Service	**2,625**	20,199
Commercial banks	**5**	3
Cash in hand	**7**	7
Liquid deposits with NLF	**16,000**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**18,637**	20,209
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**18,637**	20,209
Third Party Assets - Bank balance (not included above)	**0**	0
Third Party Assets - Monies on deposit	**0**	0

20. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	63	38	0	0	0	0	0	0	0	0	**101**
Less assets sold in the year	(31)	(26)	0	0	0	0	0	0	0	0	**(57)**
Balance at 31 March 2017	**32**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
Liabilities associated with assets held for sale at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2015	63	38	0	0	0	0	0	0	0	0	**101**
Balance at 31 March 2016	**63**	**38**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**101**
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0	0	0	0	0	0	0	0

The assets comprise two radio transmitter sites (Land and Buildings) which are surplus to requirements due to technology advances.
The sites were sold on 7 April 2016 for consideration of £250k, and the gain on sale was £189k.

21. Trade and other payables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**1,058**	404	**0**	0
NHS accruals and deferred income	**228**	126	**0**	0
Non-NHS payables - revenue	**4,956**	5,905	**0**	0
Non-NHS payables - capital	**8,086**	1,615	**0**	0
Non-NHS accruals and deferred income	**17,864**	17,541	**0**	0
Social security costs	**3,342**	2,446		
PDC Dividend payable to DH	**0**	99		
Tax	**2,622**	2,174		
Other	**3,358**	3,185	**0**	0
Total	**41,514**	33,495	**0**	0
Total payables (current and non-current)	**41,514**	**33,495**		
Included above:				
outstanding Pension Contributions at the year end	**3,229**	3,124		

22. Borrowings

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
Loans from other entities	**0**	0	**107**	107
Total	**0**	**0**	**107**	**107**
Total other liabilities (current and non-current)	**107**	**107**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
2 - 5 Years	0	107	**107**
TOTAL	**0**	**107**	**107**

23. Deferred income

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2016	**90**	56	**0**	0
Deferred revenue addition	**21**	90	**0**	0
Transfer of deferred revenue	**(53)**	(56)	**0**	0
Current deferred Income at 31 March 2017	**58**	90	**0**	0
Total deferred income (current and non-current)	**58**	90		

24. Provisions

		Comprising:						
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Continuing Care**	**Equal Pay (incl. Agenda for Change**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**14,405**	8,803	753	0	0	0	4,849	0
Arising during the year	**5,911**	50	614	0	0	0	5,247	0
Utilised during the year	**(2,181)**	(415)	(337)	0	0	0	(1,429)	0
Reversed unused	**(908)**	0	(586)	0	0	0	(322)	0
Unwinding of discount	**142**	121	0	0	0	0	21	0
Change in discount rate	**1,243**	1,154	0	0	0	0	89	0
Balance at 31 March 2017	**18,612**	**9,713**	**444**	**0**	**0**	**0**	**8,455**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**8,064**	507	444	0	0	0	7,113	0
Later than One Year and not later than Five Years	**2,634**	1,994	0	0	0	0	640	0
Later than Five Years	**7,914**	7,212	0	0	0	0	702	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2017	55,349
As at 31 March 2016	50,351

The Early Departure Costs provision of £9,713k (2015/16 £8,803k) comprises pensions relating to claims for Personal Injury Benefits. The 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 0.24% is applied.

The Legal Claims provision of £444k (2015/16 £753k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

The other provision of £8,455k (2015/16 £4,849k) includes £2,341k relocation costs for recruitment of overseas paramedics, £3,614k for service penalties, £484k for changes in VAT rules, and £1,496k in respect of pension payments due to employees made redundant prior to 1995 as a result of the restructuring of the Trust. The provisions are calculated using actuarial tables and are payable quarterly over the life of the employees.

25. Contingencies

	31 March 2017	31 March 2016
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(182)**	(218)
Net value of contingent liabilities	**(182)**	(218)

26. Analysis of charitable fund reserves

	31 March 2017 £000s	31 March 2016 £000s
Restricted / Endowment Funds	54	194
Non-Restricted Funds	27	19
	81	213

The Trust Charitable Funds are not considered material and are therefore not consolidated with the Trust financial statements.

Non-restricted funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

27. Financial Instruments

27.1. 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. Because of 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 2017 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.

27.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		24,794		**24,794**
Receivables - non-NHS		3,912		**3,912**
Cash at bank and in hand		18,637		**18,637**
Total at 31 March 2017	**0**	**47,343**	**0**	**47,343**
Receivables - NHS		6,416		6,416
Receivables - non-NHS		4,942		4,942
Cash at bank and in hand		20,209		20,209
Total at 31 March 2016	0	31,567	0	31,567

27.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables		1,286	**1,286**
Non-NHS payables		38,503	**38,503**
Other borrowings		107	**107**
Total at 31 March 2017	**0**	**39,896**	**39,896**
NHS payables		629	629
Non-NHS payables		32,293	32,293
Other borrowings		107	107
Total at 31 March 2016	0	33,029	33,029

28. Events after the end of the reporting period

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

29. Related party transactions

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

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

	Payments to Related Party £000s	Receipts from Related Party £000s	Amounts owed to Related Party £000s	Amounts due from Related Party £000s
Barnet CCG	0	12,598	0	347
Brent CCG	0	16,421	0	324
Bromley CCG	0	12,247	8	0
Camden CCG	0	10,357	0	285
Central London (Westminster) CCG	0	10,996	0	433
City And Hackney CCG	0	10,841	0	687
Croydon CCG	0	14,425	0	411
Ealing CCG	0	11,831	0	459
Enfield CCG	0	11,763	0	337
Greenwich CCG	0	11,023	0	679
Haringey CCG	0	10,076	0	347
Hillingdon CCG	0	12,640	0	502
Lambeth CCG	0	13,524	0	342
Lewisham CCG	0	11,395	0	658
Newham CCG	0	12,100	0	484
Nhs England	0	16,429	0	13,411
Southwark CCG	0	13,299	0	342

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 £1,445k (2015/16 £1,968k) and the amount owed by the Trust as at 31 March 2017 was £29k (31 March 2016 £360k).

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 2016/17.

Sheila Doyle, a non Executive Director, who joined the Trust in January 2017, is also a Partner at Deloitte LLP with whom the Trust purchased services to the value of £61k during the financial year. There were no amounts owing at 31 March 2017.

30. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	1,637,102	1,432
Special payments	306,495	58
Total losses and special payments and gifts	1,943,597	1,490

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	1,800,395	1,457
Special payments	426,394	71
Total losses and special payments	2,226,789	1,528

31. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

31.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	215,941	236,130	261,532	279,864	283,617	281,731	303,109	303,827	324,052	319,992	355,507
Retained surplus/(deficit) for the year	113	398	725	(420)	740	2,527	(417)	1,525	6,326	(4,034)	5,963
Adjustment for:											
Timing/non-cash impacting distortions:											
Adjustments for impairments	0	0	0	1,845	262	247	723	(1,235)	(237)	(377)	308
Adjustments for impact of policy change re donated/government grants assets						(23)	(44)	11	5	6	(128)
Absorption accounting adjustment							0	(39)	(46)	0	0
Break-even in-year position	**113**	**398**	**725**	**1,425**	**1,002**	**2,751**	**262**	**262**	**6,048**	**(4,405)**	**6,143**
Break-even cumulative position	**1,446**	**1,844**	**2,569**	**3,994**	**4,996**	**7,747**	**8,009**	**8,271**	**14,319**	**9,914**	**16,057**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	0.05	0.17	0.28	0.51	0.35	0.98	0.09	0.09	1.87	-1.38	1.73
Break-even cumulative position as a percentage of turnover	0.67	0.78	0.98	1.43	1.76	2.75	2.64	2.72	4.42	3.10	4.52

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

31.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

31.3. External financing

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

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	1,572	(10,010)
Cash flow financing	1,572	(10,010)
External financing requirement	**1,572**	(10,010)
Under/(over) spend against EFL	**0**	0

31.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	12,887	9,241
Less: book value of assets disposed of	(207)	(8)
Less: donations towards the acquisition of non-current assets	(159)	0
Charge against the capital resource limit	**12,521**	9,233
Capital resource limit	19,168	10,164
(Over)/underspend against the capital resource limit	**6,647**	931

32. Third party assets

The Trust held cash and cash equivalents of £nil at 31 March 2017 (£nil at 31 March 2016) relating to monies held on behalf of patients or other parties.

A copy of our full accounts is available from the Head of Financial Services at the following address:

Head of Financial Services

Finance Department

London Ambulance Service NHS Trust

220 Waterloo Road

London

SE1 8SD

Appendix - Glossary of Terms

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

STATEMENT OF COMPREHENSIVE INCOME

Statement Of Comprehensive Income (Income And Expenditure) 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.

Revenue 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.

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

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 as loans to the Trust.

Profit / (loss) on disposal of fixed assets

The difference between the value of an asset in the balance sheet and the actual sale price of the item. This could be equipment or buildings.

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

Fixed Asset / 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. Fixed assets are typically equipment or buildings.

Current Assets

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

Stock / 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.

Debtors / Receivables

Money owed to the Trust for services provided.

Creditors / Payables

Money owed by the Trust for goods and services received.

Total Taxpayers' Equity

See Public Dividend Capital

NOTES TO THE ACCOUNTS

Historical Cost Convention

The value of an asset carried in the balance sheet is the amount paid for it on the purchase date.

Accruals Convention

The accounts are prepared taking account of all income received and receivable, and all expenditure paid and payable for the goods and services delivered and received in the period, and are not based on cash receipts and payments in the period.

Off Balance Sheet

Refers to fixed 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.

Liquid Resources

Resources that can be released quickly to enable the organisation to settle debts. Typically, cash in hand or in the bank in short term accounts.

Prepayment

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 fixed assets whose useful life extends beyond the current accounting period.

Revenue Expenditure

Expenditure on the day to day operations of the Trust, pay and rations as opposed to capital expenditure.

Consumables

Non pay expenditure on items that have a life of less than one year and are therefore not fixed assets. The term relates to everything from drugs, uniform, stationery through to pieces of disposable equipment.

CCGs - Clinical Commissioning Groups

New organisation established from 1st April 2013.

Liability

A situation 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

This is essentially the NHS insurance scheme, where we pay an annual premium to cover any insurance claims that may arise during the year.

The scheme covers all the usual insurance risks around buildings, equipment, fire etc, 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

RRV

Rapid Response Vehicle

PTS

Patient Transport Service.