London Ambulance Service NHS
NHS Trust

Annual Report

2013/14

Strategic report

Who we are and what we do

The London Ambulance Service NHS Trust is the busiest emergency ambulance service in the UK providing healthcare that is free to patients at the point of delivery. We are also the only London-wide NHS trust.

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 to them, recognising that many have complex problems or long-term medical conditions.

We also run a patient transport service which provides pre-arranged transportation for patients to and from their hospital appointments. In addition, we manage the emergency bed service, a bed-finding system for NHS healthcare professionals who need to make arrangements for their seriously-ill patients.

We are led by a Trust Board made up of 12 members – a non-executive chairman, five executive directors, including the Chief Executive, and six non-executive directors.

As an integral part of the NHS in London, we work closely with hospitals and other healthcare professionals, as well as with other emergency services. We are also central to planning for, and responding to, large-scale events or major incidents in the capital.

We have over 4,500 staff who work across a wide range of roles. We serve more than eight million people who live and work in the London area. This covers about 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

In 2013/14 we handled over 1.7 million emergency calls from across London and attended more than one million incidents.

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

Chairman Richard Hunt's views

What were the key achievements last year?

It is important to recognise the efforts of all colleagues in helping to ensure that once again we achieved our main performance target, which stretched everyone in the organisation.

On top of this, we also took on the running of the NHS 111 system in south east London and it has been very pleasing to see it working well.

What improvements have patients seen over the last year?

We continued to improve the quality of care provided to patients, especially those who were most seriously ill and injured. They received a fast response from us, even though we were attending more life-threatening (Category A) calls than ever.

Improved ways of working meant that patients who needed to go to hospital had a better experience. They waited less time to be handed over by our clinicians at emergency departments, and we introduced a system to manage the flow of patients into hospitals across London, reducing queuing and diverts.

What is the board's thinking around the future direction of the Service?

The immediate challenge continues to be to ensure we have sufficient resources to meet demand and maintain our performance in this environment.

We have been developing a new five-year strategy, building on all our previous work. We will be looking at how we can make it easier for people in London to get the urgent and emergency care they need quickly and how we can do more for patients by providing more treatment at the scene or at home without needing to take them to hospital.

We also want to offer more advice and care over the phone where it is clinically safe to do so, while at the same time working closely with our partners across health, social care and the other emergency services.

How is the Service's application to become a foundation trust progressing?

We have been working with the NHS Trust Development Authority to agree a timeline on a new application, which as we meet all the necessary requirements will, given current timescales, probably see us licensed as an NHS foundation trust in 2016/17.

One of the main areas of work this year as part of this process is likely to be around consulting with our stakeholders, staff and public members about our current membership arrangements and constituency groups.

Chief Executive Ann Radmore's views

You launched a programme of changes this year. How has this gone?

We have made huge progress. This is a significant programme of change for how we run the Service. We have agreed a new rota for every ambulance station and, with union colleagues, a new role and job description for staff to work with paramedics.

Thanks to the investment we received from our commissioners, we were able to recruit more than 220 of these new staff.

We are moving in 2014/15 to implement these changes.

How have recent changes to the wider NHS affected the Service?

We are the cornerstone of the health service in London and want to work closely with clinical commissioning groups (CCGs) – who buy our services – to support their plans to improve care locally for their patients. We have been developing these relationships this year as CCGs have settled into their roles.

As part of this, during the year we started to make changes to our operational management structure to mirror the new CCG groupings and help enhance relationships with local commissioners.

What are your plans to attract new staff, and retain existing staff, over the next twelve months?

We want to increase paramedic numbers due to increases in demand and because we want to have more of these registered healthcare professionals overseeing the care of our patients. There is a national shortage of paramedics and we are actively recruiting in the UK, abroad and from other sources to both increase paramedics and other healthcare staff.

What we did see during the year was more frontline staff leaving than we were expecting, which obviously put increased pressure on other colleagues.

We have now developed a clear clinical career structure to provide staff with opportunities to develop their skills and progress their career with us. The first team of 12 advanced paramedic practitioners started delivering care in May 2014.

What are your other priorities for this year?

As always we need to continue with our focus on patients and clinical issues to deliver better care to our patients, particularly those with mental health issues. Over the next 12 months, we are also planning to get 1,000 extra defibrillators placed in public places across London.

Our vision and strategic goals

Our vision is to be a world-class service, meeting the needs of the public and our patients, with staff who are well-trained, caring, enthusiastic and proud of the job they do.

We want to deliver the highest standards of healthcare and contribute towards people who live and work in London having health outcomes that are among the best in the world.

Our strategic goals for 2013/14 were:

- to improve the quality of care we provide to our patients
- to deliver care with a highly skilled and representative workforce
- to provide value for money.

These are supported by a number of corporate objectives, details of which can be found in the following pages of this report.

Our values in 2013/14 were the same as in the previous year:

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

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

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

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

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

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

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

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

Looking ahead, we are now in the process of developing a longer term strategy to take the organisation forward to 2020.

This is due to be finalised later in 2014, and is likely to include how we can provide a more

flexible response to our patients and work more closely with partners across health and social care to integrate our services so that patients receive joined up care and experience better outcomes.

We have also continued to work with the NHS Trust Development Authority on a timeline to become an NHS foundation trust.

Our achievements during 2013/14

Strategic goal: Improve the quality of care we provide to our patients

We have an increasingly important role to play in improving the health outcomes of patients in London.

Our objectives are:

- To improve the experience and outcomes for patients who are critically ill or injured
- To improve the experience and provide more appropriate care for patients with less serious illnesses or injuries
- To meet response times routinely, and
- To meet all other quality, regulatory and performance targets.

2013/14 was another very challenging year, but despite this we were able to continue to reach our most seriously ill and injured patients quickly and provide them with a safe service.

Increasing levels of demand again made it more difficult to always attend those with less serious conditions as quickly as we would have wanted to, and we will continue to look to improve the ways in which we manage and respond to these calls.

As well as time-based targets, all ambulance services were measured against a set of clinical indicators that help assess the quality of care provided to patients.

Full details on these and other patient care issues can be found in our Quality Account, which will be published in the summer.

Change programme

At the end of April 2013, we announced plans for a two-year change programme to help improve the care we provide to patients and the working lives of our staff.

This started with a consultation process with staff, followed by the setting up of a number of different projects to look at issues such as staff rotas, annual leave arrangements and a clinical career structure, with the intention of then being able to change the way we respond to some patients.

During the year, we worked closely with staff and our unions to move this work forward, so that in 2014/15 we will be able to bring in a new frontline staffing system that will see more

patient care overseen by paramedics, along with new rotas and annual leave arrangements to help ensure that we have staff working when patients need us most.

- ***Improving the experience and outcomes for patients who are critically ill or injured***

  Trauma care: Our staff continued to take patients with life-threatening injuries to one of four specialist centres in the capital which are open round the clock, with expert clinicians available to provide the best possible care.

  Cardiac care – heart attack:
  There are eight specialist centres in London where patients who are diagnosed as suffering a common type of heart attack, known as an ST-elevation myocardial infarction, can be taken directly by ambulance staff. They can then undergo primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

  One of the national clinical indicators looks at the percentage of those patients who receive this treatment within two and a half hours of the 999 call being received. The latest available figure for the Service - from April to December 2013 - was 92.3 per cent[1], compared to 93 per cent for the full 2012/13 year.

  Cardiac care – cardiac arrest:
  Thanks to the quality of care provided by our staff, the survival rates of patients who suffer an out-of-hospital cardiac arrest continue to rate as some of the highest in the country, and our published figures are also among the best in the world.

  Published figures for between April to December 2013 show that 30.5 per cent[2] of patients whose hearts stopped beating, at home or in public, were resuscitated and discharged from hospital. In 2012/13, the full year figure was 28.4 per cent.
  There are now over 1,000 defibrillators available in public places across the capital. These include tourist attractions, airports and train stations.

  During the year, we also trained 19,900 members of the public in cardio-pulmonary resuscitation – a simple life-saving technique which involves giving chest compressions and rescue breaths to someone whose heart has stopped beating.

  We currently manage 63 community responder and co-responder schemes in London whereby volunteers are trained to attend emergency calls in their local area and provide first aid to patients until an ambulance arrives. We now have 1,273 trained volunteers within these schemes.

  Michelle's story: In June last year, Michelle Kendall, a nurse from Bromley, met up with the paramedics who treated her when she suffered a cardiac arrest in April 2013.

[1] This figure is provisional, based on data available in May 2014
[2] This figure is provisional, based on data available in May 2014. It relates the number of patients discharged alive from hospital who had resuscitation attempted following a cardiac arrest of presumed cardiac aetiology, and who also had their arrest witnessed by a bystander and an initial cardiac rhythm of ventricular fibrillation or ventricular tachycardia.

Michelle's husband David started CPR while help was on the way and Paramedics Kieren Marks, Lynsey Grant, Kenneth Chibata along with Emergency Medical Technician Matthew Marsh arrived on scene shortly after. They gave Michelle's heart four shocks with a defibrillator and it restarted.

Michelle was taken to Lewisham Hospital. Three days later, she was transferred to King's College Hospital, where she was fitted with an internal defibrillator that shocks her heart back to normal rhythm if it starts to beat irregularly.

Stroke care:
We take patients who we diagnose with stroke symptoms directly 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 – which occurs when the blood supply to part of the brain is cut off.

During the year, we took just over 10,300 stroke patients to a hyper acute stroke unit, equating to around 98 per cent of all stroke patients who we attended.[3]

One of the national indicator measures is the percentage of stroke patients who arrive at a specialist centre within 60 minutes of us receiving the 999 call. Figures available for the first nine months of last year show that we achieved this in 65.7 per cent of cases.

Full details of our performance against all the national ambulance quality indicators can be found in our 2014/14 annual quality account.

- ***Improving the experience and providing more appropriate care for patients with less serious illnesses and injuries***

During 2013/14, we treated a wide range of patients presenting with less serious conditions.

Taking patients to the right place of care: As part of a wider NHS response to managing patients with less serious conditions, we continued our work to identify suitable alternative destinations where appropriate care can be provided away from the traditional hospital environment.

[3] This figure is provisional, based on data available in May 2014

These include minor injuries units, urgent care centres and walk-in centres, some of the latter being provided as part of the services at some larger GP practices. Frontline staff have received training and guidance to enable them to better assess minor injuries, illnesses and conditions, and from this decide on the appropriate destination for patients.

Clinical telephone advice: Our clinical telephone advisors helped 70,195 patients over the phone, up from 68,479 in the previous year.

This way of responding to those with less serious illnesses and injuries was supported by the development of a new clinical hub in our main control room. This is made up of two parts – clinical advisors, who review calls and ring back patients, and clinical team leaders, who provide advice to frontline ambulance staff as well as patients.

NHS 111: In November 2013, we took over the running of the NHS 111 system in south east London after NHS Direct withdrew from the contract.

As part of the step-in arrangements – which will run until March 2015 – around 120 former NHS Direct staff joined our organisation and we also took over the management of the existing call centre.

Between the start of the contract and the end of March 2013, we handled 106,698 calls, with 97.57 per cent answered within 60 seconds against a target of 95 per cent.

In the same period, only 1.8 per cent of patients had to be called back as their query could not be directly dealt with at the time of it being received, and when this did happen more than 79.6 per cent of call backs were made within 10 minutes.

Care of mental health patients: We have continued to work with mental health trusts across London to develop arrangements so that any mental health patients who we attend can be taken to the right place for treatment.

Improving our care to all mental health patients, including those with dementia, is a priority for us in 2014/15, and our commissioners have made additional funding available for training so that we can increase our frontline staff's awareness and understanding of mental health and dementia, and equip them with the skills to enable them to decide on the best care for these patients.

We also continued to examine complaints with a mental health component, and where possible are meeting with mental health trusts to agree personalised care plans for their patients, and the options available to them apart from calling for an ambulance.

End-of-life care: We continued to work with both NHS and hospice-based end-of-life care providers to provide appropriate care and support. We also continued to develop staff skills, training and competencies, the way we collate patient information and how we communicate with local providers of end-of-life care services.

Patients with pre-arranged hospital appointments: As well responding to emergency calls, we offer pre-arranged transport for patients to and from their hospital appointments.

We carried out 184,092 of these journeys during the year, compared to 177,379 in 2012/13.

We delivered patients to hospital on time for 93 per cent of the journeys, which compares to 92 per cent in 2012/13.

In terms of departing from hospital, we left on time in 93 per cent of cases (94 per cent in 2012/13).

Ninety eight per cent of our patients had a journey time of less than an hour, an increase from 97 per cent last year.

- ***Meeting response times routinely***

We received a total of 1,733,397 emergency calls during the year, up 1.5 per cent on 2012/13.

From these, we responded to 1,090,277 emergency incidents, up from 1,068,338 in the previous 12 months.

We took 748,531 patients to a hospital accident and emergency department, compared to 747,360 in 2012/13.

We also conveyed 91,380 people to another appropriate care centre, such as a minor injuries unit – this figure was 89,996 last year.

A further 256,448 patients were attended by our staff but were not taken anywhere for further medical treatment.

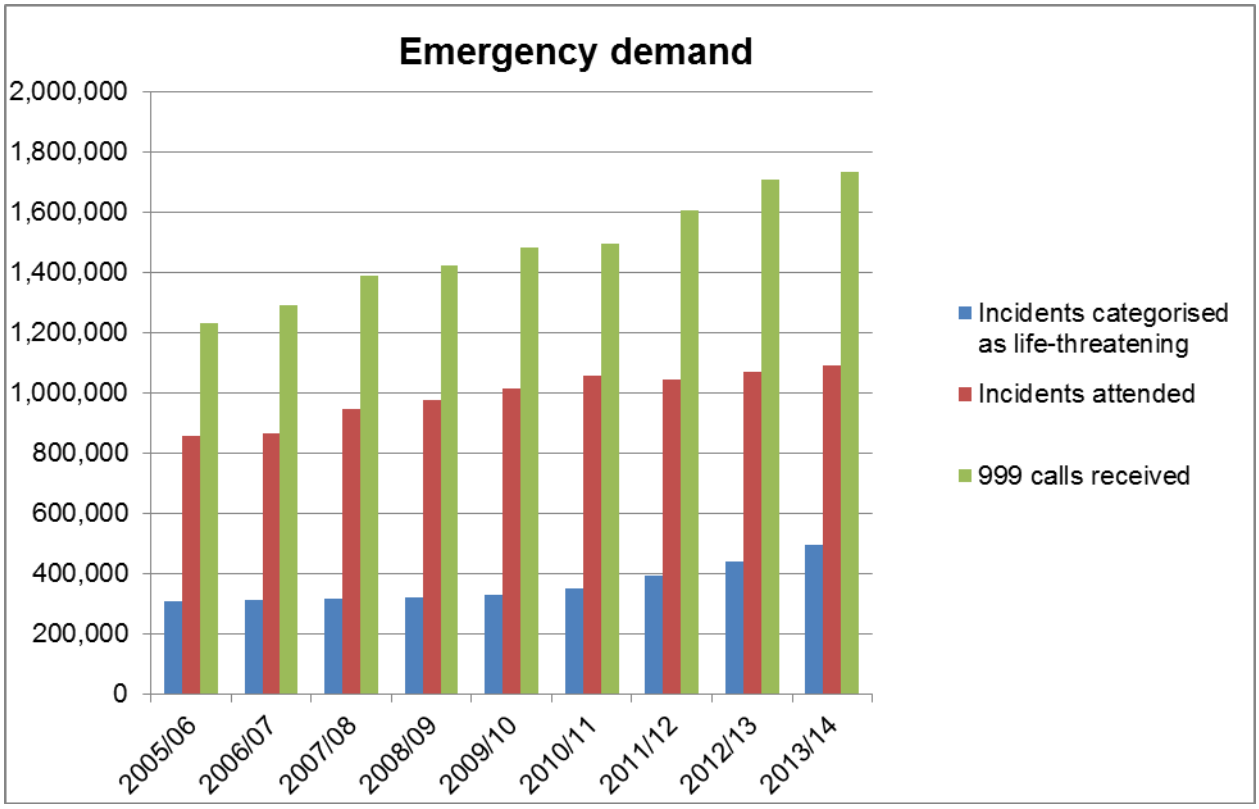
Category A: Of the total calls received, 496,348 were treated as life-threatening (Category A), compared to 465,197 in 2012/13.

Despite this increase, for the eleventh year in a row we managed to achieve the national response time targets to reach:

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

We attended a total of 460,615 Category A incidents, compared to 438,067 in 2012/13, and we reached 75.36 per cent (347,150) of these patients within eight minutes.

We arrived at 97.86 per cent (450,787) of Category A patients within 19 minutes, against the target of 95 per cent.



Category C: All other calls fall into one of four C categories. We received 1,227,879 calls to Category C (lower priority) patients compared to 1,242,279 last year. A total of 629,149 were responded to by ambulance crews (compared to 642,233 in 2012/13) and we reached 84.1 per cent of these patients within our target time of 60 minutes, compared to 86.47 per cent in last year.

- ***Meeting all other quality, regulatory and performance requirements***

The Care Quality Commission carried out an inspection visit in August 2013 which found that we met all key standards and that "the organisation was well-led with arrangements in place to monitor the quality of its service and effectiveness in the provision of care."

The Director of Nursing and Quality is the lead for infection prevention and control and a scorecard is presented each month showing performance against key infection prevention and control indicators.

The Trust Board is also now being held to account by the NHS Trust Development Authority for compliance with the new provider licence requirements and the Board statements, and during the year the Board approved submission of declarations stating full compliance with the Board Statements and Monitor Compliance for 2013/14.

We have a local counter fraud specialist, whose contact details are available to all staff on our intranet site, and also an anti-bribery policy.

Strategic goal: Deliver care with a highly skilled and representative workforce

We want all staff on the frontline to have the skills to assess and treat a wide range of conditions, and those in other functions have the right skills to support them.

We also want to improve the diversity of our workforce, and focus on engaging with our staff more so that they are motivated and feel valued, and have a greater say in how we improve our service.

To achieve this goal we will:

- develop our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population, and
- engage with our staff to improve patient care and productivity.

- ***Developing our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population***

  Our workforce: At the end of March 2014, we had a workforce of 4,650 staff, made up of 2,602 men and 2,048 women.

  This was broken down as follows:

Staff group	Male	Female	Total
Directors	8	5	13
Other senior managers	276	139	415
All other staff	2318	1904	4222
Total	2602	2048	4650

  Over the course of the year, a total of 447 people left the Service – a turnover rate of 10.7 per cent, compared to 9.6 per cent in 2012/13.

  While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in higher numbers than usual. Over 160 paramedics left during 2013/14, and so despite actively recruiting to this role we were left with around 250 vacancies at the end of the year.

  As well as offering eligible staff within our Service the opportunity to train to become paramedics and increasing our intake of graduates from universities, we have started to look overseas and have been approved to sponsor work visas for non-European paramedics.

  On a more positive note, we were able to recruit more than 220 new A&E support staff, who in the future will work alongside paramedics as part of the frontline response to emergency calls.

  We also made significant progress in developing a formal clinical career structure to help attract new staff and retain current employees. This included introducing a new role of advanced paramedic practitioner, who has additional skills to treat patients with complex conditions. The first group of advanced paramedic practitioners became operational in May 2014.

The rate of sickness among our staff for was 6.5 per cent, against a target of 5.5 per cent. This compares with a sickness rate of 5.32 per cent in 2012/13.

Our approach to equality and inclusion: 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
- 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
- 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.

During the year, we took 19th place in the charity Stonewall's Top 100 Employers list – up from 22nd place in the previous year. We were also recognised in the top 10 of their Healthcare Equality Index. Both were significant achievements and recognition of our inclusive policies and support networks for staff. As well as a Lesbian, Gay, Bisexual and Transgender Forum (LGBT), we also have a very active Deaf Awareness Forum and a new Black and Minority Ethnic (BME) Forum. Our LGBT forum was also recognised as one of Stonewall's star performer network Groups.

Disabled employees: Our recruitment and selection policy is designed to ensure that recruitment to our organisation, as well as promotion within it, is managed in an equitable way and based on an objective assessment of candidates against the requirement of the job. This is supported by a disability employment policy, which outlines commitments around promotion and training of disabled employees. We are members of the Business Disability Forum as well as Carers UK. We have signed up to the Two Ticks 'positive about disabled people scheme' – as part of which and our diversity forum for disabled people and carers, known as Enable, provides staff with a

voice on policy and decision-making for our disabled employees and staff who are carers, including their involvement as 'critical friends' in our equality analysis.

We are members of Stonewall's Diversity Champions Scheme and the Employers' Network for Equality and Inclusion

We are also members of Opportunity Now, a membership organisation representing employers who want to transform the workplace by ensuring inclusiveness for women; and we are members of Race for Opportunity which is a race diversity campaign committed to improving employment opportunities for ethnic minorities across the UK.

This year we will be updating our Equality and Inclusion Strategy as it has reached the end of its three-year cycle.

- ***Engaging with our staff to improve patient care and productivity***

Employee involvement
We recognise that an engaged workforce is key to improving our services and productivity, and we are committed to communicating and engaging with staff to achieve this.

Our staff engagement score, informed by the 2013 NHS staff survey, was 2.97 (based on a score range from 1 to 5). This was calculated from findings related to staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Service as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

This was down from 3.18 in 2012 and compared with a national ambulance trust average of 3.19.

Staff survey findings: A total of 1,777 staff members completed the 2013 survey, giving a response rate of 40.8 per cent. This was an increased rate of response against the 2012 staff survey which saw a response rate of 37.1 per cent.

The results showed a number of areas of concern, including increases in the percentage of employees who feel we do not have enough staff which is impacting on their ability to do their job properly, and an increase in staff who do not feel valued or recognised for the work they do.

Work has already started to address a number of the areas which staff have highlighted, but it is clear that there is still much more to do. This includes our modernisation programme (announced last April, with the aim of improving patient care and the working lives of staff), recruitment campaigns and a new approach to reward and recognition which is being developed as a result of the work of the Listening into Action reward and recognition project.

Listening into Action: In March 2012, we signed up to be part of Listening into Action (LiA), which was already being used by a number of other trusts across the country to change the way they listen to and involve staff.

Led by the Chief Executive, it is an approach designed to bring about positive change through collaboration with staff and has taken place through 2013/14.

In May 2013 over 250 members of staff attended ‘Big Conversation’ events where they got together to talk about the issues that get in the way of doing their job.

Key themes from the events informed seven projects to be taken forward: communications, 111 feedback, refreshments at hospitals, Medical Priority Dispatch System, learn about each other, recognition of excellence and Health Care Professional (HCP) education and development.

Each project had members of staff working on trialling and implementing new ideas to improve the way things work.

A number of changes have been made across the Service and we are planning to run LiA for a second year. We have been talking to those staff who worked on the 2013/14 projects to identify lessons learned and to get their views on what year two of the programme could look like.

Staff conferences: There were a number of internal conferences throughout the year which provided staff with an opportunity to hear about our future plans, and to raise issues that matter to them. In total, 10 events were held for managers and team leaders, while there were also six held for all staff last July to find out about developments in the Service.

We also held our first webinars for staff, and plan to run more of these in the future.

Opportunities for giving feedback and sharing ideas: We continued to use ‘temperature check’ surveys for staff to give feedback and suggestions on how to make improvements for the benefit of patients and their own working lives.

We also set up a closed social networking site, where staff can discuss issues and ask questions of managers. This now has around 1,500 staff as registered users.

Health and well-being: Staff volunteering as part of the LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative continued to provide support to colleagues on issues from work-related stress to family and social problems.

Health and safety: All staff are also encouraged to report any incidents or near misses, such as those involving patient safety or abuse or violence that they may themselves have experienced from patients or members of the public.

During the year, 1,501 clinical incidents were reported, compared to 2,554 in 2012/13. However, the number of reported manual handling incidents increased from 459 to 652.
In total, there were 4,995 incidents in 2013/14, compared to 5,873 in 2012/13.

The reports are collated by the Health, Safety and Risk department and information shared for the Risk Management and associated group and appropriate departments – please see the Annual Governance Statement for more information.

Partnership working with the unions: We continued to use our long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place. These arrangements helped to support the introduction of a number of different initiatives and ways of working to maintain levels of patient care over the winter period.

We consulted on the major issues, opportunities and challenges facing the Service, and we plan to maintain these working relationships when we become a foundation trust.

The staff side to the Staff Council, the senior consultative group within our Service, has been offered and accepted a governor seat as part of the planning process for foundation trust status.

Representation on our Council of Governors: When we achieve foundation trust status, staff will be able to stand for election to our Council of Governors. We are proposing three seats for staff representatives. This is separate from, and in addition to, the seat for a staff side representative from the Staff Council.

Strategic goal: Provide value for money

It continues to be very important that we provide Londoners with a service that represents value for money.

To achieve this goal we will use our resources efficiently and effectively.

- ***Using our resources efficiently and effectively***

We received £14.8m of investment from our commissioners to support the first year of our change programme and recruit more than 220 new A&E support staff.

We were also allocated a further £7.7m to fund a range of initiatives to ease pressure on the wider NHS in London during the busy winter period. The money formed part of the allocation to London's health system and was used to fund a number of initiatives, including a dedicated team to help to manage the pressure on all London hospitals by monitoring the numbers of patients taken to each hospital and requesting ambulance crews travel to a different emergency department when a particular hospital started to become too busy.

At the same time, we continued to make savings in line with the NHS wide need for efficiencies and achieved our target of £10 million during the year.

Major incident planning: We continued to train and prepare for major incidents, both within our own organisation and as part of exercises with other emergency services.

The collapse of a ceiling at the Apollo Theatre in December 2013 was declared a major incident and around 100 staff attended the scene in Shaftesbury Avenue. A casualty clearing area was set up in the foyer of the theatre and 79 patients were treated – with 56 of them taken to hospital, mostly with minor injuries.

A number of debrief sessions were held after the incident to find out what lessons could be learned ahead of any future incidents.

Governance of our organisation

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

The board assurance framework and corporate risk register are presented to the Trust Board each quarter, and further scrutiny is applied through the Quality and Audit Committees. The risk register is reviewed in detail by the Risk Compliance and Assurance group on a quarterly basis.

Full details can be found in our governance statement on page 26 of this document.

Our use of feedback to make improvements

We view feedback from patients, their families and the public as important way of driving improvements to our service.

One of the most valuable forms of feedback we receive is through complaints, of which we received 1,060 during the year, up from 976 in 2012/13.

This increase reflected a growth in 999 demand, with the most frequent cause for complaint being a delay in an ambulance being sent, especially to patients assessed as less seriously ill or injured; and changes in how we manage 999 calls, with some callers being referred to NHS 111 or other care providers.

Our Learning from Experience Group continue to monitor emerging trends arising from complaints and other sources of feedback, and a patient or a relative regularly attends our Trust Board meetings to tell their story about their experience of using our Service.

Our Patient Experiences Department received more than 6,000 general enquiries last year.

Principles for Remedy

We manage our complaints handling process in accordance with the Health Service Ombudsman's good practice guidance, Principles of Remedy. This includes:

- All complaint responses include information about the recourse opportunity to, and contact details for, the Health Service Ombudsman.

- Our website and all our staff can offer information about how to make a complaint about the service we provided.

- Activity and themes arising from complaints are regularly reported to the Trust Board

- Our Learning from Experience Group reviews the themes and issues emerging from complaints and the action taken to improve services and the experience of patients.

Sustainability report

We remain committed to making improvements in all aspects of our environmental performance.

Environmental monitoring and reporting enables us to quantify the environmental and social effects of delivering our service; to improve both our management of any associated adverse environmental and social impact, and our overall environmental performance; and to work towards achieving the targets in the NHS Carbon Reduction Strategy.

In 2012, the Carbon Trust reviewed and approved our five-year carbon management plan which sets out how we will reduce our carbon footprint as part of our contribution to tackling climate change. A carbon footprint is measured in tonnes of carbon dioxide equivalent (tCO2e). This is based on a baseline for the Service of 61,950 tonnes CO2e that was calculated in 2010/11.

There are three areas in which we will focus our activity – fuel consumption, energy use and procurement. We aim to reduce our energy and fuel consumption by 25 per cent over the five-year period, and by focusing on procurement we will cut indirect emissions from products and services by 10 per cent. It is envisaged that this will achieve total costs savings of over £5.5m. As the data we are using becomes more reliable, we are able to better assess our carbon footprint and to identify areas where additional efforts are required.

The overall trajectory is downwards from the baseline figure of 61,950 tCO2e – a reduction of 32 per cent achieved primarily from a reduction in procurement spend and fuel.

<u>Environmental impact performance indicators</u>

Area		Non financial data 10/11 (baseline)	Non financial data 11/12	Non financial data 12/13	Non financial data 13/14	Financial data 10/11 (baseline)	Financial data 11/12	Financial data 12/13	Financial data 13/14
Finite resource	Water	24	17	15	12	97,189	91345	102,028	97,297
	Electricity	3994	4125	4407	4260	1,055,486	1,054,406	1,136,592	1,262,162
	Gas	1576	1313	1807	1563				
	Fuel	12387	12082	11519	11346	5,846,323	5,383,166	4,316,464	4,912,252
Procurement	Procurement	43,969	19,285	24,730	24,877	74,524,230	56,084,612	68,651,920	67,709,602
Total		**61950**	**36822**	**42478**	**42058**	**81,523,228**	**62,613,529**	**74,191,005**	73,981,313

1. Carbon footprint estimated from water and energy consumption data submitted to ERIC
2. The carbon footprint for procurement in 2011/12 -2013/14 has been estimated by assigning DEFRA emission factors per pound of spend against individual cost centres. This is an improvement on the method used in 2011 to estimate the baseline figure for 2010/11.

Fuel consumption: Our core activity means that we have high levels of fuel consumption. In 2013/14 we used over 4.2 million litres of fuel, compared to 4.3 million litres in 2012/13. In 2013/14 there was an increase of 1.45 per cent in incidents attended but a decrease of circa 2.5 per cent in fuel consumption. As well as treating more patients in their homes we are also resolving more calls through clinical telephone advice. Thirty three per cent of the 70,195 calls that were assessed as being suitable for clinical telephone advice in 2013/14 were resolved without a physical response being dispatched.

Energy use: Although over half of our 70 ambulance stations are more than 50 years old, when measured against other ambulance services we score well in our energy consumption per metre. In partnership with SALIX we have ring fenced funding for investment in a number of initiatives. However, despite the investment we have seen an increase of 4.5 per cent in our energy consumption compared to our baseline data for 2010/11. This was due to changes in our estate and Bow becoming our second 24/7 control room. In 2014/15, the majority of our estate had SMART metering installed; this will enable us to receive data and bills based on actual consumption rather than estimates. In addition we recycled 93 per cent of our waste.

Procurement: The overall trend is downwards from the baseline of circa 43,969tCO2e to 24,877tCO2e.

Looking ahead to this and future years, our environmental priorities will include:

- further investment in energy conservation works to reduce carbon emissions from energy use across our estate
- continuing to raise staff environmental awareness
- reviewing procurement arrangements to identify opportunities for carbon reduction and cost savings
- working with suppliers to minimise waste and identify opportunities for associated carbon reduction.

Changes to the London healthcare system

The Health and Social Care Act 2012 came into effect on 1 April 2013 and signalled significant changes to the management of NHS services in London. We are now commissioned by 32 clinical commissioning groups and this is coordinated through the North West London Commissioning Support Unit.

London's strategic health authority was disestablished on 31 March 2013 and we are now performance managed through the NHS Trust Development Authority, who will also support us through the foundation trust application process.

NHS England (London) coordinates the commissioning arrangements across London and holds the 32 clinical commissioning groups accountable.

Directors' report

Our Trust Board

In 2013/14 our Trust Board was made up of 12 members – a non-executive chairman, five of the Service's executive directors, including the Chief Executive, and six non-executive directors.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. All executive appointments are permanent and subject to normal terms and conditions of employment. The non-executive directors are appointed by the same method through the NHS Trust Development Authority.

There were a number of changes to the Trust Board during the year.

Non executive directors:

Roy Griffins and Caroline Silver both completed their second term of office on 28 February 2014. Theo de Pencier and Fergus Cass were appointed as non-executive directors with effect from 1 March 2014.

Roy Griffins, non-executive director, was deputy chairman of the Trust Board until the end of his office on 28 February 2014. Jessica Cecil, non-executive director, has taken on the role with effect from 1 March 2014. Jessica previously held the role of senior independent non-executive director, which has now passed to Theo de Pencier.

Bob McFarland was appointed as the clinical non-executive director and chair of the Quality Committee with effect from 1 December 2013, following a period of acting as an associate non-executive director.

Executive management team:

The Chief Executive reviewed and then implemented a new executive management team structure comprising the following:

Fionna Moore, Medical Director (voting member of the Trust Board)

Steve Lennox, Director of Nursing and Quality (voting member of the Trust Board)

Jason Killens, Director of Operations (voting member of the Trust Board)

Andrew Grimshaw, Director of Finance and Performance (voting member of the Trust Board)

Sandra Adams, Director of Corporate Affairs/Trust Secretary (non-voting regular attendee of Trust Board)

Karen Broughton, Director of Transformation and Strategy (non-voting regular attendee of Trust Board)

Charlotte Gawne, Director of Strategic Communications (non-voting)

Mark Whitbread, Director of Paramedic Education (non-voting regular attendee of Trust Board)

David Prince, Director of Support Services (non-voting regular attendee of Trust Board)

Paul Woodrow, Director of Performance (non-voting)

Mike Evans, Director of Business Development (non-voting)

Jane Chalmers, Director of Modernisation (non-voting and interim position).

Lizzy Bovill commenced a long-term secondment with NHS England (London) in June 2013. Peter Suter left the Service in June 2013 and Caron Hitchen, Director of Workforce, in September 2013.

The Board has six formal sub-committees: the Strategy Review and Planning Committee, the Quality Committee, the Audit Committee, the Finance and Investment Committee, the Remuneration and Nominations Committee and the Charitable Funds Committee.

The Strategy Review and Planning Committee is made up of all the board members and is chaired by the Chairman.

Four non-executive directors and the Chief Executive made up the membership of the Quality Committee, which was chaired during the year by non-executive director Roy Griffins and then Bob McFarland from December 2013. The composition of the committee was reviewed in March 2014 and the new structure will commence in the first quarter of 2014/15.

The membership of the Audit Committee comprises three non-executive directors and was chaired by non-executive director Caroline Silver, who also chaired our Charitable Funds Committee.

The Finance and Investment Committee was chaired by non-executive director Nick Martin and has three non-executive directors as its members.

The Remuneration and Nominations Committee is chaired by the Trust Chairman and all non-executive directors are members.

Non-executive directors

Richard Hunt CBE joined us as Chairman in July 2009. He was formerly the International President of the Chartered Institute of Logistics and Transport, and has experience extending across the aviation, logistics, international oil and brewing sectors. Richard is a former Chief Executive of Aviance Ltd which handles logistics at UK airports, and he was Chief Executive of EXEL Logistics Europe, the largest UK transport and logistics business. He has also served as a non-executive on the Highways Agency Advisory Board. Richard was appointed CBE for services to logistics and transport in the 2004 New Year Honours.

Jessica Cecil took up her post on 1 December 2010. She has over 20 years of experience working in broadcasting on flagship television programmes such as *Newsnight*, *Panorama* and *Tomorrow's World*. She is now Head of Business Management at the BBC. Jessica was the senior independent non-executive director in 2013/14.
She is the member of the Quality and the Finance and Investment committees.

John Jones started as an associate non-executive director in October 2012, and took up his substantive role on 1 January 2013. He has 17 years' experience at board level in the NHS and has held a number of executive finance director positions. As a Director of Finance with Hertfordshire Partnership NHS Foundation Trust, John helped them to attain foundation trust status. John is a member of the Chartered Institute of Management Accountants and the Chartered Institute of Public Finance and Accountancy. He is a member of the Audit Committee, and Finance and Investment Committee.

Nicholas Martin took up the post in October 2012, and is a member of the quality committee. He has thirty years' experience of corporate finance advising a wide range of companies from different sectors. He has served on a number of boards and governing bodies in executive and non-executive roles, including Cambridge University, City of Westminster College, Hammersmith Hospitals NHS Trust, NHS City & Hackney Primary Care Trust and NHS Haringey Primary Care Trust. Nick is a barrister, a Chartered Fellow of the Chartered Institute of Securities & Investment, and a former Cabinet Special Adviser.
He is the chair of the Finance and Investment Committee and a member of the Quality Committee.

Robert McFarland took up his post in May 2013, as an associate non-executive director. Robert worked as a Consultant General and Vascular Surgeon for over 20 years and recently retired from St George's Healthcare NHS Trust. Throughout his career he has worked in both district hospitals and regional teaching hospitals. In 2007, Robert was appointed as Clinical Director for Trauma and Emergency Surgery at St George's Hospital, which opened as one of four major trauma centres serving London and Surrey in 2010. Robert was also Clinical Director of the South West London and Surrey Trauma Network and was a member of the Clinical Advisory Panel, London Trauma System.
He is the chair of the Quality Committee and attends the Audit Committee.

Fergus Cass joined us in March 2014. He was a non-executive director of NHS North West London until the replacement of primary care trusts in 2013 and previously served on the board of NHS Kensington and Chelsea. He worked for the multinational consumer goods company Unilever for 36 years, initially in finance and later as a general manager, heading businesses in Africa and South Eastern Europe. He holds degrees in economics and is a qualified accountant. Fergus is a trustee of Hospices of Hope, which supports palliative care in Romania and neighbouring countries, and of Book Aid International.

He is a member of the Quality and the Audit Committees.

Theo de Pencier joined the Service in March 2014. Theo is the Chief Executive of the Freight Transport Association (FTA) representing industry's freight interests by road, rail, sea and air. The FTA has over 14,000 members who operate more than 200,000 trucks (half of the total in the UK), consign 90 per cent of rail freight and 70 per cent of visible exports. Theo's early career was spent in sales and marketing with brand leading food and drink manufacturers Heinz and Diageo. He has over 30 years' Board level experience in the logistics and supply chain industry working for NFC and Danzas before joining Bibby Line Group in 1999 as Managing Director of Bibby Distribution. He joined FTA in July 2007.
He is a member of the Audit and Finance and Investment Committees.

Executive directors

Chief Executive Ann Radmore joined the Service in January 2013 after working as Chief Executive of NHS South West London where she led the establishment of the South West London Cluster in early 2010. Ann was previously Chief Executive of NHS Wandsworth and led the trust out of financial difficulties into a high performing primary care trust. After graduating from Cambridge University, Ann joined the NHS in 1983 as a national management trainee. She has worked in both specialist teaching and acute hospital and community settings as well as commissioning and a strategic health authority, and has managed a wide range of clinical and support services. She has led two major hospital redevelopments, one in Greenwich and one at Queen Mary's Roehampton. Ann also led the Londonwide implementation of the ground-breaking stroke and cardiovascular models – which significantly improved outcomes for patients through specialist units.

Director of Finance and Performance Andrew Grimshaw initially joined the Service on an interim basis in January 2013 and was appointed to the permanent post in March. Having joined the NHS as a trainee accountant in 1989, he has worked at district general hospitals, specialist and teaching hospitals throughout his career. He has worked as a Director of Finance since 2004 both for NHS trusts and foundation trusts.

Director of Nursing and Quality Steve Lennox was appointed as an executive director in January 2011, after joining us in September 2010. He was previously a member of the Chief Nurse's healthcare-associated infections and cleanliness team at the Department of Health where he worked at a national level with acute trusts, mental health trusts and ambulance trusts. A Registered General Nurse and a Registered Mental Nurse, Steve has worked in a variety of different clinical fields including HIV, critical care and neurosurgery.

Medical Director Dr Fionna Moore MBE was appointed in December 1997 and was made an executive director in September 2000. She chairs our clinical, quality safety and effectiveness committee, and clinical audit and research group. Fionna has more than 21 years' experience as a consultant in emergency medicine, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She is a BASICS doctor and holds a fellowship in immediate medical care from the Faculty of Pre-Hospital Care of the Royal College of Surgeons Edinburgh. In 2009, Dr Moore was appointed Trauma Director for London.
Director of Operations Jason Killens has 16 years' experience working in both clinical and senior management posts. His current responsibilities include the strategic planning

and command of major public events, and he was the Service's Strategic Commander for the Queen's Diamond Jubilee celebrations and the 2012 Olympic and Paralympic Games.

The Trust Board is supported by other non-voting directors and one senior manager who attend the Board meetings.

Director of Corporate Affairs Sandra Adams took up her post in July 2009. Sandra joined us from Moorfields Eye Hospital NHS Foundation Trust, where she held the post of Director of Corporate Governance and had project managed the application to become one of the first NHS foundation trusts in the country. Sandra had previously worked in commissioning of acute services, and in a number of community and hospital posts, including managing acute service reconfiguration in south west London.

Director of Transformation and Strategy Karen Broughton joined the Service in December 2013 after working as Chief Operating Officer at the North West London Commissioning Support Unit. She has 28 years of experience in the health service and has held a variety of operational and strategic positions at acute hospitals, community health organisations and primary care trusts. Karen leads on the development and implementation of the Service's strategy for 2020 and on the negotiations with our commissioners.

Director of Business Development Mike Evans has 20 years of business development experience and a track record of delivering top line growth and commercial improvements for world leading healthcare and medical device businesses, including AXA Assistance and BUPA. He has significant commercial strategy and international sales and marketing expertise, and he has worked at board level for the past ten years.

Director of Strategic Communications Charlotte Gawne joined the Service in January 2014. She has led communications teams at NHS England, London hospitals and NHS Direct and directed several public consultations for service reconfigurations using innovative patient-engagement techniques. She recently led on setting up the new communications processes for emergency planning for NHS England in London and south England. Charlotte has considerable experience of working with political stakeholders, patient groups, national media, GP commissioners and local communities.

Director of Support Services David Prince joined the Service in January 2014. A business leader with 26 years' experience at executive level across most business functions but specialising in HR. For most of his career, he worked in the Royal Mail holding a number of senior positions. He has also worked for the National Autistic Society and a large care company. David is passionate about cultural change, business performance improvement and service transformation.

Director of Performance Paul Woodrow joined the Service in 1991. His career has included time spent working as a paramedic – including a secondment on London's Air Ambulance – and clinical team leader. He has since held a number of managerial positions with responsibility for the operational delivery and performance. Before taking up his current post, Paul completed secondments with NHS London and Great Western Ambulance Service.

Director of Paramedic Education and Development Mark Whitbread took up his post in January 2014 and is responsible for the clinical training, education and development of

frontline staff. He was the Service's first Paramedic Consultant leading on the cardiac and major trauma strategy for London.

Director of Modernisation Jane Chalmers joined the Service in January 2013. Her first career was in the Royal Air Force, where she trained as an air traffic controller and then completed a number of senior appointments. These included roles in national and multi-national strategic communication, strategic planning and commanding the training school which trained all the air traffic controllers and operations officers for the RAF and the Royal Navy. Since leaving the RAF, Jane has worked in the public sector and took up her first role in the NHS in 2009. She has been a programme manager for a reconfiguration programme and for the re-organisation programme which planned and delivered the transition of five primary care trusts into one cluster. Latterly she was the Director of the Chief Executive's office in NHS South West London.

Meetings

The Board meets in public eight times a year. Details of the meetings are published on our website at www.londonambulance.nhs.uk

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

Directors' interests

A register is held of directors' interests. This is available on request from the Director of Corporate Affairs.

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 and Strategy which defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and subsequent management of the identified risks and the responsibilities of individuals and it describes the Trust Board's corporate responsibility for the system of internal control and robust risk management.

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 and with the portfolio team at the NHS Trust Development Authority 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 2013/2014 this has included service developments in the provision of 111 services to South East London from November 2013 and the implementation of a range of initiatives to enhance capacity and ensure safe care is provided during the Winter months. We have continued to increase the number of calls we handle and resolve through hear and treat and, during the year, we introduced the Clinical Hub which is operated by senior paramedics and provides enhanced clinical assessments to support hear and treat dispositions for appropriate patients. The Clinical Hub also provides clinical support and expertise for operational ambulance crews and non-clinical staff within the control rooms. We have worked with emergency departments and commissioners to improve the handover of patients from our service into an acute healthcare setting with a particular emphasis on improving handover and turnaround times. We started the programme of modernisation during 2013/14 and this remains on track to be fully implemented in 2014/15. This programme includes: the review and development of new roster patterns across frontline operations to match the current activity profiles, bringing a local focus to the future arrangements; implementation of the Clinical Hub and a structured clinical career progression; changes to annual leave, active area cover and rest break arrangements for front line operational staff; a review of the skill mix on front line ambulances and proposals to move towards a single tier of emergency ambulances that are able to respond to the full range of emergency calls thereby increasing the capacity of the Service to meet demand.

We actively engage with a wide range of stakeholders across London. We have undertaken approximately 1086 patient and public involvement events including local

community and foundation trust membership events, all of which have been well received, based on feedback from those attending.

The governance framework of the organisation

Information on the Trust Board committee structure and the attendance records of members is attached (annexes 1 to 7).

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 governance structure was fully reviewed in the first half of the year with the new arrangements implemented from 1st October 2013. This included transferring the oversight for risk management from the Quality Committee to the Audit Committee. A further review of the function and remit of the Quality Committee was undertaken in March 2014 following the appointment of a new non-executive director chair. The committee will take on more of a clinical focus in 2014/15 with membership revised to include the three clinical director leads – Medical, Nursing and Quality and the newly-appointed Director of Paramedic Education and Development – and these new arrangements will commence from April 2014.

The Trust Board reviews its effectiveness annually along with that of the reporting committees and the quality, safety and risk-related committees: Risk Compliance and Assurance, Clinical Quality Safety & Effectiveness, and Learning from Experience. The Risk Compliance and Assurance Group was disestablished in 2013/14 following the review of the governance structure. Risks are now reviewed by the Senior Management Team before being added to the corporate risk register for review and oversight by the Audit Committee. With these changes implemented and the later review of the Quality Committee, the Trust Board can take assurance from the governance structure that was in place by 31st March 2014. The Trust Chair and Director of Corporate Affairs/Trust Secretary undertake a post-board review each month to ensure the agenda has been covered, sufficient time 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. The board agenda is informed by the forward planner which is reviewed and updated after each meeting.

The annual board effectiveness review has regard to the principles set out in the Corporate Governance Code and other recommended good practice on board governance, such as Monitor's Code of Governance, and The Healthy NHS Board 2013. The Trust Board reviewed its effectiveness in July 2013, based on the Code and there were no areas of non-compliance to report. The review identified an overall rating of 'good' and areas where further development was required, for example; board structure and processes, board composition and diversity, time commitment of non-executive directors, and relationships with external stakeholders. These were reflected in the independent board governance assurance framework review which had been undertaken in March 2013 and reported in April 2013 and for which actions were already underway. The review was undertaken by an independent party and positive assurance was given; the outcome of the review reflected the changes being undertaken with board appointments, formal succession planning, the need for the board to continue to focus on developing the Trust strategy, and better use of board committees. A board development programme is in place which is coordinated by the Director of Corporate Affairs and comprises

training and development across strategy, governance and statutory duties. The board holds 4 strategy sessions each year, and two of these are awaydays.

The Trust Board receives quality, financial and performance information that provides assurance on the discharge of statutory responsibilities. The NHS Trust Development Authority implemented a system of monthly submissions of self-certification of compliance with a set of board statements and Monitor's compliance framework. A number of areas were identified as requiring further work to achieve full compliance including: fit and proper persons test; CQC registration compliance; and competition oversight. These have all been addressed during the year and full compliance statements are now submitted.

Attendance by board members at Trust Board meetings is recorded in the minutes and included in the annual effectiveness review. Attendance at key board committees is also monitored and recorded by the Committee Secretary.

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 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. During 2013/14 the committee took on responsibility for the review of the corporate risk register as well as oversight of the systems and processes in place to manage risk. From October 2013 the committee undertakes a review of the effectiveness of the corporate risk register at each meeting. The committee meets 5 times during the year with one meeting held without the internal or external auditors present.

At the Trust Board meeting on 3rd June 2014 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 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 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 action taken to address coroners' recommendations on preventing future deaths.

The Chair of the Quality 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 reports from its reporting committees: Clinical Quality Safety and Effectiveness and Learning from Experience. This included the Risk Compliance and Assurance group until September 2013 prior to that group being disestablished. 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 on 25th March 2014 the Quality Committee chair provided assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee meets six 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. At the Trust Board meeting the chair of the committee reports on the cash position, cash management, liquidity, CIP progress, and capital expenditure. The committee meets six times during the year although this increased in frequency during 2013/14 to meet the volume of work required.

The Trust Board works within the remit of the Standing Orders and Standing Financial Instructions and Scheme of Delegation. Each of these is currently under review as part of an annual review. The Trust has prepared its constitution, governance rationale and standing orders in readiness for foundation trust status and will update these prior to application. The constitution has been updated in draft form in 2013/14 to reflect Monitor's Model Core Constitution and therefore the requirements of the Health and Social Care Act 2012. The governance rationale meets the requirements of Monitor's Code of Governance and will be updated in 2014/15 in readiness for the application process.

The Trust was subject to a number of external independent reviews during 2013/14. KPMG undertook the Board Governance Assurance Framework review.

The Trust received unconditional registration from the Care Quality Commission (CQC) in March 2010 to provide the following regulated activities:

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

The CQC undertook an unannounced compliance inspection in August 2013 and the Trust achieved full compliance against the standards assessed.

The Trust can confirm that all premises which we own, occupy or manage had fire risk assessments that complied with the Regulatory Reform (Fire Safety) Order 2005. We also achieved compliance with the Department of Health Fire Safety Policy.

Risk assessment

The organisation's major risks relate to safety, performance, finance and workforce as described in the Board Assurance Framework. Two clinical risks were included in the Board Assurance Framework in 2013/14 relating to maternity and non-conveyance.

The Risk Management Policy and Strategy defines the risk management process which specifies the way risk (or change in risk) is identified, assessed and managed through controls. We were reassessed at level one of the NHSLA risk management

standards for ambulance trusts with full compliance reported.
The Risk Management Policy and Strategy describes the process for embedding risk management throughout the Trust and during 2013/14 we have made further progress with managing local risk register processes. The corporate risk register is reviewed by the Audit and Quality Committees and by the Trust Board as it contains the highest level of risks facing the organisation. Risks can be escalated to the Senior Management Team for discussion and addition to the corporate risk register if required. We have also aligned project management risks with the corporate risk register. The policy and strategy were updated and re-formatted in 2012/13 in line with NHSLA requirements and are currently under review. KPMG undertook a review of risk management in August 2013 and stated that improvement was required. The key areas for improvement related to: top down risk identification; implementation of board assurance framework processes and changes to the structure and reporting; and risk training for the board. The board took assurance at the meeting on 25th March 2014 from the revised board assurance framework that progress was being made to address the recommendations of the review in order to strengthen risk management processes. Members of the Audit Committee have received risk training as have the executive directors and senior management team. Top down risks are identified through the risk register, board assurance framework and programme work.

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. 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 Senior Management Team 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.

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 by the Executive Management Team, Audit Committee and the Trust Board on a quarterly basis. Twenty three risks were added in 2013/14 and 15 were archived having reached their target level or being closed as they were no longer relevant. A list of the new risks is attached as an annex to this statement (annex 8).

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

There were 13 lapses of data security in 2013/14 but none reached the threshold for reporting to the Information Commissioner.

The Trust achieved 81% against the Information Governance toolkit and is at level 2 overall. The slight dip from last year's 82% is due to the fact that the Trust no longer meets Level 3 for two of the Information Security requirements. Not all of the work required to maintain Level 3 had been completed, due to the fact that the Information Security manager post was vacant from October 2013 to March 2014. An appointment has now been made and progress will be made with relevant areas of the toolkit in 2014/15.

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 was reviewed and simplified. This now shows the key risks facing the Trust during the quarter, mapped to the strategic objectives and annual priorities. Not all of these risks will be the highest scoring risks on the corporate register as some may have a lower risk score but be particularly key at that point in time. 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 complied with.

The Senior Management Team manages the corporate risk register whilst the Audit Committee assesses the effectiveness of the corporate risk register at each meeting. The Trust Board, Quality Committee and Executive Management Team receive an integrated performance report and a quality dashboard showing monthly performance and any identified risks, from which improvements and mitigations will be sought.

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 local counter fraud specialist (LCFS) attends four meetings of the Audit Committee per year and monthly executive counter fraud meetings. KPMG have provided the local counter fraud service since April 2013.

The Internal Auditors attend four meetings of the Audit Committee per year and work closely with the Governance and Compliance team to execute the annual audit workplan. Internal audit also attend meetings of the Quality Committee and the committee has input to the development of the annual audit workplan. This work is also informed by the executive team.
KPMG have provided the internal audit service to the Trust since April 2013.

Pricewaterhouse Coopers are the external audit provider.

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 Quality Account and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant Issues

The Trust declared 36 Serious Incidents to commissioners in 2013/14. The top two themes relate to delays in response times for C2 patients and to mental

health/overdose patients. The Trust recognised the potential risks to patient care arising from the increasing gap between demand and the available resources and, together with its lead commissioners, commissioned ORH to undertake a capacity review. This informed the contract for 2013/14 with the first year of a two-year modernisation programme that would support the Trust in its modernisation plans thereby improving and increasing the Trust's ability and resources to respond to demand on its services. The Trust also received additional funding in December 2013 to support increased resourcing to meet the winter demands. The pressures of demand continue and are subject to ongoing discussions with commissioners

Three Internal Audit reviews received limited assurance with the following key issues raised:

a) Serious incidents were not being investigated and reported within the timescales required within the National Framework.
b) Cyber security required action against a number of high priority recommendations in order to improve the Trust's controls to prevent and detect cyber attacks.
c) Contract management testing identified a number of areas of high spend where no contractual arrangements were in place and also indicated that procurement processes were not consistently followed.

The outcome of these reviews identified six high priority recommendations resulting in a limited assurance opinion and action plans are being implemented to address these.

During Christmas Day and then separately during Boxing Day the Service experienced service interruptions to its control room call handling systems. The problems and the causes were separate and not related and were relatively quickly resolved. A full review was undertaken and immediate mitigating action taken. The full review has resulted in a number of recommendations which are now being pursued or are already implemented.

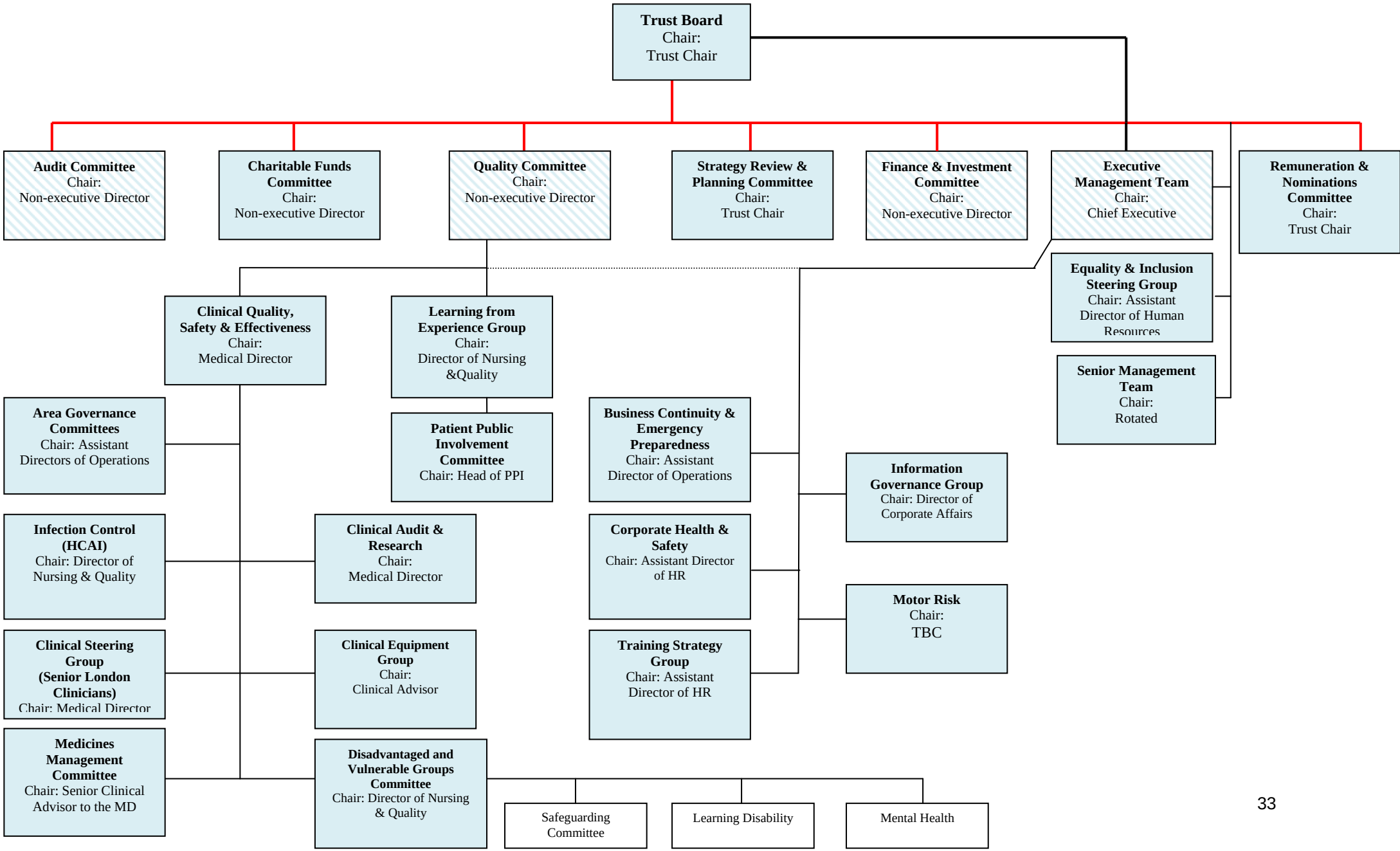
The Head of Internal Audit's opinion is as follows:
Based on the work undertaken in 2013/14, significant assurance can be given for core financial systems, however limited assurance can be given that there is a generally sound system of internal control on key financial and management processes.

Accountable Officer : Ann Radmore, Chief Executive

Organisation: London Ambulance Service NHS Trust (RRU)

Date: 3 June 2014

Annex 1 Governance Structure – February 2014



Annex 2 Committee membership

Formal Trust Board committee	Chair	Current members
Audit committee	Non-executive director, Caroline Silver until 28 February 2014 Non-executive director, John Jones from 1 March 2014	Roy Griffins (non-executive director) John Jones (non-executive director) Theo De Pencier (non-executive director) – member from 1 March 2014 Fergus Cass (non-executive director) – member from 1 March 2014
Charitable funds committee	Non-executive director, Caroline Silver	
Quality committee	Non-executive director, Roy Griffins until 10 December 2013 Non-executive director, Bob McFarland from 11 December 2013	Ann Radmore(Chief Executive) Jessica Cecil (non-executive director) Nick Martin (non-executive director) Fergus Cass (non-executive director) from 1st March 2014 Fionna Moore (Medical Director) Steve Lennox (Director of Nursing and Quality)
Finance & investment committee	Non-executive director, Nick Martin	John Jones (non-executive director) Jessica Cecil (non-executive director) Theo De Pencier (non-executive director) from 1st March 2014 Andrew Grimshaw (Director of Finance and Performance) Sandra Adams (Director of Corporate Affairs) Steve Lennox (Director of Nursing and Quality) David Prince (Director of Support Services) Karen Broughton (Director of Transformation and Strategy)
Strategy review and planning committee	Trust Chair, Richard Hunt CBE	All board directors, voting and non-voting.
Remuneration and Nomination committee	Trust Chair, Richard Hunt CBE	All non-executive members of the Trust Board

Annex 3 – Attendance at Trust Board meetings

	4 June 2013	25 June 2013	23 July 2013	24 September 2013	26 November 2013	20 December 2013	28 January 2014	25 March 2014	Comments
Trust Board members (voting)									
Richard Hunt (Non-Executive Chair)	✓	x	✓	✓	✓	✓	✓	✓	
Fergus Cass (Non-Executive Director)							✓	✓	Joined on 01/03/2014
Jessica Cecil (Non-Executive Director)	✓	✓	x	✓	✓	✓	✓	✓	
Theo de Pencier (Non-Executive Director)								✓	Joined on 01/03/2014
Roy Griffins (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	Term ended on 28/02/2014
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	✓	✓	✓	✓	✓	
Caron Hitchen (Director of Workforce)	x	x	x						Left on 18/09/2013
John Jones (Non-Executive Director)	x	✓	✓	✓	✓	✓	✓	✓	
Steve Lennox (Director of Nursing and Quality)	✓	✓	✓	✓	✓	x	✓	✓	
Jason Killens (Director of Operations)	✓	✓	✓	x	✓	✓	✓	✓	Became voting member on 01/10/2013
Nick Martin (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Bob McFarland (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	Associate NED until 01/12/2013
Fionna Moore (Medical Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Ann Radmore (Chief Executive)	✓	✓	✓	x	✓	✓	✓	✓	
Caroline Silver (Non-Executive Director)	✓	✓	✓	x	x	✓	✓	✓	Term ended on 28/02/2014
Non-voting									
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	x	✓	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓							On secondment from June 2013
Karen Broughton (Director of Transformation and Strategy)						✓	✓	✓	Joined on 16/12/2013
Jane Chalmers (Director of Modernisation)	✓	✓	✓	✓	✓	✓	✓	✓	
Tony Crabtree (Assistant Director of HR)	✓	✓	✓	✓	✓	✓			
Angie Patton (Head of Communications)	✓	✓	✓	✓	✓	✓			
David Prince (Director of Support Services)							✓	✓	Joined on 02/01/2014
Peter Suter (Director of Information Management and Technology)	✓								Left on 07/06/2013
Mark Whitbread (Director of Paramedic Education and Development)							✓	✓	Joined on 02/01/2014
Paul Woodrow (Director of Performance)	✓	✓	✓	✓	✓	x	✓	x	
Vic Wynn (Acting Director of Information Management and Technology)	✓	✓	✓	✓	✓	✓			

Annex 4 – Attendance at Quality Committee meetings

	17 June 2013	21 August 2013	23 October 2013	11 December 2013	26 February 2014	Comments
Quality Committee members						
Roy Griffins (Non-Executive Chair)	✓	✓	✓	✓	✓	Term ended on 28/02/2014
Jessica Cecil (Non-Executive Director)	x	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)	✓	✓	x	✓	✓	
Bob McFarland (Non-Executive Director)	x	✓	✓	✓	✓	Associate Non-Executive Director until 01/12/2013 Chair of the Committee from 11/12/2013
Ann Radmore (Chief Executive)	x	x	x	x	x	
Steve Lennox (Director of Nursing and Quality)	✓	✓	✓	✓	✓	Full member from 23/10/2013
Fionna Moore (Medical Director)	✓	✓	✓	✓	x	Full member from 23/10/2013
Attending						
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	✓	✓	✓	✓	
Tony Crabtree (Assistant Director of Human Resources)	✓	x	x	x		Acting Director of Workforce until December 2013
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	x	x	x	
Caron Hitchen (Director of Workforce)	x					Left on 18/09/2013
Jason Killens (Director of Operations)	x	x	x	x	x	
David Prince (Director of Support Services)					✓	Joined on 02/01/2014
Paul Woodrow (Director of Performance)	✓	x	✓	✓	✓	

Annex 5 – Attendance at Audit Committee meetings

	15 April 2013	18 April 2013	13 May 2013	3 June 2013	2 September 2013	11 November 2013	3 February 2014	Comments
Audit Committee members								
Caroline Silver (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	Term ended on 28/02/2014
Roy Griffins (Non- Executive Director)	✓	✓	✓	✓	✓	✓	✓	Term ended on 28/02/2014
John Jones (Non-Executive Director)	✓	✓	✓	x	✓	✓	✓	
Attending								
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	✓	X	✓	✓	✓	
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	✓	✓	✓	✓	
Ann Radmore (Chief Executive)	✓	✓	✓	x	x	x	✓	

Annex 6 – Attendance at Strategy Review and Planning Committee meetings

	30 April 2013	10 September 2013	25 February 2014	Comments
Trust Board members (voting)				
Richard Hunt (Non-Executive Chair)	✓	✓	✓	
Fergus Cass (Non-Executive Director)			✓	Joined on 01/03/2014
Jessica Cecil (Non-Executive Director)	✓	✓	✓	
Theo de Pencier (Non-Executive Director)			✓	Joined on 01/03/2014
Roy Griffins (Non-Executive Director)	x	x	x	Term ended on 28/02/2014
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	
Caron Hitchen (Director of Workforce)	x			Left on 18/09/2013
John Jones (Non-Executive Director)	✓	✓	x	
Steve Lennox (Director Nursing and Quality)	✓	✓	✓	
Jason Killens (Director of Operations)	✓	✓	✓	Became voting member on 01/10/2013
Nick Martin (Non-Executive Director)	✓	x	✓	
Bob McFarland (Non-Executive Director)	X	x	✓	Associate NED until 01/12/2013
Fionna Moore (Medical Director)	✓	✓	x	
Ann Radmore (Chief Executive)	✓	x	✓	
Caroline Silver (Non-Executive Director)	✓	x	✓	Term ended on 28/02/2014
Non-voting				
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓			On secondment from June 2013
Karen Broughton (Director of Transformation and Strategy)			✓	Joined on 16/12/2013
Jane Chalmers (Director of Modernisation)	✓	✓	✓	
Tony Crabtree (Assistant Director of Human Resources)	✓	✓		
Mike Evans (Director of Business Development)			✓	Joined on 11/11/2013
Charlotte Gawne (Director of Strategic Communications)			✓	Joined on 02/01/2014
Angie Patton (Head of Communications)	✓	✓		
David Prince (Director of Support Services)			✓	Joined on 02/01/2014
Peter Suter (Director of Information Management and Technology)	✓			Left on 07/06/2013
Mark Whitbread (Director of Paramedic Education and Development)			✓	Joined on 02/01/2014
Paul Woodrow (Director of Performance)	✓	✓	✓	
Vic Wynn (Acting Director of Information Management and Technology)	✓	✓		

Annex 7 – Attendance at Finance and Investment Committee meetings

	14 May 2013	20 June 2013	19 July 2013	18 September 2013	18 October 2013	22 November 2013	24 January 2014	20 March 2014	Comments
Finance and Investment Committee members									
Nick Martin (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Jessica Cecil (Non-Executive Director)	x	x	✓	x	✓	✓	x	✓	
John Jones (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Theo de Pencier (Non-Executive Director)								✓	Joined on 01/03/2013
Attending									
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	x	x	✓	✓	✓	✓	
Karen Broughton (Director of Transformation and Strategy)							✓	✓	Joined on 16/12/2013
Tony Crabtree (Assistant Director of Human Resources)	x	x	x	x	✓	✓			
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	✓	✓	✓	✓	✓	
Steve Lennox (Director of Nursing and Quality)	x	x	x	x	✓	x	✓	x	
Vic Wynn (Acting Director of Information Management and Technology	✓	✓	✓	✓	✓	✓			

Annex 8

New Risks Added to the Trust Risk Register in the Period 2013 – 2014

Risk ID	Headline Risk
371	Maintaining Level 2 for IG Toolkit requirement.
372	Failure to write to addresses and inform individuals of their inclusion on the location alert register, resulting in incorrect address being included putting patients at risk.
373	Crews not carrying out a comprehensive dynamic risk assessment when attending high risk addresses resulting in delays in treating the patient.
375	Single members of staff with responsibility for supporting and developing MDTs may become unavailable resulting in loss of detailed technical knowledge and potential failure of services.
376	The Trust Board fails to fulfil all its statutory duties.
379	Category C call could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources.
381	The service does not comply with DH guidance on the re-use of linen for patients affecting quality of cared delivered and reputation risk to the organisation.
382	(MPS) being incorrectly triaged affecting the ability of the LAS to effectively prioritise resources.
383	The processes and enabling technology for operating on paper across two sites are not sufficiently resilient resulting in a delayed LAS response.
384	Unsecured LAS equipment taken onto a third party ambulance may cause injury following an RTC.
385	Total level of financial loss due to theft and criminal damage to the organisation is not accurately reported.
386	Tail lift failures on operational ambulances will impact on patient care.
387	Call handling system being unsupported by Priority Dispatch Systems
388	Increase in turnover rates leading to staff reducing by significant numbers.
389	Unexpected cost liabilities arising from operating 111 Services from Beckenham.
390	Demand for patients in South East London for 111 services exceed capacity at Beckenham.
391	Patients placed on the Co-ordinate my Care (CMC) Database may not have their addresses flagged in a timely manner.
392	Expenditure will not be maintained within budget - adverse impact on income and expenditure position and credibility with the NTDA and DH plus FT application.
393	Cash not being properly managed impacting on credibility with NTDA and the DH and impact on FT application.
394	CIPS may not be identified or delivered – impacting our credibility with the NTDA and DH plus impact on FT application.
395	Effective financial control environment is not maintained leading to fraud and errors in financial reporting - impacting our credibility with the NTDA and DH plus impact on FT application.
396	No disciplines exist for planning ahead could impact on our credibility with the NTDA and DH plus impact on FT application.
397	Capital expenditure is not properly planned or delivered leading to loss of control over capital projects. Could impact on our credibility with the NTDA and DH plus impact on FT application.

2013/14 Financial Summary Statements

Financial review

The seven year break-even performance is set out below. The figures 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.

Break-even performance	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Retained surplus/(deficit) for the year	398	725	-420	740	2,527	-417	1,525
Adjustments for impairments	0	0	1,845	262	247	723	-1,235
Adjustments for impact of policy change re donated grants asset	0	0	0	0	-23	-44	11
Absorption Adjustment	0	0	0	0	0	0	-39
Break-even in-year position	398	725	1,425	1,002	2,751	262	262
Break-even cumulative position	1,844	2,569	3,994	4,996	7,747	8,009	8,271
Break-even cumulative position as a percentage of turnover	0.78	0.98	1.43	1.76	2.75	2.64	2.72

The surplus in 2013/14 led to an improvement on the cumulative position for the thirteenth year running, and remained well within the limit of 0.5% of turnover permitted by the Department of Health.

On income and expenditure we reported a surplus of £262,000 for the year, and therefore performed better than the break-even target set by the Department of Health for 2013/14.

The trust had an under shoot on its external financial limit (EFL) of £0.8m for the year. The trust is permitted to under shoot its EFL.

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

In the capital programme £6.9million was spent on a range of projects, including ambulances, new technology projects and projects to improve the estate. Overall, we under spent by £3.3m against our capital resource limit, which we are permitted to do. The capital programme was funded using earned income.

We were able to pay 86% and 69% of our non-NHS and NHS trade invoices respectively within 30 days, which was an improvement on 2012/13 but below the 95% target set by the Department of Health.

Balance sheet

The largest item on the balance sheet is £134 million of fixed assets (£133 million in 2012/13) comprising land, buildings, plant and machinery, information technology, fixtures and

intangibles. We fund the investment in capital assets through our capital programme. In 2013/14 we invested £6.9 million (£9.7 million in 2012/13). The most significant additions related to the replacement of ambulances, projects to improve the estate and new technology.

We have net working capital of £3.9 million (deficit £3.3 million in 2012/13) and long-term creditors and provisions of £12.3 million (£13.7 million in 2012/13). We had £6.4 million cash in the bank as at 31 March 2014 (£5.5 million in 2012/13).

We obtained and fully drew down a £10 million loan from the Department of Health to fund capital expenditures in 2009/10. The loan is spread over eight years with an average fixed interest rate of 2.65 per cent. The interest paid in 2013/14 was £140,000 per annum.

In 2010/11, we obtained a loan of £107,275 from Salix Finance Ltd to support our capital investment in technical measures to improve energy efficiency. The loan was drawn down in August and December 2010 for £60,000 and £47,275 respectively. It is an interest free, unsecured loan with two to five year repayment terms.

Our assets are ultimately owned by the public and the taxpayers' equity section of the balance sheet shows the component elements. Public dividend capital is £62.5 million (£62.5 million in 2012/13) of the equity – this represents the Department of Health's investment in us and annual dividends are payable on this sum. A further £40.7 million (£33.4 million in 2012/13) is held in a revaluation reserve representing the accumulated increase in value of our estate.

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

Financial plan 2014/15

We have formally submitted a plan for 2014/15 that takes into account planned contracted income levels and the expenditure budgets that have been set for the new financial year. The plan is set to deliver a surplus of £3.0 million.

Detailed financial planning work is in progress in preparation for our Foundation Trust application.

Financial risk

We monitor 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.

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2014 for all land and buildings. The net gain and loss on revaluation was £9.6 million and the total impairments were £1.2 million.

IAS 19 requires us to accrue for remuneration earned but not yet taken. In this instance, we have made an accrual for annual leave of £3.7 million for the current financial year (£3.6 million in 2012/13).

Subsequent events after the balance sheet date

There was no important event occurring after the financial year end that has a material effect on the 2013/14 financial statements.

Other information

PricewaterhouseCoopers LLP was our external auditor for the year ended 31 March 2014. We paid £95,000 (£91,000 in 2012/2013) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our Audit Committee. PricewaterhouseCoopers LLP have not undertaken any non-audit work during the year ended 31 March 2014.

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.

We conform 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 2013-14 NHS Manual for Accounts issued by the Department of Health.

The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

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.

Ann Radmore
Chief Executive
3 June 2014

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

Ann Radmore
Chief Executive
3 June 2014

Andrew Grimshaw
Financial Director
3 June 2014

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2014

	2013-14 £000	2012-13 £000
Gross employee benefits	**(208,717)**	**(211,242)**
Other costs	**(90,005)**	**(87,779)**
Revenue from patient care activities	**302,273**	**301,285**
Other operating revenue	**1,554**	**1,824**
Operating surplus	**5,105**	**4,088**
Investment revenue	**112**	**77**
Other losses	**41**	**(233)**
Finance costs	**(381)**	**(498)**
Surplus for the financial year	**4,877**	**3,434**
Public dividend capital dividends payable	**(3,391)**	**(3,851)**
Transfers by absorption - gains	**39**	**0**
Net Gain/(Loss) on Transfers by absorption	**39**	**0**
Retained (deficit)/surplus for the year	**1,525**	**(417)**

Other comprehensive income	2013-14 £000	2012-13 £000
Impairments and reversals	**(1,247)**	**(861)**
Net gain on revaluation of property, plant and equipment	**9,614**	**1,741**
Total comprehensive income for the year*	**9,892**	**463**

*This sums the rows above and the surplus for the year before adjustments for PDC dividend and absorption accounting

Financial performance for the year		
Retained surplus/(deficit) for the year	**1,525**	**(417)**
Impairments	**(1,235)**	**723**
Adjustments to donated asset	**(11)**	**(44)**
Adjustment re Absorption accounting	**(39)**	**0**
Adjusted retained surplus)	**262**	**262**

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

a) Impairments to fixed assets: 2009/10 was the final year for organisations to revalue their assets to a modern equivalent asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.
b) The 2011/12 Treasury FReM changed the treatment of donated assets. Donated assets are now shown as income and are not considered part of the organisation's operating position.

Note that prior year performance is not re-assessed following accounting restatements

PDC dividend: balance receivable at 31 March 2014	**9**
PDC dividend: balance payable at 31 March 2013	**(6)**

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2014

	31 March 2014	31 March 2013
	£000s	£000s
Non-current assets:		
Property, plant and equipment	**121,627**	119,021
Intangible assets	**12,296**	13,628
Total non-current assets	**133,923**	132,649
Current assets:		
Inventories	**3,498**	3,264
Trade and other receivables	**22,804**	16,075
Cash and cash equivalents	**6,436**	5,500
Total current assets	**32,738**	24,839
Total assets	**166,661**	157,488
Current liabilities		
Trade and other payables	**(22,840)**	(24,546)
Provisions	**(4,750)**	(2,098)
Borrowings	**0**	(309)
Capital loan from Department	**(1,244)**	(1,244)
Total current liabilities	**(28,834)**	(28,197)
Net current assets/(liabilities)	**3,904**	(3,358)
Non-current assets plus/less net current assets/liabilities	**137,827**	129,291
Non-current liabilities		
Provisions	**(9,114)**	(8,731)
Borrowings	**(107)**	(641)
Capital loan from Department	**(3,099)**	(4,343)
Total non-current liabilities	**(12,320)**	(13,715)
Total Assets Employed:	**125,507**	115,576
FINANCED BY:		
TAXPAYERS' EQUITY		
Public Dividend Capital	**62,516**	62,516
Retained earnings	**22,675**	20,053
Revaluation reserve	**40,735**	33,426
Other reserves	**(419)**	(419)
Total Taxpayers' Equity:	**125,507**	115,576

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**62,516**	**20,053**	**33,426**	**(419)**	**115,576**
Changes in taxpayers' equity for 2013-14					
Retained surplus for the year		1,525			**1,525**
Net gain on revaluation of property, plant, equipment			9,614		**9,614**
Impairments and reversals			(1,247)		**(1,247)**
Transfers between reserves		1,058	(1,058)	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs		39			**39**
Net recognised revenue for the year	**0**	**2,622**	**7,309**	**0**	**9,931**
Balance at 31 March 2014	**62,516**	**22,675**	**40,735**	**(419)**	**125,507**
Balance at 1 April 2012	**62,516**	**19,304**	**33,712**	**(419)**	**115,113**
Changes in taxpayers' equity for the year ended 31 March 2013					
Deficit for the year		(417)			(417)
Net gain on revaluation of property, plant, equipment			1,741		1,741
Impairments and reversals			(861)		(861)
Transfers between reserves		1,166	(1,166)	0	0
Reclassification Adjustments					
Net recognised revenue/(expense) for the year	**0**	**749**	**(286)**	**0**	**463**
Balance at 31 March 2013	**62,516**	**20,053**	**33,426**	**(419)**	**115,576**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2014

	2013-14 £000s	2012-13 £000s
Cash Flows from Operating Activities		
Operating Surplus	**5,105**	4,088
Depreciation and Amortisation	**15,202**	12,956
Impairments and Reversals	**(1,235)**	723
Interest Paid	**(168)**	(300)
Dividend Paid	**(3,406)**	(3,897)
Increase in Inventories	**(234)**	(452)
Increase in Trade and Other Receivables	**(6,733)**	(6,163)
(Decrease)/Increase in Trade and Other Payables	**(609)**	5,908
Provisions Utilised	**(924)**	(1,160)
Increase in Provisions	**3,264**	2,305
Net Cash Inflow from Operating Activities	**10,262**	14,008
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**82**	77
Payments for Property, Plant and Equipment	**(6,277)**	(11,468)
Payments for Intangible Assets	**(1,112)**	(655)
Proceeds of disposal of assets held for sale (PPE)	**41**	36
Net Cash Outflow from Investing Activities	**(7,266)**	(12,010)
NET CASH INFLOW BEFORE FINANCING	**2,996**	1,998
CASH FLOWS FROM FINANCING ACTIVITIES		
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(1,244)**	(1,244)
Capital Element of Payments in Respect of Finance Leases	**(816)**	(504)
Net Cash Outflow from Financing Activities	**(2,060)**	(1,748)
NET INCREASE IN CASH AND CASH EQUIVALENTS	**936**	250
Cash and Cash Equivalents at beginning of the period	**5,500**	5,250
Cash and Cash Equivalents at year end	**6,436**	5,500

Remuneration report

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

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

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

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

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

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 51 to 52.

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2012/13 was in the range of £216,001 to £220,000. This was 5.63 times the median remuneration of the workforce, which was £38,415. In 2012/13, the banded remuneration of the highest paid director £180,001 to £185,000. This was 4.73 times the median remuneration of the workforce, which was £38,604.

In 2013/14, 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:

- a change to the remuneration of the most highly-paid individual through an increase se in pay received in 2013/14
- a change in the workforce composition in 2013/14 leading to a small decrease in median pay.

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 2013/14

Name and Title	Salary (bands of £5000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5000) £'000	Long term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5000) £'000
Richard Hunt, Chairman	£20,001-£25,000	£0	£0	£0	£0	£20,001-£25,000
* Caroline Silver, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
* Beryl MaGrath, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
* Roy Griffins, 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	£0-£5,000	£0	£0	£0	£0	£0-£5,000
** Theo de Pencier, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Ann Radmore, Chief Executive	£190,001-£195,000	£0	£0	£0	£167,501-£170,000	£355,001-£360,000
*****Andrew Grimshaw, Finance Director	£135,001-£140,000	£0	£0	£0	£55,001-£57,500	£195,001-£200,000
**Jason Killens, Director of Operations	£55,001-£60,000	£3,700	£0	£0	£42,501-£45,000	£105,001-£110,000
**** Caron Hitchen, Director of Human Resources	£75,001-£80,000	£0	£0	£0	£0	£75,001-£80,000
Stephen Lennox, Director of Health Promotion & Quality	£90,001-£95,000	£0	£0	£0	£0	£90,001-£95,000
*** Fionna Moore, Medical Director	£80,001-£85,000	£0	£0	£0	£0	£80,001-£85,000

The figures shown under the heading 'expense payments' refer to the provision of lease car.
* The following directors left the Trust: Beryl MaGrath on 30 April 2013, Caron Hitchen on 18 September 2013, Roy Griffins on 31 March 2014 and Caroline Silver on 31 March 2014.
** The following directors joined the Trust: Robert McFarland on 1 May 2013, Fergus Cass on 1 March 2014 and Theo de Pencier on 1 March 2014. Jason Killens was appointed Director of Operations on 1 October 2013.
*** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.
****The Trust made an additional compensation payment to Caron Hitchen in the banding of £155,001 to £160,000 for loss of office in 2013/14
*****Andrew Grimshaw was Interim Director of Finance between 1 April 2013 and 9 June 2013. During that period he was paid by a firm of recruitment consultants. He was appointed Director of Finance on 10 June 2013. The disclosures above include all payments made to him by the recruitment consultants for his services as a Director and all amounts paid to him by the Trust since appointment.

Remuneration 2012/13

Name and Title	Salary (bands of £5000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5000) £'000	Long term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5000) £'000
Richard Hunt, Chairman	£20,001-£25,000	£0	£0	£0	£0	£20,001-£25,000
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Brian Huckett, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Beryl MaGrath, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Roy Griffins, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Murziline Parchment, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Nicholas Martin, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
John Jones, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Ann Radmore, Chief Executive	£40,001-£45,000	£0	£0	£0	£32,501-£35,000	£75,001-£80,000
Andrew Grimshaw, Interim Finance Director	£75,001-£80,000	£0	£0	£0	£0	£75,001-£80,000
Peter Bradley, Chief Executive	£105,001-£110,000	£2,000	£0	£0	£7,001-£7,250	£110,001-£115,000
Michael Dinan, Director of Finance	£100,001-£105,000	£0	£0	£0	£7,251-£7,500	£110,001-£115,000
Martin Flaherty, Deputy of Chief Executive	£105,001-£110,000	£3,800	£0	£0	£44,001-£44,250	£145,001-£150,000
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0	£0	£0	£0	£100,001-£105,000
Stephen Lennox, Director of Health Promotion & Quality	£90,001-£95,000	£0	£0	£0	£0	£90,001-£95,000
Fionna Moore, Medical Director	£65,001-£70,000	£0	£0	£0	£0	£65,001-£70,000

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2014 (bands of £5,000)	Cash equivalent transfer value at 31 March 2014	Cash equivalent transfer value at 31 March 2013	Real increase in cash equivalent transfer value	Employers contribution to stakeholder pension To nearest £100
Richard Hunt, Chairman	**	**	**	**	**	**	**	
Caroline Silver, Non-Executive Director	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Beryl MaGrath, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, 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	**	**	**	**	**	**	**	
Ann Radmore, Non-Executive Director	£7,501-£10,000	£25,001-£27,500	£65,001-£70,000	£200,001-£205,000	£1,347,564	1,122,210	£140,466	
Andrew Grimshaw, Director of Finance	£2,501-£5,000	£7,501-£10,000	£30,001-£35,000	£90,001-£95,000	£509,077	£467,271	£22,068	
Jason Killens, Director of Operations	£0-£2,500	£2,501-£5,000	£20,001-£25,000	£70,001-£75,000	£314,495	£271,859	£12,794	
Caron Hitchen, Director of Human Resources	*	*	*	*	*	*	*	
Stephen Lennox, Director of Healthcare Promotion	£0-£2,500	£0-£2,500	£35,001-£40,000	£105,001-£110,000	£624,871	£605,842	£3,990	
Fionna Moore, Medical Director	*	*	*	*	*	*	*	

* Fionna Moore has opted out of the NHS pension scheme. Caron Hitchen has ceased being employed by the Trust.

** As non-executive directors 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 pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

“A change in the Government Actuarial Department’s (GAD) actuarial factors has occurred during the year, following revised guidance from HM Treasury. NHS Pensions are using the most recent set of actuarial factors produced.”

Reporting of other compensation schemes – Exit packages Note 10.4

	2013-14			2012-13		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
£25,001-£50,000	0	2	2	1	0	1
£50,001-£100,000	0	9	9			
£150,001-£200,000	1	0	1	1	0	1
Total number of exit packages by type (total cost	**1**	**11**	**12**	2	0	2
Total resource cost (£000s)	**157**	**659**	**816**	103	0	103

Redundancy and other departure costs have been paid in accordance with the provisions of the 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 Note 10.5

	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirements contractual costs	11	659
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	8	1,236
Non-contractual payments requiring MHT approval	0	0
Total	**19**	**1,895**

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

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

Off-Payroll engagements Table 1

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	12
Of which, the number that have existed:	
for less than one year at the time of reporting	10
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	1
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.

Off-Payroll engagements - Table 2

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, 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 2013 and 31 March 2014	13
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	10
Number of new engagements for whom assurance has been requested	13
Of which:	
Assurance has been received	13
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	None
Number of Individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	26

Accountable Officer: Ann Radmore, Chief Executive

Organisation: London Ambulance Service NHS Trust

Date: 3 June 2014

Staff sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total days lost	58,717	53,317
Total staff years	4,394	4,443
Average working days lost	13.40	12.00

	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	**8**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**700**	407

Better Payment Practice Code – measure of compliance

Better Payment Practice Code

Measure of compliance	**2013-14 Number**	**2013-14 £000s**	2012-13 Number	2012-13 £000s
Non-NHS payables				
Total Non-NHS Trade Invoices Paid in the Year	**55,639**	**71,850**	49,368	64,627
Total Non-NHS Trade Invoices Paid Within Target	**47,874**	**57,223**	39,893	49,073
Percentage of NHS Trade Invoices Paid Within Target	**86.00%**	**79.64%**	80.81%	75.93%
NHS payables				
Total NHS Trade Invoices Paid in the Year	**402**	**2,794**	311	**3,357**
Total NHS Trade Invoices Paid Within Target	**277**	**1,570**	171	**1,866**
Percentage of NHS Trade Invoices Paid Within Target	**68.90%**	**56.20%**	54.98%	55.59%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust has signed up to the government prompt payments code.

External financing

We are given an external financing limit which it is permitted to undershoot.

	£000s	**2013-14 £000s**	2012-13 £000s
External financing limit		**(1,983)**	(1,998)
Cash flow financing	**(2,996)**		(1,998)
Unwinding of Discount	213		0
External financing requirement		**(2,783)**	(1,998)
Undershoot/(overshoot)		**800**	0

This summary financial statement does not contain sufficient information to allow as full an understanding of our results and state of affairs, nor of our policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. Where more detailed information is required a copy of our full accounts and reports are obtainable free of charge.

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

Financial Controller
Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Explanation of statutory financial duties

Break-even duty

We are required to break-even on our income and expenditure account taking one year with another.

External financing limit (EFL)

The external financing limit (EFL) is the means by which the Treasury, via the Department of Health and NHS London, 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.

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

Each year, we are allocated an EFL as part of the national public expenditure planning process.

Capital resourcing limit (CRL)

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

Under spends against the CRL are permitted and overspends against the CRL are not permitted.

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

Capital cost absorption duty

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