London Ambulance Service NHS
NHS Trust

Annual Report 2015/16

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FOREWORD FROM THE NEW TRUST CHAIRMAN, HEATHER LAWRENCE

Emergency services are facing increasing demand and the London Ambulance Service is no exception. This Annual Report highlights how my predecessor, Richard Hunt, in leading the Board, and together with our Chief Executive Fionna Moore have been working to improve services for the population of London. I would like to acknowledge here the contribution Richard Hunt made over the last seven years as Chairman of the Service.

As incoming Chairman, it is my view that we need to continue to develop and alter our service to better meet the changing needs of the population, particularly for the elderly and those with mental health issues where dispatch to hospital may not be the best solution. I am committed to our working with the Sustainable Transformation leads across health services, the other blue light services and our stakeholders to ensure that we are integral to the planning and development of emergency services. The problems hospitals face in increasing demand for accident and emergency services is echoed across the Service. Change is a constant state of play and we need to also work with our staff to embrace the changes that are needed to meet the needs of Londoners in the 21st century.

I have joined at a difficult time, as in addition to facing increasing demand we were placed in „special measures" following an inspection by the Care Quality Commission. The Governance of the organisation will be strengthened by developing a fresh vision and strategy for the service combined with strengthened system and processes.

People make our organisation and we will work with our staff to ensure that we are strongly recommended as an excellent place to work. Together we will work to make LAS an excellent service for Londoners and for staff and in these ways will come out of special measures.

CHAIRMAN RICHARD HUNT'S FOREWORD

It has been a difficult year for the Service. The Care Quality Commission (CQC) visited us in June 2015 and published their report in November. Whilst we received a "good" rating for our overall care of patients, the report highlighted a number of areas of concern.

With demand once again increasing, particularly amongst our most seriously ill and injured patients, and a national shortage of paramedics the year proved particularly challenging. Under such circumstances it is important to recognise that whilst we maintained a safe level of service, we fully acknowledge that we couldn't always provide the quality of service that we would have liked. However, it is excellent to see that our „caring and compassionate" staff were fully recognised in the CQC's report. Throughout these challenging times, they have remained committed, dedicated and proud of the work they do. And these reflections on the year represent a further opportunity to say thank you to all my colleagues.

Since the CQC inspection we have made significant progress in a number of areas and this was recognised by the CQC at our Quality Summit in December. Since then we have developed and launched our Quality Improvement Plan. This not only sets out the action already taken since the CQC inspection but also details our improvement plans, how we will deliver them and over what time period. Whilst there is still much work to do progress has already been made to deliver better care for patients and to provide a more supportive working environment for our staff.

Despite difficult circumstances we have made some significant achievements over the past year. In January 2016 we launched the London Ambulance Service Academy, providing an opportunity for staff within the Service to qualify as paramedics. The Academy has been designed after feedback from staff on the need for further education and development opportunities and has now been delivered as the first part of our CQC improvement plan. It is an important investment in the future of the service and provides the opportunity for us to support colleagues in their own development.

During the Christmas and New Year period we ran a high profile alcohol campaign in collaboration with the Metropolitan Police Service, London Fire Brigade and the Greater London Authority. 'Eat, Drink and Be Safe' was designed to manage demand from alcohol related calls during this busy and challenging time. London Ambulance Service saw a 12.5 per cent decrease in alcohol related calls over New Year. Well done to everyone involved.

This year has also been a time for change for me personally. I will be leaving the Service after seven years at year end (March 2016). I will have the opportunity to consider what to do next in addition to my immediate task of taking on the role of Commanding Officer of the Engineer and Logistic Staff Corps (advisors to the Ministry of Defence).

I am incredibly proud to have been part of the London Ambulance Service, and of the care and compassion that I see colleagues provide every day. In thanking all colleagues for what they do and dealing with the pressures of increasing demand I would also like to thank them for the support they have given me.

I am handing over to Heather Lawrence in April who has over 40 years of frontline NHS experience and is joining us from Monitor, the regulator for NHS foundation trusts, where she has served as a non-executive director.

I wish everyone at the Service every success in the future and I will always look back and remember my time here with pride and affection.

CHIEF EXECUTIVE FIONNA MOORE'S FOREWORD

Despite 2015/16 being an incredibly challenging year for the Service we have made significant progress since 2014/15 to improve the Service for both staff and patients. Although the report from the Care Quality Commission (CQC), published in November 2015, was very disappointing we had already begun making improvements in staffing, performance and staff engagement.

Since then we have developed and made progress against the objectives in our quality improvement plan, working closely with stakeholders, staff and patients to make our organisation stronger. In 2015/16 we recruited over 700 staff, easing the pressure on existing staff who work incredibly hard. We have also seen improvements in our staff survey results with 47 indicators showing an improvement, reflecting the positive changes we've made. We are resolutely determined to deliver month on month improvements to the Service through our quality improvement plan and significantly improve the organisation for our patients and our staff by the end of 2016.

Demand on the Service has continued to increase, with an increase of over 20,000 incidents in comparison with 2014/15. Demand has been particularly high recently, with March 2016 seeing the highest number of Category A (immediately life threatening) incidents the Service has ever seen. With demand increasing we have been mindful of how we respond to 999 calls, ensuring we provide the highest standards of patient care but recognising that conveying patients to hospital is not always the best option.

As an example of responding to demand and to improve the support available to patients, we introduced mental health nurses to our clinical hub in February 2015. These nurses support people with mental health concerns who need the right support but who in many cases do not need, or want, an ambulance. They provide enhanced mental health assessments over the phone, assisting patients with accessing support from their local mental health teams, referring them to their GP or upgrading their call if there is an immediate risk or clinical need. In the past year our mental health nurses responded to 5,961 calls, with 15.9 per cent managed by phone.

We have also been working toward greater integration between the London Ambulance Service and other services through the Introduction of Coordinate My Care (CMC). CMC enables us to access patient records entered onto the CMC system when a 999 call is received. We now have over 13000 patients on the system, which is accessed every day by frontline staff. We are continuing to work with CMC and others to develop this tool for the benefit of patients with a range of illnesses. CMC has been particularly useful in helping patients with end of life care plans; ensuring they receive the most appropriate care and avoiding unnecessary conveyance to emergency departments.

We have continued to work closely with other emergency services in London and launched two pilots this year with the Metropolitan Police Service (MPS) and London Fire Brigade (LFB). The pilots see the MPS and LFB corresponding alongside us to incidents in a small number of London boroughs. The pilots enable us to work together and share resources, saving more lives across London. We are already seeing some great success stories through these pilots and London has 124 defibrillators available through these pilots.

Despite the challenges over the past year we have achieved a lot and have clear plans for how we will continue to improve the Service.

PERFORMANCE REPORT

Who we are and what we do

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 provide clinical assessments over the phone to more callers with less serious illnesses and injuries. The number of patients we manage over the phone is the highest in the country with patients referred to NHS 111, given additional clinical advice over the phone by a clinical advisor, or sent a non-emergency transport vehicle to take them to an urgent care center or emergency department.

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 of the Service"s 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 2015/16 we handled over 1.8 million emergency calls from across London and attended more than one million incidents. Incidents in London rose by 20,000 in 2015/16, putting us under significant pressure.

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

OUR VISION AND STRATEGIC GOALS

In 2015 we set our vision 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.

In 2016/17 our vision is „Making the LAS great".

Our strategic goals 2015/2016 were:

- To improve the quality and delivery of our urgent and emergency response
- To make the London Ambulance Service a great place to work
- To improve our organisation and infrastructure
- To develop our leadership and management capabilities

Our values in 2015/2016 were:

Care: Helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.
Clinical excellence: Giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.
Commitment: Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; Learning and growing to deliver continual improvement

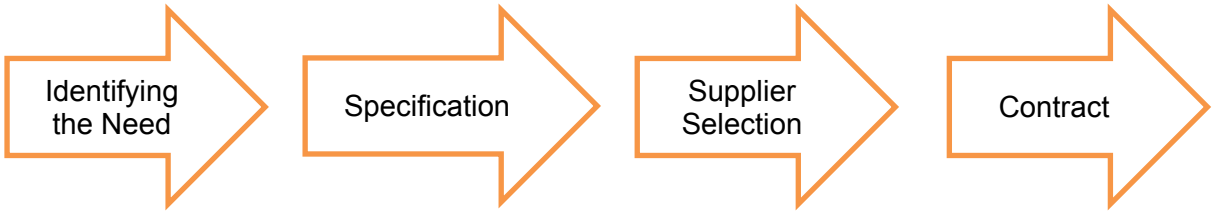
Strategic Report Issues

Sustainability

One of the key aims of the Trust Procurement Strategy 2016-2019 is to imbed Corporate Social Responsibility (CSR) within its supply chain. The Trust is committed to sustainable procurement by ensuring that social, economic and environmental issues are considered during all stages of a procurement process. The Trust is working towards developing a policy and suite of procedures to ensure that we continue our commitment to CSR.

A recent report conducted by the London Universities Procurement Consortium (LUPC) calculated our indirect carbon footprint was 22,417 tonnes of CO2e (carbon dioxide equivalent) from our 2014/15 purchasing activity. This is a 16% decrease on 2013/14 activity.

The Procurement Strategy 2016-2019 states Sustainability will be considered where appropriate to a contract. This can be applied at different stages in the procurement process, for example:



Activities can include:

Identifying the need
Question whether the purchase is really essential, or could use be made of an existing product or a more environmentally friendly product or service. Consider working with potential suppliers to look at packaging, transport or production processes.

Specification
Although careful consideration needs to be given to the way in which goods and services are specified in tender documents to ensure the Trust does not act in an anti-competitive manner, consideration can be given to the goods or service over its lifecycle, „whole life costing".

Supplier Selection
Potential suppliers can be asked to demonstrate their environmental technical competence, where this is relevant to the subject of the contract, for example in waste disposal contracts.

Contract
Award criteria must be relevant to the subject of the contract but consideration can be given to using a range of criteria including quality, technical merit, aesthetic and functional characteristics and running costs, all of which can have a direct impact on the environment. In managing the contract we can work with suppliers on continuous improvement to performance such as reduced transportation & packaging.

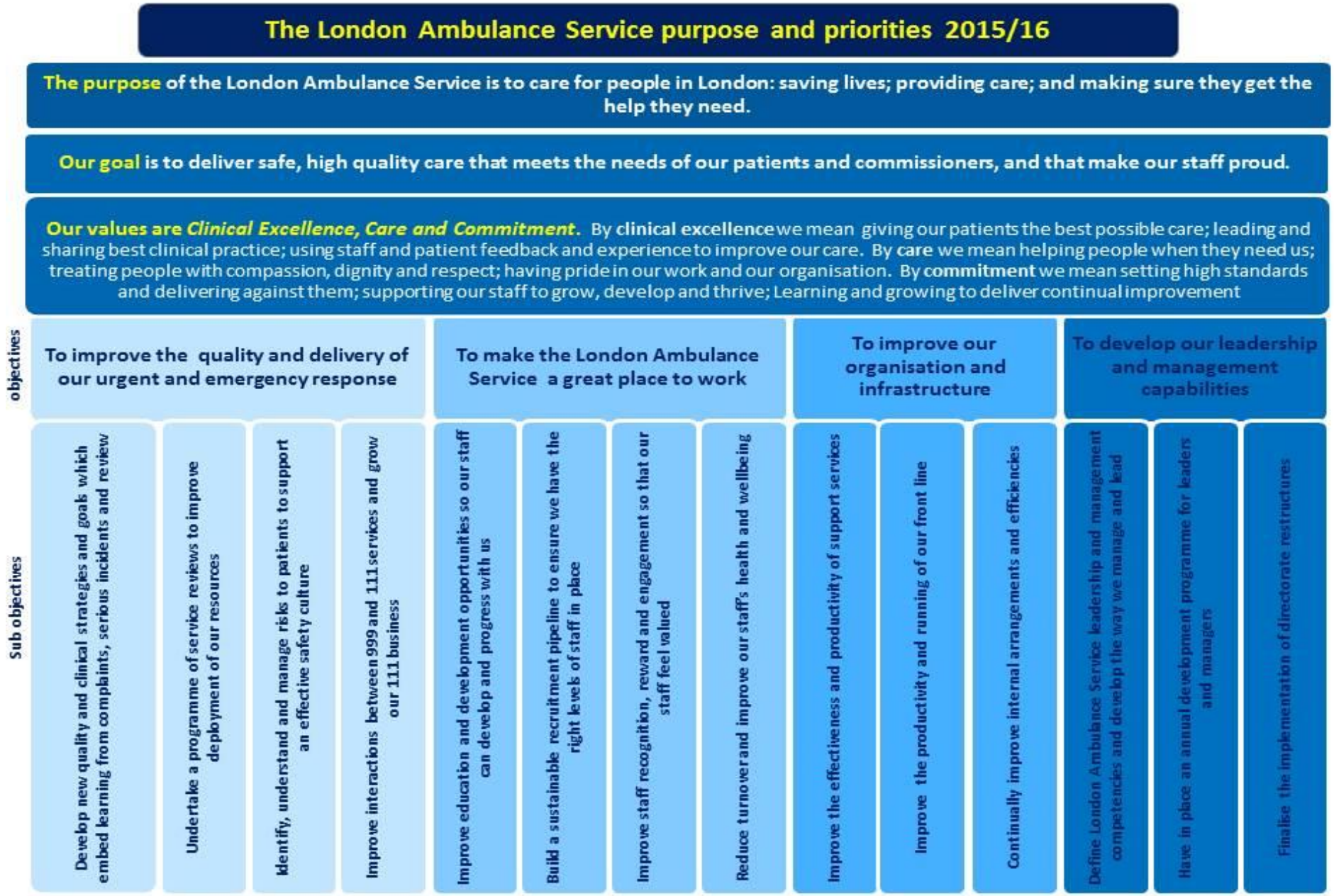
Equality and diversity

2015/16 has been the second year of our equality strategy 2014-19 and in January 2016 the London Ambulance Service was again recognised by Stonewall as one of the top employers in the country. In Stonewall Top 100 Employers we were ranked 46th overall, up 16 places from 2015, and one of the top five health and social care organisations in the country. Stonewall highlighted that this ranking was because of our inclusive policies, equality training for staff and the continued work of our LGBT Forum.

2015/16 has also seen the Trust increasingly active in supporting staff who have reported bullying and/or harassment. This has included the introduction of a telephone advice line and the interim appointment of a specialist manager who is delivering training for managers and staff across the Trust. We have also developed a revised Dignity at Work Policy which supports an approach, when it is judged appropriate, to resolve issues through conversation between those involved.

Looking forward to 2016/17 equality and diversity forms a key part of our quality improvement plan. We want to make sure that we are an equal opportunity employer, and that our staff from all backgrounds feel included and part of the workforce. This will include running focus sessions across all staff to gather opportunities for improvement, ensuring equality objectives are embedded within the appraisal process and updating mandatory training for all line managers to include equality and diversity. We will also review the recruitment processes, particularly in relation to internal promotion opportunities.

LONDON AMBULANCE SERVICE PURPOSE AND PRIORITIES 2015/2016



TO IMPROVE THE QUALITY AND DELIVERY OF OUR URGENT AND EMERGENCY RESPONSE

Sub objective – Develop new quality and clinical strategies and goals which embed learning from complaints, serious incidents and review

Learning from experiences

London Ambulance Service is committed to delivering the highest level of safety ensuring risks are kept to a minimum for all of our patients, staff, visitors and local community. The complexity of healthcare and the ever-growing demands to meet health care needs means that there will always be an element of risk in providing high quality, safe, health care services. We recognise that effective reporting and analysis of incidents and complaints and good risk management is an integral part of good management practice and should become part of the Trust"s culture.

We have acknowledged that, historically, the number of clinical and safety incidents being reported was low. The reasons for this included fear of punitive action, poor safety culture in the organisation, lack of understanding among clinicians about what should be reported, lack of awareness of how reported incidents are analysed, and how the reports lead to changes that improve patient safety.

Over 2015/16 a great deal of work has been done to build an environment where staff feel confident and supported to report incidents and are assured that reports will be dealt with openly, respectfully and thoroughly. We have addressed the cultural concerns that staff reported about reporting incidents by providing assurance that staff will be supported and treated fairly and in a timely and consistent manner.

Using the *NHS Confederation Act on reporting: five actions to improve safety reporting* as a template, we have improved patient safety by:

- giving feedback to staff
- focussing on learning
- engaging frontline staff
- making it easy to report
- making change matter

To support this process and, where possible, allow for local investigation and resolution, we have appointed Quality, Governance and Assurance Managers across London and Clinical Team Leaders who have received appropriate training in incident investigation and feedback.

Focus on learning

We are using themes from incidents and complaints in educational sessions for staff in order to share learning. Sessions have included airway management refresher sessions, maternity updates and multi-agency teaching sessions. An increasing number of staff involved in incidents have written case reports for clinical updates to share their learning and reflections. We have been clear in all sessions that incident reporting is about reducing the risk for patients not apportioning blame to individuals.

Engaging frontline staff

Clinical team leaders have now been given protected time to provide clinical supervision and feedback to their team members. This means staff can talk through cases where they were concerned and be guided as to whether it constitutes an incident.

Serious Incidents

The Serious Incident group meets weekly to review cases raised as potential Serious Incidents – the membership of this group has been broadened to include staff officers who are frontline paramedics. We have set up local area governance and mortality meetings, facilitated by the medical directorate, where clinicians bring cases and discuss them in a supported and open forum.

Making it easy to report

As a mobile healthcare provider it is important that the process for reporting is simple and effective. We have commissioned the introduction of DATIX web, which will go live during 2016/17. Whilst we are waiting for this to be introduced we have ensured that incident reporting forms (LA52s) are on all the front-line vehicles and that clinical team leaders are available to receive and review these once they are submitted. This combined with more confidence that incidents will be addressed, has resulted in increased reporting and in particular self-reporting. We have provided a single point of contact email for potential Serious Incidents and Medicines Management Incidents. The Clinical Hub has a Quality Governance Manager on duty every shift that is able to talk to crews immediately after an incident, provide guidance and support and escalate issues in real time to the on call medical and operational managers.

Making change matter

All incidents, complaints and claims are monitored by the respective department i.e. Patient Safety Department, PALS, Complaints and Legal Services Department and Regulation, Compliance and Quality Improvement Department. The increase in self-reporting of incidents indicates that we have made progress towards staff believing that reporting systems are to improve safety and not to seek to blame individuals. We produce three monthly „Learning from incidents" reports which pull together all the themes from incidents, complaints and inquests – this is shared both internally and externally. In addition themes of incidents and complaints, Serious Incident recommendations and audit recommendations are monitored through the Clinical Safety and Standards Committee, chaired by the Medical Director, and the key themes are reported to the Trust Board through the Quality Committee. Trust audits are be undertaken to assess whether learning has been embedded into everyday practice.

Our use of feedback to make improvements

Feedback from patients, their families and the public is an important way of driving improvements to our service. This is captured by our Patient Experiences team who managed 3,800 enquires and 1,025 complaints this year.

Activity and themes arising from complaints are regularly reported to the Trust Board. Our Learning from Experience Group also reviews the themes and issues emerging from complaints and the action taken to improve services. Some patients are also invited to tell their story in person to the Trust Board,

Some of the changes we have brought about arising from complaints and service-user feedback include the following:

- Amending the *elderly fallers protocol* which automatically prompts an upgrade to the level of emergency priority when there is a delay exceeding 60 minutes in an ambulance response. This now takes account of elderly patients who have sustained a suspected injury as a result of the fall but have been helped up from the floor.

- Asking the National Academy to review the way patients with diabetic problems are assessed to take account of ketone levels within the triage protocol

- Reviewing the way we assess children who have swallowed a foreign object to make sure we know that their airway is clear (this is because retching can suggest a potential blockage)

Improving performance

We have completed an internal review and introduced a range of measures to improve our complaint management performance, including improving the information available on our website to make it easier for service-users to make a complaint and updating our intranet so that staff are familiar with the process and know how to help a patient who wishes to make a complaint.

Sub objective – Undertake a programme of service reviews to improve deployment of our resources

In 2015, London Ambulance Service and South West Ambulance Service Trust (SWAST) were the first two ambulance Trusts to be selected to pilot the first phase of the "Ambulance Response Programme" initiative. This pilot allowed call handlers in our Emergency Operations Centre"s up to a maximum of 180 seconds to undertake a more comprehensive assessment for a pre-determined selection of 999 calls before the response time clock started. This additional time gave call handlers the ability to make a more detailed diagnosis and to ensure the appropriate response was provided to the patient.

In terms of the outcome, we have seen a reduction in the number of cancellations due to better dispatching decisions. It is important to note that there have been no adverse incidents, safety issues or complaints as a result of the pilot.

In addition to this, a number of workshops were held throughout the summer of 2015 to consider the benefits of our solo responders not being automatically backed up by an ambulance on certain calls. This system is already in use in other ambulance Trusts.

We launched a pilot for a limited number of call types. The pilot allowed paramedics on scene to assess the patient"s need for conveyance to hospital before the ambulance arrived and subsequently determine whether and what type of further intervention was required. Secondly, it ensured that an ambulance response was only sent to patients who needed it.

A pilot commenced to test the concept within the Trust after the Medical Director selected and agreed a very limited number of call types. Our solo responders currently have four options for requesting additional resource and these options are based upon how quickly and what type of vehicle resource is needed. The benefits of this pilot to the Trust are currently being evaluated.

Sub objective – Identify, understand and manage risks to patients to support an effective safety culture

Patient Safety Incidents

Serious Incidents

In total across 2015/16 62 incidents were deemed to meet the criteria to be declared as serious to NHS England (London), a 41 per cent increase compared to 2014/15. Each declared Serious Incident (SI) is then subject to a full investigation using Root Cause Analysis (RCA) methodology with SMART recommendations put in place to mitigate the likelihood of repeat occurrences.

For the third year in a row the numbers declared have increased significantly (18 in 2012/13 and 39 in 2013/14, 44 in 2014/15). This continues to demonstrate a better understanding and use of the internal incident reporting process and a firm organisational belief in the channel for identifying Serious Incidents. It also reflects a more open reporting culture in a time of increasing demand on the Trust.

As in previous years, the number of ambulance delays related to SIs has remained high, although in 2015/16 we have seen a wider range of incidents declared, including HR related issues, information governance issues and medicines management. This wider range of incidents raised by members of staff that are then declared further demonstrates the increasing confidence of our staff in the purpose and benefit of reporting errors and incidents.

Process and governance

The SI group membership includes four executives and meets weekly. Following a review of the terms of reference this year the membership has expanded to include more subject matter experts. This has resulted in more informed and quicker decision making. We have been happy to host a variety of observers at the meeting, both external in the form of commissioners and the NHS Trust Development Authority and internal, with an increasing number of staff with a quality or governance focus to their roles demonstrating an interest in the discussion and decision making process for SIs. The purpose of the meeting is to provide an open and challenging discussion to incidents raised, and this has been reflected in feedback from our external stakeholders. We have also seen a continuing number of inquests and complaints raised to the group for evaluation and decision.

Each SI has executive and senior management leads who review and sign off the report before it is submitted; we also involve our legal services team and seek external legal advice as required. Ensuring the Duty of Candour is complied with is essential and this now forms an integral part of the discussion for responsibilities as when a patient safety SI with moderate or severe harm is declared and a Family Liaison Officer is appointed.

We expect that 2016/17 we will see further increases in the number of incidents considered and declared as DatixWeb is introduced making incident reporting more accessible to our staff and managers.

Future developments

The numbers of SIs declared by the Trust are lower than some of our peers; however, this could be seen as a measure of the safety of the service rather than a poor process for

capturing errors and incidents. Other ambulance services also declare trolley breaches, whereas the arrangements in London are for these to be declared by the acute trust responsible. The Service is taking part in an ambulance service initiative to share the details of SIs declared to allow for better learning and comparison across Trusts using the Proclus/Zeal system. It is important that in 2016/17 we continue to work on reducing the length of time it can take to investigate an SI and the level of quality of the report that is produced. As such approximately 30 members of staff have undertaken RCA training in the latter part of 2015/16 to help ensure this is done. In addition to this there are now clear channels for escalation of overdue SIs to both senior and executive management.

How we are implementing Duty of Candour

The Service has taken a multifaceted approach to implementing and embedding the Duty of Candour into the culture of the organisation. In addition to the appointment of Family Liaison Officers in Serious Incidents, there have been several classroom-based Family Liaison Officer training sessions for clinical managers to help explain the purpose of the Duty of Candour and what is required to fulfil that duty. In addition to this a dedicated Duty of Candour session has been included on Core Skills Refresher training 2015.3 for all clinical staff. In 2016/17 Duty of Candour will be included as a mandatory training module for all staff with an attached multiple choice competency test and it will be included on Trust induction for all new staff. These initiatives have run alongside a continuing internal communications programme.

'Sign up to Safety' campaign

In 2015/16 the Trust enrolled on to the Sign up to Safety campaign in order to contribute to the system-wide ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This meant signing up to five specific pledges:

1. Putting safety first - commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans

2. Continually learning - make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are

3. Being honest - be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

4. Collaborating - take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use

5. Being supportive - help people understand why things go wrong and how to put them right. Giving staff the time and support to improve and celebrate progress.

We have seen progress so far in maternity where a six weekly "Risk Summit" set up to discuss complaints, serious incidents, PALS, claims and inquests has used the Sign up to Safety pledges to help inform its agenda. Work continues to improve the safety of the service we provide by effective engagement with staff involved in incidents and providing proactive training on maternity risks to clinical staff. Learning points are also shared at a London-wide heads of midwifery meeting. The ambition for 2016/17 is to replicate this

approach in other high risk areas of our activity. In addition to this we publish a quarterly learning from experience report, picking up a number of themes from across Serious Incidents, complaints, inquests, incidents and claims. This report is shared at the Quality Governance Committee and with our commissioners. In regards to "being honest" we are working extensively to integrate the Duty of Candour in to the culture of the organisation as detailed above and staff involved in Serious Incidents are offered support through the process, including staff welfare, evidencing our commitment to being supportive.

Sub objective – Improve interactions between 999 and 111 services and grow our 111 business

We have continued to make strong progress with our 111 services over the year. Our South East London service provision for 111 has regularly met national targets and is still considered a high performing provider of the 111 service in London. Last year we handled over 294,000 calls and saw overall call volume increase, in the last quarter of 2016 actual call demand was frequently higher than predicted.

Our performance against calls answered in 60 seconds has been regularly met, only dropping below the national target of 95 per cent in February 2016 to 92.4 per cent, the first time since December 2014. We have consistently met the target of less than 5 per cent for calls abandoned in 30 seconds and continue to maintain one of the lowest rates pan London, for percentage of answered calls transferred to 999, averaging 7.6 per cent.

To ensure we constantly improve our service, we have worked closely with our 111 commissioners during the year to meet their service need and cost expectations, for example, initiating a review of forecast activity, with the quality of the service remaining good despite challenges across the London Urgent and Emergency Care (U&EC) system.

In order to strengthen relationships, we have also continued to work with commissioners across the capital and have representation at pan London strategic groups, such as the Integrated Emergency and Urgent Care Committee to collaborate and promote the interaction across the U&EC system.

We have improved interactions between 999 and 111 by implementing a number of joint pilot projects between commissioner, provider and wider healthcare system. We have introduced a broader organisational approach to improve internal communication and awareness through a staff exchange and visit of our 111 and 999 control rooms, this will in turn look to support future training on both Pathways and the Advanced Medical Priority Dispatch System (AMPDS).

We have been preparing to grow our 111 business and created a bid infrastructure that includes; key stakeholders; small medium enterprises (SMEs); management process and collateral, as well as scrutinising key requirements within the commissioning landscape to ensure we are prepared and ready for the re-commissioning of services and commissioner intent. We have identified and monitored the 111 bid opportunities in year and considered each procurement opportunity as released in the public domain. As a result, our executive leadership team (ELT) made a decision not to progress with two contract procurements.

TO MAKE THE LONDON AMBULANCE SERVICE A GREAT PLACE TO WORK

Over 2015/16 we have been working on a number of areas to make sure that the Service is a great place to work for all of our staff. We want to be an equal opportunities employer where staff enjoy their work, have their opinions heard and feel supported in their day to day roles and in developing their careers with us.

Sub objective – Build a sustainable recruitment pipeline to ensure we have the right levels of staff in place

Advert to action

The aim of Advert to Action was to ensure sufficient staffing levels were in place to meet patient needs by filling the large vacancy gap that existed at March 2015. During 2015/16 our extensive recruitment activities saw us recruit 717 frontline staff, resulting in a net increase of our frontline workforce by 314 whole time equivalent (wte).

To fill our vacancies, we have conducted three separate recruitment trips to Australia, recruiting over 550 wte paramedics, and have learned lessons from each trip, so that we now target graduates from specific universities to ensure we recruit the most suitable candidates who have the skills that we need.

Looking forward to 2016/17, we have a further recruitment trip to Australia in the first few months of the new financial year and are working hard to strengthen our graduate package to ensure that we are best placed to recruit UK graduates when they finish their training.

We also recruited locally for our Emergency ambulance crew roles, bringing in 252 new frontline staff into the Trust

To address the national shortage of Paramedics we have been working closely with Health Education England (HEE) locally and nationally. We worked closely with HEE when they developed their workforce plan for 2015/16 to acknowledge the shortage of paramedics and the need to increase the pipeline of future paramedics. The HEE investment plan demonstrates this by committing to increase paramedic training by over 87 per cent by 2017/18.

Although not part of the advert to action project, to ensure we are less reliant of recruitment from abroad we have also launched the LAS Academy to offer existing staff the opportunity to train as paramedics.

We also work closely with universities to ensure that they train the right number of paramedics so that they provide a strong workforce pipeline for the future. Last year, locally, we increased the number of paramedic undergraduate places with our four main universities.

Sub objective – Reduce turnover and improve staff's health and wellbeing

Bullying and harassment

Following the publication of the findings of the 2013 NHS staff survey and an independent report commissioned by the Service, we have undertaken an extensive range of activities to tackle bullying and harassment within the organisation. To help us with this, in November 2015 we appointed a bullying and harassment specialist to lead the activities and have also

appointed an organisational change specialist to support our work on changing the culture within the organisation. The Trust Board also nominated a Non-Executive Director; Theo De Pencier to ensure the issue was addressed.

During the year we:

- set up a confidential telephone advisory service for staff members to report any cases as well as to receive advice
- revised and re-launched the Service‟s bullying and harassment policy with a new focus on mediation and facilitated conversations to encourage early and informal resolution of issues.
- have substantially increased the amount of training that is taking place within the Trust, all of the Executive Leadership team and Senior Leadership Team undertook bullying and harassment awareness training
- have designed and launched a simple easy-to-follow guide for staff to understand and report bullying and harassment.
- rolled out bullying and harassment awareness workshops across the service with bespoke sessions for teams where requested. In 2015/16 we ran 18 workshops for 250 staff.

We are also in the final stages of commissioning external facilitators in mediation skills training to train 25 staff in mediation skills to support our move to improve communication and conflict resolution skills within the organisation.

Sub objective – Improve education and development opportunities so our staff can develop and progress with us

Training

2015/16 has seen the Service make a number of improvements in the training and development available to our staff, as well as making a number of commitments on how we are going to further improve our training and development in 2016/17. This includes recruiting an organisational development specialist to review the development opportunities we have on offer.

For our frontline staff we have redesigned our core skills refresher training and education to ensure that it meets the needs of the organisation, which in 2015/16 included ensuring that all frontline staff received major incident training. In January 2016 we launched the London Ambulance Service Academy to offer existing non-registered clinical staff the opportunity to train as a paramedic.

All our 185 Clinical team leaders have received management development in the form of a two day bespoke management course developed and delivered by Cranfield University. The two days have also been embedded into future team leader courses. Clinical team leaders have also received a HR master class on managing attendance, disciplinary and grievances.

In order to help our staff improve their IT skills, we have launched the NHS IT skills pathway which is available to all staff. This is a recognised route of learning for the whole of the NHS workforce.

Supporting staff

One of the main ways in which we have improved our support to staff in 2015/16 is the establishment of a new Clinical team leader (CTL) role. Our CTLs have 50 per cent of their

time protected in order to support their staff and they have received bespoke training on a number of subjects to help them in this role. As a result of the new CTLs we have seen a substantial increase in the number of Clinical Performance Indicators (CPI) completed. The CPI is a tool we used to continuously audit the care we provide to our patients and the CTLs use them to provide constructive feedback to their crews.

CTLs have also increased the number of Operational Workplace Reviews (OWRs) which are carried out, enabling further opportunities to provide staff with support and feedback on their clinical practice. In the six months before the new CTLs came into post between 10 and 60 were carried out each month. Immediately following the new CTLs going live this number jumped to between 160 and 190 per month.

Looking forward to 2016/17 we will work to ensure that all staff are supported and have opportunities to develop within the Trust. This will include completing appraisals, and enhancing our training for staff, including the increased use of e-learning.

Sub objective – Improve staff recognition, reward and engagement so that our staff feel valued

We are keen to listen to staff and act of what they have to say. Our approach is to try to provide clear messages and the opportunity to feedback to the senior leadership team, while supporting and empowering local managers to tailor the way they do this to engage with their staff.

Chief Executive Dr Fionna Moore held a series of roadshows across the Service in September and October 2015, which were attended by around 900 staff. As well as being an opportunity to update people on current issues and initiatives, the meetings included a chance for discussion and for staff to feedback their own ideas and views.

As a result of work across the Service and our staff engagement and recognition activities we have begun to see improvements in the NHS staff survey results. The NHS staff survey was sent to all staff towards the end of 2015, with a response rate of 35 per cent (compared to 35.7 per cent in 2014).

The findings showed improvements in a number of areas compared to the previous year‟s survey, whilst also reflecting the pressure the organisation has faced and staff concerns on key issues – which were already being addressed through our quality improvement plan in response to our Care Quality Commission inspection and report.

Our staff engagement score, informed by the 2015 NHS staff survey, was 3.13 (based on a score range from 1 to 5).This was up from 2.78 in 2014, but was still below the average for all ambulance trusts of 3.39.This figure is 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.

We have a monthly briefing system, Team Talk, which is designed for cascading information through the organisation and gaining feedback, which is then reported back to the Executive Leadership Team for their information and action. This feedback is then made available to all staff – along with details of actions that are being taken as a result. During the year, feedback received in this way led to the reintroduction of our internal magazine, LAS News, and which includes staff generated content.

Key themes and topics discussed on our closed staff Facebook site are also included in the Team Talk feedback reports. This group, which now has more than 2,800 members, enables

direct communication and engagement with a large part of the workforce, as well as the chance for questions and discussions. Since July 2015, it has been successfully administrated by a group of around 20 peer moderators who volunteer their time to make the group a better forum for staff.

Another key development during the year was the launch of a new intranet site, which is fully accessible from all work computers and on personal phones and other mobile devices.
Ideas for the structure of the site, and content to be included, came from a survey open to all staff, as well as focus groups attended by a cross-section of people from different areas and departments across the organisation. Feedback has continued to be invited since the site was launched to help inform future developments.

We introduced our VIP Awards scheme in 2015 to recognise the work of people across the organisation and held the first awards ceremony in April that year. Nominations are considered by voting panels made up of colleagues from the same staff groups, with the overall winners from each then going forward for a service wide vote to become Employee of the Year.

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

TO IMPROVE OUR ORGANISATION AND INFRASTRUCTURE

Sub objective - Improve the effectiveness and productivity of support services

Work has continued throughout 2015/16 to maintain, renew and increase the size of the fleet in support of frontline staff. This is a key area of work for the Trust, as the vehicles we use are the place where our services are provided.

In 2015/16 104 double crewed ambulances were replaced and a business case developed and approved for the procurement of a further 140 across 2016/17. In addition, 60 new fast response cars were also procured and are currently in the process of being converted for operational use. We expect these to become operational at the start of the new financial year. These new vehicles will replace our eldest vehicles, they will be more reliable, will spend less time in the garage and are cheaper and easier to maintain. The procurement of vehicles has also allowed the Trust to expand the size of its fleet, with ambulance numbers increasing from 420 in 2014 to over 450 by 2016. Increasing the size of the fleet helps reduce the downtime for crews as vehicles can be replaced more easily when things go wrong, such as mechanical failures and accidents.

Considerable effort has gone into improving the supply and availability of equipment across 2015/16. The Logistics Department has been working to ensure that equipment is available where and when staff need it. A trial has started of a new system to prepare vehicles prior to operational use; this will also help to reduce costs by reducing wastage and duplicated effort. Early indications are this trial will make a considerable impact on equipment management processes and help to ensure frontline staff can focus on treating patients.

Estates

We have continued to look at ways of reducing our energy usage and in the last 12 months we have replaced the lighting in a number of vehicles garages with LED lighting, which reduces electricity usage and routine maintenance. The air conditioning and boilers at New

Malden were also replaced and the main roof at LAS HQ was replaced with additional insulation added. The estates team will continue to look at ways of reducing energy usage further in the future.

We have re-tendered a number of estates contracts to ensure that value for money is achieved and that staff have a safe working environment. These have included the Fire safety contract for the maintenance of Fire alarms, emergency lighting and portable firefighting equipment, water quality testing and Security and Fire risk assessments.

A new site for paramedic training has been identified to replace the current facilities. This will ensure that appropriate and sufficient facilities are available for the on-going training of trainee paramedics.

The Trust has also been working in partnership with Commissioners to secure new premises for the South East London 111 service, which we have been operating for several years as step in providers to ensure continuity of the service. We continue to work with the Metropolitan Police Service and London Fire Brigade to explore further options for collaboration and have recently been looking into a number of potential options for closer working, including the potential of sharing control rooms.

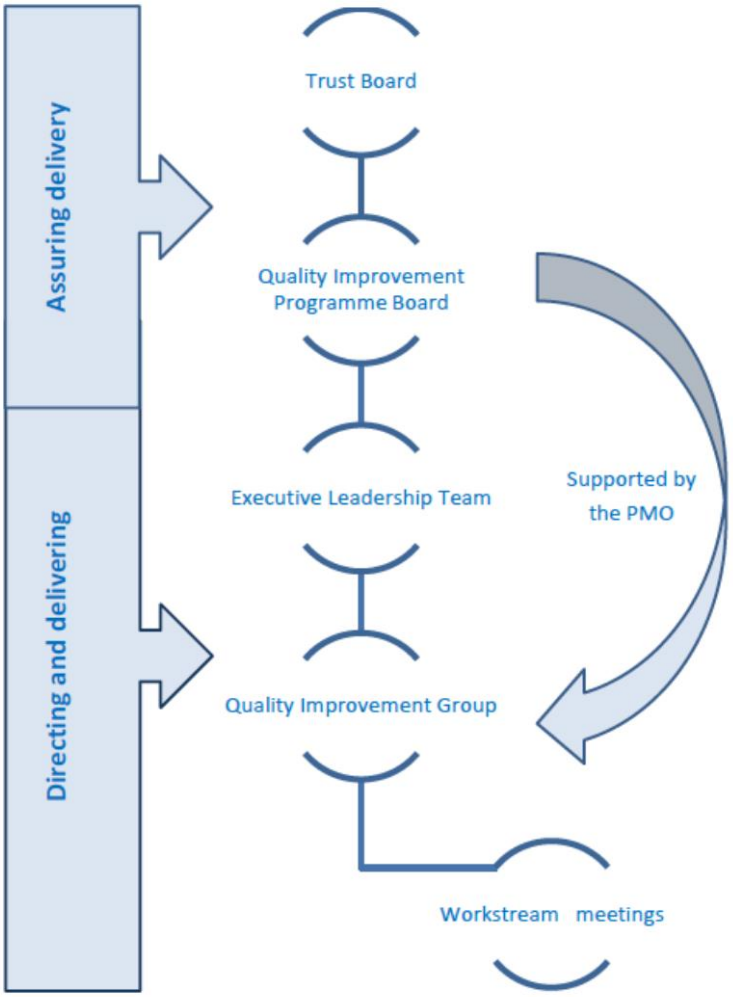
Other work has included the introduction of a new access control system with the production and issue of circa 5000 new ID cards and the disposal of a redundant radio transmitter site. We will review and develop our estates strategy in 2016/17 and continue to look at ways of improving the efficiency and effectiveness of our estate.

Project/Change management

During 2015/16 the main change management programme in the Service was the 2015/16 Improvement Programme. This programme had robust programme management arrangements with the support of PA consulting who brought project and change management expertise to the organisation. The programme governance included clear lines of responsibility and the use of tried and tested project tools and documentation. Following the conclusion of the programme a number of lessons learned were included in the final report.

Following our 2015 CQC inspection we launched our Quality Improvement Programme (QIP) ensuring that we have taken on board the lessons that were gleaned from the Improvement Programme. It was in part due to these lessons that we have ensured that the QIP has clarity of purpose and definitions, high profile visibility across the organisation and strong buy in from all areas of the organisation.

Building on arrangements that were put in place for the Improvement Programme, the QIP has strong programme governance in place to ensure the effectiveness of the management of the programme and the associated projects. The diagram below identifies how the project will be governed to ensure productivity and efficiency.



The Trust Board will have oversight of the delivery of our improvement plan through the **Quality Improvement Programme Board**. The Programme Board, chaired by the Chairman, will review progress towards the quality improvement plan and key performance indicators on a monthly basis. A formal report from the Quality Improvement Programme Board will be presented at each formal meeting of the Trust Board.

The Executive Leadership Team oversees delivery and approves any changes to the projects.

The **Quality Improvement Group**, chaired by the Chief Executive, will meet monthly to review progress against the whole plan and each of the five work steams individually, assessing risks and directing interventions to ensure deadline delivery. This group will report to the Executive Leadership Team.

Each of the five work streams is led by an Executive Director. Executive Directors will hold monthly **work stream meetings** to ensure delivery against actions and milestones

HR department

2015/16 has seen a number of improvements in productivity and effectiveness within the HR department. For the department as a whole, a diagnostic exercise was carried out by an Interim Director to identify areas of good practice as well as where improvements could be made in the service the HR department provides to the organisation. In 2016/17 we will recruit a permanent Workforce Director who will build on this diagnostic exercise and review the department to ensure it is an effective service providing high quality HR support to the organisation.

Significant improvements have been made in the Recruitment team over the past year. One of the key enablers to the improvement we have seen is the implementation of an interim structure, which was agreed in November 2015/16, ensuring that the team has the necessary resources to efficiently handle the volume of work required by the organisation.

The interim structure included securing two senior recruitment managers who have a dedicated focus on specific areas.

We have improved the effectiveness of our systems by implementing the TRAC applicant tracking system in November 2015, which we are now embedding in business as usual.

We have also made great strides in improving the effectiveness of our workforce information function. We brought in a specialist to improve our systems and processes and as a result we have seen an improved ability to capture accurate workforce information. 2016/17 will see further improvements as we launch a programme to ensure that we make best use of our ESR system.

Learning & development

In Q3 of 2015/16 we began a re-launch of our learning and development function by recruiting a Learning and Organisational Development Specialist as well as appointing an Assistant Director of People and Organisational Development who has been reviewing the Learning and Organisational Development opportunities across the Service.

2016/17 is going to be an exciting year as we begin to establish the Learning and Organisational Development function alongside the launch of a new People and Organisational Development (POD) Strategy. This strategy and its commitments will, amongst other things, focus on improving the accessibility and effectiveness of Learning and Development across the organisation. The strategy‟s overall aim is building the Trust‟s capacity to achieve its priorities through planned development, improvement and implementation of strategies, structures and processes that lead to continuous organisational improvement.

To support all of this, an important area will be the need to have strong, resilient leaders capable of dealing with change and who role model our vision, values and behaviours so staff in turn can do the same. The POD strategy outlines a detailed approach to leadership, behaviours and development as well as talent management and succession planning.

Business performance reporting

During 2015/16 we undertook a review of our Information Management and Technology (IM&T) and Information Management Services. This Review resulted in the functions of the Management Information Team separating. One part remaining within the IM&T Directorate, focused on everyday core system data, with the other moving into the Performance Directorate to form the new Business Intelligence Team.

Within the Performance Directorate some of the initial areas that we are focusing on include;

- Embedding the Purpose and Values of our Service within our reporting and analysis
- Provision of accurate, qualitative data with intelligence for Sectors, Group Stations and Teams
- Providing Trust Board with comprehensive analysis that supports effective decision-making
- Working more closely in partnership with our Commissioners for the benefit of Londoners‟
- Engagement with our wider Healthcare Community and Statutory Bodies
  In addition, a dedicated Head of Forecasting and Planning has been appointed to lead on the strategic and operational statistical analysis for the Service.

Extensive work has been conducted to review and enhance reporting, both in terms of the reporting structure and the metrics used within internal and external performance reports. The main objectives of the Business Intelligence Team and Forecasting and Planning Team (which now make up the Performance Directorate) are to provide high-quality data and intelligence to support the Trust‟s decision making processes with quantifiable evidence. Detailed analysis is conducted and performance against key measures is monitored throughout the year, with improved granularity, transparency and consistency.

Additionally, a newly implemented Operations Framework, supported by enhanced reporting and mathematical modelling, allows risks to performance and trends to be identified more quickly and easily.

Forecasting and Modelling

Throughout 2015/2016, the forecasting model utilised by the Trust was further developed to facilitate regular tracking of actual performance against the predictions going forward (as before), as well as identify the cause of variance of realised performance from the predictions.

Two distinct models now exist: a strategic model which predicts demand and performance over the next financial year, providing the justification for the trajectory agreed in the contract; and an operational forecasting model, forecasting performance four weeks ahead to provide evidence for more immediate proactive decision-making. Combining, both models gives us the ability to track performance against what was expected under the current circumstances, and against the trajectory that represents the contract.

Trend analysis of the intelligence produced by the forecasting reports not only allows for the areas of improvement and good practice to be clearly identified, but also serves to give early warning of shifting trends, risks and issues.

Enhanced Reporting

The Integrated Performance Report serves to provide a high-level, executive summary to the Trust Board and Executive Leadership Team, giving organisational oversight of all key metrics across the service. Underpinning the Integrated Performance Report is a Key Performance Indicator (KPI) Assurance Report, providing the monthly status of key areas against the position of previous months, allowing progression to be tracked. Importantly, it provides a link between Financial, Operational, Quality and Workforce KPI areas.

Performance in each of these four areas for each KPI is reported against national and local targets/thresholds where available. We also include trajectories and forecasts from the performance forecasting models where applicable, enabling progress to be tracked against expected profiles and against the contract. Crucially, this allows the report to be utilised as a method for early detection of future risks when comparing current and previous performance against the assumptions of the contracted plan.

The KPIs monitored by the Trust and presented regularly in these reports are listed in the following table, grouped by the four areas examined within the high-level Integrated Performance Report:

QUALITY	PERFORMANCE	WORKFORCE	FINANCE
Adverse Incidents (Patient)	A8 Performance	Vacancy Rate (Frontline Paramedic)	Cash Balance - Monthly Profile
Adverse Incidents (Staff)	A19	Vacancy Rate (Frontline)	Capital Service Capacity
Potential Serious Incidents Referred To SI Group	R1	Vacancy Rate (Trust)	Liquidity Days
Serious Incidents (LAS Declared)	R2	Turnover Rate (Frontline Paramedic)	Access To Pdc For Liquidity Support
Serious Incidents (LAS Declared) Overdue	Calls	Turnover Rate (Frontline)	Cash Balance - Monthly Profile
Regular Reporting Of Incidents - Shared Learning	Incidents	Turnover Rate (Trust)	Income And Expenditure Deficit By Month
Total Complaints	Cat A Incidents	Sickness (Trust)	Income And Expenditure Deficit Cumulative
Complaint Acknowledgement 3 Days	Cat C Incidents	Sickness (Frontline)	Income Variance From Plan
Complaints Response (Over 35 Days)	Patient Facing Vehicle Hours (PFVH)		Cip Delivery Against Plan
Controlled Drug Incidents - Not Reportable To LIN	Full Job Cycle Time		Cip Forecast Against Plan
All LIN Reportable Incidents	Job Cycle Time (JCT)		Forecast Capital Spend Against The CRL
Overall Medication Errors	Multiple Attendance Ratio (MAR)		
Missing Equipment Incidents	EOC - Call Answering Rate		
Failure Of Device/Equipment/Vehicle Incidents	EOC - FRU Cat C Share		
CPI - Completion Rate			

The Business Intelligence Team has also been fundamental in the creation of the Quality Improvement Programme (QIP) Report; developing a tool that allows collected data to be stored, analysed and reported in a consistent way, giving transparency across the Trust of the QIP progress.

Operations Framework

A new Operations Framework has recently been implemented, restructuring the way the Operations Directorate identifies and responds to the challenges affecting organisational objectives. The Performance Directorate have developed the supporting report framework for the new meeting cycles, the objective being to make information more transparent, consistent and accessible.

New data analytics dashboards are now being used to confidently inform decision making groups with visual evidence. They allow for easy transfer of information across the service, and show the trends of main operational measures across a definable time period. The dashboards, available at a pan-London and sector level, enable operations staff to understand and influence performance in their own area, examine their contribution to the LAS position, as well as compare how they perform against neighbouring sectors. Such transparency encourages communication and accountability in addressing Trust challenges. It also means that actions can be tailored to local areas and the resultant impact at a global level compared against the contracted performance targets and shorter-term forecasted positions.

This new reporting approach, along with regular collaborative review sessions of the trends and forecasts under the new framework, allows key messages and required actions to be identified quickly, escalated to the Executive Leadership Team efficiently and shared throughout the Trust more effectively.

Sub objective - Improve the productivity and running of our front line

The Service established an improvement programme to run throughout 2015/16 with a remit to implement a range of performance improvement initiatives across the Service. The intention was to help improve response times and support the delivery of the national response time standards.

The programme brought together a series of projects that aimed to address longstanding operational challenges facing the Service and improve our delivery against national and contractual targets; build internal and external confidence in the Service"s ability to deliver high quality, reliable patient services; deliver sustainable, lasting changes that are positively

supported by our staff; deliver a better quality of working life and improve wellbeing for our current and future staff.

The key achievements of the 2015/16 improvement programme include:

- the roll out of the Clinical Information and Support Overview (CISO) performance management tool for frontline staff, which has improved the information available to staff and managers to support improvements in staff performance
- the introduction of revised transport options for frontline staff, which were simpler to use and gave us a potential increase in frontline capacity because staff were able to use alternative transport resources where this was clinically appropriate
- the introduction of a new non-emergency transport service (NETS) that is designed to help release pressure on frontline capacity
- the appointment of a new occupational health provider
- the design of the FRU (ambulance car) co-ordinator role and the identification of FRU co-ordinators in each station group to support improvements to FRU response times
- the reduction in our multiple attendance ratio which improved efficiency and the availability of ambulances.

Sub objective - Continually improve internal arrangements and efficiencies

All NHS organisations are required to seek efficiencies as part of national planning guidance. Across 2015/16 we were asked to identify £9.0m of savings, this represents 2.5% of operating costs. This total was achieved in full. To achieve this the Trust continually looks at what it spends to ensure what is purchased is needed, effective and represents value for money – which does not always mean simply looking for the lowest price.

The Trust works to achieve this by looking at:

- What it buys. Is a good or service needed to support the objectives of the organisation and the safe delivery of patient care?
- Does the good or service deliver what is required? The Trust will seek to identify a specification for what it needs to ensure that what is purchased is fit for purpose and does not include unnecessary additional items. This also helps to ensure that we are clear about what we plan to purchase to avoid problems with buying the wrong or an incomplete solution
- The price we pay. We work closely with suppliers to ensure we get the best prices we can. This does not mean the cheapest price, but rather the best price for what we need something to do. We work to tender requirements for goods and services to a range of suppliers to ensure we review what is available.

When looking for efficiencies we try and focus on non-frontline activities. This helps to protect our frontline services. However, we do continually seek to improve ways of working within all services, including frontline to ensure that we maximize the effective use of our staff and resources in responding to the needs of Londoners.

Examples of efficiencies made across 2015/16 include:

- Reducing accident damage costs through better care of vehicles and reducing insurance costs - £0.5m
- New IT systems. These were both more effective and cheaper than those they replaced - £0.5m
- Improved store and stock management, including achieving better prices from suppliers - £0.8m

- Fuel, more efficient use and seeking low prices - £1.0m
- Controlling staff costs in support functions. This including controlling temporary staff costs and identifying savings that could be made from reorganising activities - £1.0m.

TO DEVELOP OUR LEADERSHIP AND MANAGEMENT CAPABILITIES

Sub objective - Define London Ambulance Service leadership and management competencies and develop the way we manage and lead and have in place an annual development programme for leaders and managers

We have provided Clinical Team Leaders (CTL) with a two day development programme which was designed and delivered by Cranfield University to provide CTLs with some additional development and support to be able to undertake the first line management elements of their new role. This was delivered from May 2015 through to January 2016 and has been incorporated into future clinical team leader courses planned for this financial year.

We have been working with Defence Medical Services who are designing our senior manager leadership programme. The delivery of this programme commences in May 2016.

We have held the first of regular workshops / modules with staff across the Trust where values and behaviours will be explored which will result in a behaviour model.

In line with the people and organisational development strategy the Trust will be following the NHS Leadership framework for 2016/2017. The framework consists of nine leadership dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results

Each of the dimensions has four levels which will be applied to different managerial / leadership levels within the Trust:

- Essential (First line managers and new managers to the Trust / in to role)
- Proficient (Managers up to Assistant Director level)
- Strong (Assistant Director and Deputy Director level)
- Exemplary (Directors)

Sub objective - Finalise the implementation of directorate restructures

London Ambulance Service started its operational management restructure in 2014/15 in order to better meet the needs of our frontline staff; to implement key elements identified in our 2014 staff survey action plan; to improve our engagement with Clinical Commissioning Groups and other external stakeholders; to simplify and focus management roles to improve production levels and high quality care; and to deliver cost savings and increase efficiency.

Following the consultation process, the department of Operational Business Change and Innovation (OBCI) was tasked in 2015/16 with establishing a steering group to oversee the implementation of the new structure. To prepare effectively for implementation, there was on-going communication with all affected staff; a library of job descriptions for all operations management roles was created and staff were matched accordingly; and a plan for all recruitment activity was published and co-ordinated by the OBCI department.

All Band 8A (and above) managers commenced their new roles in full on 3 August 2015. Clinical Team Leaders (CTLs) also started working with their 50:50 operating model on this day, this enables CTLs to spend 50 per cent of their time on patient facing duties and the other 50 per cent of their time on managing their staff. The existing Duty Station Officers (Band 7s), who were moving into the new Group Station Manager and Incident Response Officer roles, worked with their current teams during the month of August to undertake training and handover preparation. The operations directorate formally moved to its new structure on 7 September 2015.

The Director of Operations is now developing the terms of reference for a formal review of the new structure with Human Resources. This review will be completed by the end of June 2016.

Governance of our organisation

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

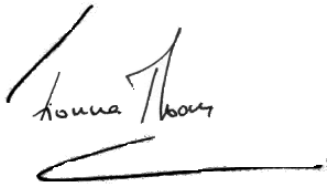
The board assurance framework and corporate risk register are presented at each meeting of the Trust Board, and further scrutiny is applied through the Quality Governance and Audit Committees. The risk register is reviewed in detail by the Executive leadership team each month.

Full details can be found in our governance statement on page 33 of this document.

Accountable Officer: Dr Fionna Moore, Chief Executive

Organisation: London Ambulance Service NHS Trust (RRU)

Signature:



Date: 02 June 2016

DIRECTOR'S REPORT

Our Trust Board

In 2015/16 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. An exception was made to this in 2015/16 with a number of interim and acting appointments made which are described below. The non-executive directors are appointed by the same method through the NHS Trust Development Authority.

In February 2016 the Trust Chair, Richard Hunt, announce his resignation from the Board to take effect on 31 March 2016. Heather Lawrence has been appointed as Trust Chair and will take up the position on 1 April 2016.

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

Fionna Moore was substantively appointed to the post of Chief Executive in July 2015 having been Acting Chief Executive since January 2015.

Fenella Wrigley was substantively appointed to the role of Medical Director in March 2016 having been the Acting Medical Director since January 2015.

Paul Woodrow, Director of Performance, was appointed as Acting Director of Operations (voting) in September 2015 following the departure of Jason Killens.

Jill Patterson was appointed as interim Director of Performance (non-voting) in September 2015 having been the interim Head of Performance since August 2014.

Mark Whitbread retired from the role of Director of Paramedic Education and Development in December 2015.

Andrew Watson was appointed as Chief Information Officer in March 2016 and is a non-voting director.

The Trust Board has six formal sub-committees: the Strategy Review and Planning Committee, the Quality Governance Committee, the Audit Committee, the Finance and Investment Committee, the Remuneration and Nominations Committee and the Charitable Funds Committee. During 2015/16 the Trust Board agreed to the establishment of two further Board committees: Workforce and Organisational Development, and the Quality Improvement Board. The latter is time-limited and provides board assurance on progress with the Quality Improvement Programme whilst the Trust is in Special Measures. The Trust Board also agreed to dis-establish the Strategy Review and Planning Committee and to hold a private Board meeting in its place. The Trust Board now meets monthly with the exception of August.

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

Four non-executive directors and four executive directors made up the membership of the **Quality Governance Committee**, which was chaired during the year by non-executive director Bob McFarland. The Committee reviewed its terms of reference in March 2016.

The membership of the **Audit Committee** comprises three non-executive directors and was chaired by non-executive director John Jones.

The **Finance and Investment Committee** was chaired by non-executive director Nick Martin and has three non-executive directors and two executive directors as its members. The Committee reviewed its membership in March 2016 and is proposing to increase the number of executive directors as members of the committee.

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

The membership of the **Charitable Funds Committee** was reviewed and updated during 2015/16 and comprised the Trust Chairman Richard Hunt, who chaired the committee, and one executive director.

The **Quality Improvement Group** was established in January 2016 as a time-limited Board committee providing oversight and assurance on the Quality Improvement programme which commenced in January 2016. The Committee is chaired by the Trust Chair and its membership comprises two non-executive directors and two executive directors.

The Trust Board agreed to establish a **Workforce and Organisational Development committee** to be chaired by Fergus Cass, non-executive director, with non-executive and executive directors as members, and this will come into effect early in 2016/17.

BOARD PROFILES

Non-executive directors

Richard Hunt CBE joined us as Chairman in July 2009 and ended his term of office in March 2016. 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. Richard also chaired the Charitable Funds Committee and the Quality Improvement Programme Board.

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 was Chief of Staff to 4 Director-Generals and is now Controller of Make it Digital at the BBC. Jessica is the Deputy Chairman of the Trust Board. She is a member of the Quality Governance and 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 Fellow member of the Chartered Institute of Management Accountants, and a member the Chartered Institute of Public Finance and Accountancy and a Fellow Chartered Director of the Institute of Directors. He is the chair of the Audit Committee, and a member of the Finance and Investment Committee.

Nicholas Martin took up post in October 2012. 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 Governance Committee.

Bob McFarland took up his post in May 2013, as an associate non-executive director and was appointed to his substantive role in March 2014. Bob worked as a Consultant General and Vascular Surgeon for over 20 years and retired from St George's Healthcare NHS Trust in 2010. 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 center‟s 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 Governance Committee and a member of the Quality Improvement Programme Board. Robert 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 Governance and Audit Committees and will chair the Workforce and Organisational Development Committee when it is established early in 2016/17.

Theo de Pencier joined the Service in March 2014. Theo was until early in 2015 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 industries working for NFC, Danzas and Bibby Line Group. He is a member of the Audit, Finance and Investment and Workforce committees and is the current Senior Independent Director. In addition to LAS he is also a Board member of Transport Focus - the independent watchdog for train, bus and tram passengers and users of the strategic road network.

GOVERNANCE STATEMENT

London Ambulance Service NHS Trust

Organisation Code: RRU

Governance Statement

Scope of responsibility

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

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

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

In 2015/16, the demand on the Service continued to increase, with an increase of over 20,000 incidents in comparison with 2014/15. Demand has been particularly high recently, with March 2016 seeing the highest number of Category A (life threatening) incidents the Service has ever seen. With demand increasing we have been mindful of how we respond to 999 calls, ensuring we provide the highest standards of patient care but recognising that conveying patients to hospital is not always the best option. The Trust has worked in partnership with Commissioners, the TDA and NHS England (London) under the oversight of the Regional Oversight Group, to review performance trajectories and has an agreed position going forward in 2016/17.

In 2015/16 the Trust achieved 63.8% for the national performance target of Category A8 minutes and 95.4% 19 minutes. The Trust Board takes its assurance on the quality and accuracy of the data through the integrated performance report and national reporting of Ambulance Quality Indicators. The London Ambulance Service NHS Trust is not required to

monitor elective waiting time data.

Whilst facing these challenges, our primary concern has been and continues to be the safety of the service we provide. It is essential as an organisation that we learn from our underperformance and apply that learning to improve services moving forwards. Managing and mitigating against any potential performance impact on patient quality and safety is our fundamental priority. A key mitigation for quality and safety is workforce and the Trust has recruited over 700 front line staff in 2015/16 and has seen a reduction in the frontline vacancy rate down to 3.6%. Paramedic turnover ended the year at an improved figure of 11.6% and the overall sickness rate for the Trust is down to 5.1%.

The Care Quality Commission (CQC) undertook a planned inspection under the Chief Inspector of Hospitals Inspection regime, in June 2015. The Trust commenced planning and preparation for this in February 2015 on notification of the date of Inspection. The Inspection took place from 1 – 5 June 2015 with some subsequent follow-up inspection visits. The CQC issued a Section 29A Warning Notice to the Trust on 1 October 2015 with the recommendation to the NHS Trust Development Authority that the Trust be placed in Special Measures. The key areas of concern covered within the Section 29A Warning Notice were:

- Bullying and harassment
- Recruiting enough frontline staff
- Resilience (HART)
- Medicines Management
- Governance and risk management
- Underreporting of incidents.

The CQC published the outcome report in November 2015 and the Trust was rated Inadequate on 29 November 2015:

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

The Trust immediately implemented a range of actions in response to the Warning Notice and was able to give positive and evidenced assurance of progress at the Quality Summit on 2 December 2015. With input from the TDA and other key stakeholders the Trust published its Quality Improvement Plan in January 2016. The Plan is supported by a robust governance and programme framework to ensure that the Trust improves its compliance against the CQC standards and moves out of Special Measures within a reasonable and paced timeframe.

The TDA undertook a review with the Trust against the Well-led Framework (the Well-Led Review) for Governance in recognition of the challenges faced by the Trust including:

- Ongoing underperformance against the national ambulance standards
- High numbers of paramedic vacancies
- The identification of a perceived culture of harassment and bullying as evidence by an independent report that the Trust had commissioned in 2014/15.

The timing of the review coincided with the receipt of the Section 29A Warning Notice from the CQC and the subsequent placement of the Trust in Special Measures. The TDA found limited assurance with regard to quality assurance, risk management, staff engagement and development, and workforce and operational oversight, and made a number of recommendations to support improvement.

Governance consultancy support was procured for 3 months to undertake a review of Board governance arrangements, the risk register and the Board Assurance Framework (BAF). This work was completed in March 2016 and the Trust Board has implemented an action plan to address the outcome of the Board governance review. Progress has been made with the framework for risk management and in the development of the BAF.

The governance framework of the organisation

The Trust Chair, Richard Hunt, stepped down from the role on 31 March 2016 having been with the London Ambulance Service NHS Trust since June 2009. Richard is replaced by Heather Lawrence with effect from 1 April 2016.

Other changes to the Trust Board and executive team included the substantive appointment of Dr Fionna Moore as Chief Executive; the departure of Jason Killens, Director of Operations, in September 2015 for the South Australia Ambulance Service, and the appointment of Paul Woodrow as Acting Director of Operations. Paul‟s substantive role is that of Director of Performance. Dr Fenella Wrigley was appointed to the role of Medical Director in March 2016 having been in the acting role since February 2015. Andrew Watson was appointed as Chief Information Officer in March 2016.

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 Trust Board agreed to establish a Workforce and Organisational Development Committee and the first meeting will be held on 16 May 2016 and will be chaired by a non-executive director. A Quality Improvement Programme Board was established in January 2016 as a time limited committee of the Board, chaired by the Trust Chairman, to provide oversight of the Quality Improvement Plan and board assurance of progress against the plan.

Terms of reference for the Audit, Quality Governance, and Finance & Investment Committees were reviewed and updated in 2015/16. A further review of membership for each was undertaken as an outcome from the governance review undertaken by an external consultant.

The reporting structure for the Executive Leadership Team was reviewed during the year and the new structure commenced in March 2016. This includes the re-establishment of the Risk Compliance and Assurance Group, and the establishment of a Quality Improvement Group, Environment and Resources group, and Operations Board. Each of the key executive-chaired committees provides assurance to a Board committee.

With the re-establishment of the Risk Compliance and Assurance Group, key risks and the Board Assurance Framework are now reviewed by a committee comprising Executive directors, senior managers and subject matter experts, on a monthly basis. This group reports through to the Executive Leadership Team and provides assurance on risk management systems and processes to the Audit Committee.

The Finance & Investment and Quality Governance Committees review financial, quality and safety risks. The Trust Board reviews the corporate risk register and Board Assurance Framework at each meeting held in public.

The Trust Chair and Director of Corporate Affairs/Trust Secretary undertake a post-board review each month to ensure the agenda has been covered, sufficient time has been allotted to agenda items and effective contribution and scrutiny given. The Board agenda, papers and practice are continuously reviewed and adapted to ensure that reporting is appropriate and timely. Following the external governance review the processes for Board and committee agendas and papers have been strengthened.

The Board agenda is informed by the forward planner which is reviewed and updated after each meeting and includes a patient or staff story, an integrated performance report, quality and safety reporting, financial reporting, and key business and governance items.

The external governance review had 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 receives quality, financial and performance information that provides assurance on the discharge of statutory responsibilities. The NHS Trust Development Authority operated, until quarter four of 2015/16, a system of monthly submissions of self-certification of compliance with a set of board statements and Monitor‟s compliance framework.

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

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. The committee undertakes a review of the effectiveness of the corporate risk register at each meeting. The committee met 5 times during the year with the internal and external auditors present and held one meeting without auditors. The Audit Committee met once with auditors only.

At the Trust Board meeting on 31 May 2016 the Audit Committee chair provided assurance to the board of the effectiveness of the Trust‟s systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework.

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

The Chair of the Quality Governance Committee provides a report to the following meeting of the Trust Board. This report includes the committee‟s assessment of quality as taken from the reports and evidence presented to the committee, including the corporate risk register. The committee receives assurance from its reporting committees: Clinical Safety and Standards and Improving Patient Experience. The Committee did not receive an assurance report from the 3rd committee, Professional Education and Standards, however the committee was dis-established in the review of the Executive Leadership Team governance structure and its work subsumed into the afore-mentioned committees. 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 31 May 2016 the Quality Governance Committee chair provided assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee met 7 times during the year.

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

The Trust Board works within the remit of the standing orders and standing financial instructions and the scheme of delegation. These were reviewed and approved by the Trust Board on 25 November 2014. The Audit Committee granted an extension to these

documents at its meeting on 15 February 2016 for further review by September 2016.

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

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

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.

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

The Internal Auditors, KPMG, have been reviewing the Trust"s risk management arrangements over a three-year period and, from the review in 2015/16, stated that risk management arrangements at London Ambulance Service NHS Trust („the Trust") had reached an overall assessment of „*Significant assurance with minor improvement potential*". The 4 areas for improvement related to: gaps in assurance, mitigating actions, local risk register updates, and identification of risk ownership. Local risk registers had been identified as a compliance gap in one of the earlier reviews and the Trust had been working with managers during a time of significant operational pressure to ensure that risk was being managed at a local level and to ensure that risks were being reviewed and escalated as appropriate. This was evidenced through the internal audit recommendation tracker reviewed at each meeting of the Audit Committee and progress was being made within the timescale set. This compliance gap was reflected in the CQC Warning Notice and Inspection Report which required the Trust to *'improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.'* The Trust implemented a programme of risk management training for all managers in November 2015 and had trained 263 managers by 31 March 2016, with an ongoing programme of training for 2016/17 onwards. An audit was undertaken of local risk registers and further work undertaken to ensure that all operational, support and corporate functions had up to date risk registers. This was reviewed by the Risk Compliance and Assurance Group in April 2016 and work is now underway to align local registers to the corporate risks. The Trust Board will review strategic risks to its 2016/17 plan in April 2016. These risks will then guide the Board

Assurance Framework. The key risk areas facing the Trust in 2015/16 were: service performance, clinical and quality, and financial.

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 Risk Compliance and Assurance Group or monitored at a local level. The Serious Incident Group meets weekly to review any serious incidents that need investigating and may need to be formally declared as Serious Incidents. The group monitors the progress of SI investigations and escalates any delays to the Executive Leadership Team.

New risks with a net severity rating of High (over 15) are added to the corporate risk register and the board assurance framework which are reviewed monthly by the Risk Compliance and Assurance Group and the Executive Leadership Team. A new approach to the treatment of risk was agreed in March 2016 for implementation in 2016/17 in line with the revised Risk Management Policy. 23 risks were added in 2015/16. 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.

The Trust reported one data security incident to the Information Commissioner and this was declared and investigated as a serious incident. A Patient Report Form (PRF) folder containing 15 PRFs was handed over by a paramedic to another so that the drug numbers and other details could be copied. The paperwork was later identified and then confirmed as missing. The staff involved have undergone information governance training and all station staff have been instructed not to pass paperwork to other colleagues.

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

The risk and control framework

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

The Risk Compliance and Assurance Group manage the corporate risk register whilst the Audit Committee assesses the effectiveness of the corporate risk register at each meeting. The Trust Board, Quality Governance Committee and Executive Leadership 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) attended 3 meetings of the Audit Committee in 2015/16 and monthly executive counter fraud meetings. KPMG have provided the local counter fraud service since April 2013. The Audit Committee approved an extension of the contract for a further 2 years within procurement rules.

The internal auditors attended 5 meetings of the Audit Committee during 2015/16 and work closely with the Governance and Assurance team to execute the annual audit work plan which is developed in conjunction with the Trust Executive. KPMG have provided the internal audit service to the Trust since April 2013. The Audit Committee approved an extension of the contract for a further 2 years within procurement rules.

Ernst Young are the external audit provider. The Trust will be appointing an external audit provider during 2016/17 for commencement in 2017/18 and the Trust Board has established an Auditor Panel through the Audit Committee to oversee this process.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive management team within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant Issues

The CQC Chief Inspector of Hospitals undertook a planned Inspection of the Trust in June 2015 to assess compliance against the following 5 quality domains: safe, caring, effective, responsive, and well-led. The CQC issued a Section 29A Warning Notice to the Trust and recommended to the TDA that the Trust be placed in Special Measures. The CQC rated the Trust as Inadequate. The Trust has implemented a Quality Improvement Plan overseen by a Quality Improvement Programme Board which provides assurance to the Trust Board. External governance and oversight is provided through the Commissioners Quality and Risk Group and the Regional Oversight Group which comprises membership from commissioners, NHS Improvement (TDA), and NHS England.

In 2015/16 we received 1.8 million emergency calls from across London. Category A demand for the London Ambulance Service rose by 15.9% and we responded to more than one million incidents. This put the Trust under significant pressure. This pressure has continued through the year with record levels of demand being experienced the 4th quarter of the year.

The Trust had worked with McKinsey, NHS England (London) and the TDA in the

development of a model for performance trajectories in 2015/16 and this was built into the contract for the year. It became evident early in 2015/16 that the model was not sufficiently robust and the Trust then worked closely with commissioners, NHS England (London) and the TDA to set a new trajectory against which performance would be monitored. A trajectory of 67.6% has been agreed for 2016/17.

The Trust implemented a substantial recruitment campaign in 2014/15 resulting in 700 new front line staff starting in 2015/16.

The outcome of the TDA Well-led Review is supported by an action plan and changes have already been made to areas of Board governance. This work will continue with the new Trust Chair during 2016/17.

Internal audit undertook 8 reviews during 2015/16 in line with the annual work plan and raised 39 recommendations, of which 4 recommendations were determined as high priority within the following reviews:

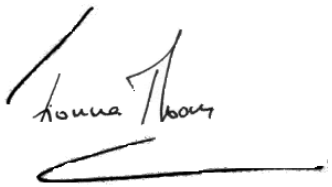
- Flexible working arrangements (2)
- Registration Authority audit (2)

Actions will be identified and implemented to address each recommendation.

The Head of Internal Audit's opinion is one of:
„Substantial assurance with minor improvements required". „Our work has confirmed that there is generally a sound system of internal control which is designed to meet the Trust"s objectives, although we had identified areas where the controls in place could be enhanced or improved."

Accountable Officer : Dr Fionna Moore, Chief Executive
Organisation: London Ambulance Service NHS Trust (RRU)

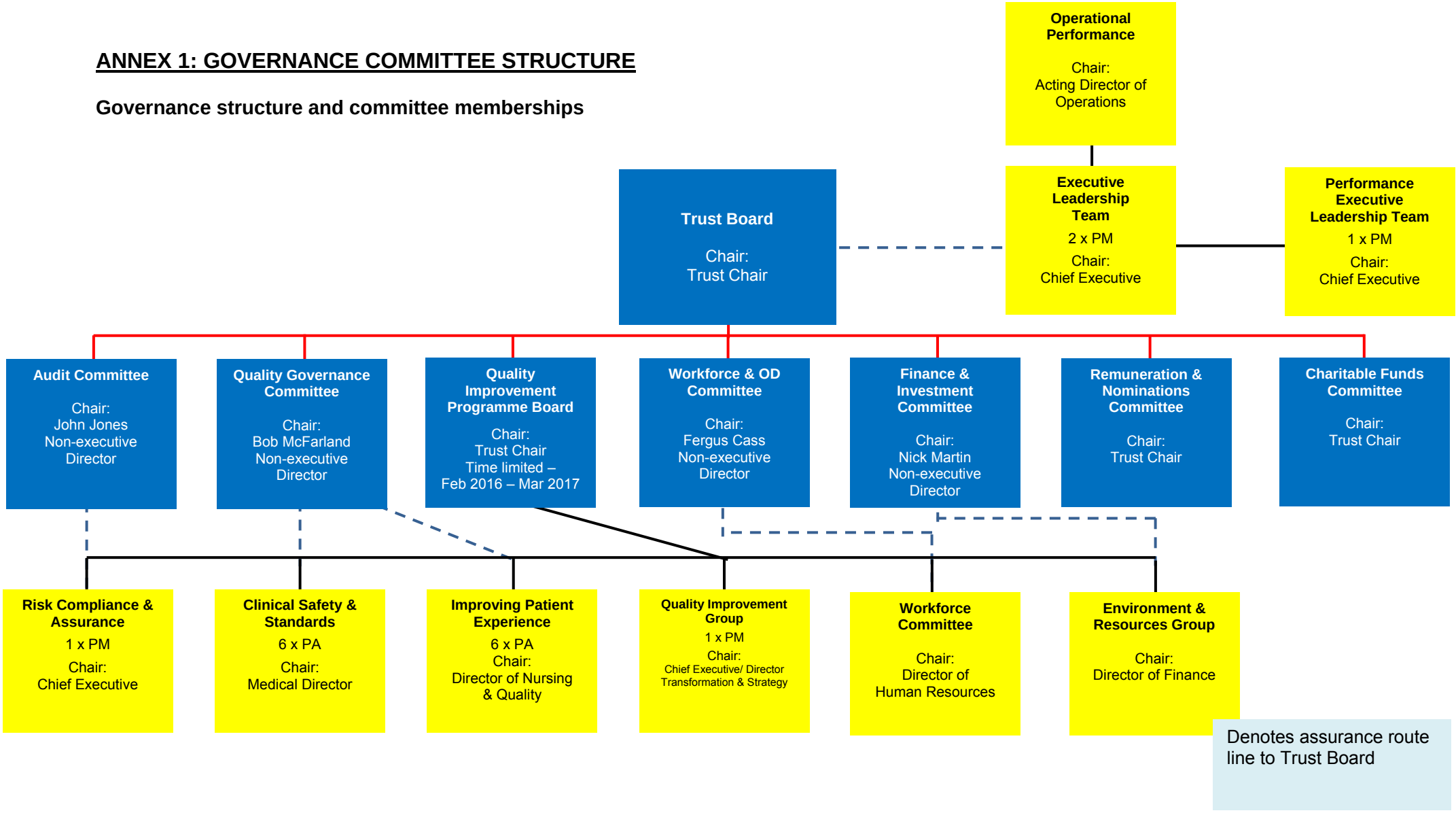
Signature:



Date: 02 June 2016

ANNEX 1: GOVERNANCE COMMITTEE STRUCTURE

Governance structure and committee memberships



ANNEX 2: COMMITTEE MEMBERSHIP 2015/16

Formal Trust Board committee	Chair	Current members
Audit committee	Non-Executive director, John Jones	John Jones (Non-Executive director) Theo de Pencier (Non-Executive director) Fergus Cass (Non-Executive director)
Charitable funds committee	Trust Chair, Richard Hunt CBE	Richard Hunt (Trust Chair) Andrew Grimshaw (Director of Finance and Performance)
Quality governance committee[1]	Non-Executive director, Bob McFarland	Jessica Cecil (Non-Executive director) Nick Martin (Non-Executive director) Fergus Cass (Non-Executive director) Fenella Wrigley (Acting and now substantive) (Medical Director) Zoe Packman (Director of Nursing and Quality) Mark Whitbread (Director of Paramedic Education and Development) to December 2015 Sandra Adams (Director of Corporate Affairs) Jason Killens (Director of Operations) to September 2015 Paul Woodrow (Acting Director of Operations) from October 2015
Finance & investment committee	Non-Executive director, Nick Martin	John Jones (Non-Executive director) Jessica Cecil (Non-Executive director) Theo de Pencier (Non-Executive director) Andrew Grimshaw (Director of Finance and Performance) Sandra Adams (Director of Corporate Affairs)
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
Quality Improvement Programme Board (time-limited committee with specific assurance role)	Trust Chair Richard Hunt, CBE	Fergus Cass (Non-Executive director) Bob McFarland (Non-Executive director) Fionna Moore, Chief Executive Karen Broughton, Director of Transformation, Strategy and Workforce Charlotte Gawne, Director of Strategic Communications

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

ANNEX 3: ATTENDANCE AT TRUST BOARD MEETINGS 2015/16

= attended a = apologies	2nd June 2015	28th July 2015	29th September 2015	24th November 2015	2nd February 2016	29th March 2016	Comments
Trust Board members (voting)							
Richard Hunt (Non-Executive Chair)	x	x	x	x	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	a	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	x	x	a	x	
Nick Martin (Non-Executive Director)	x	x	x	x	x	x	
Bob McFarland (Non-Executive Director)	x	x	x	x	a	x	
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	x	x	x	
John Jones (Non-Executive Director)	x	a	x	x	a	x	
Jason Killens (Director of Operations)	x	x					Left 25th September 2015
Zoe Packman (Director of Nursing and Quality)	x	x	x	x	x	x	
Paul Woodrow (Acting Director of Operations)				x	x	a	Appointed as Acting Director of Operations 28th September 2015
Fionna Moore (Chief Executive)	x	x	x	x	x	x	Acting CEO to 23rd July 2015 and substantive CEO from 24th July 2015
Fenella Wrigley (Acting Medical Director)	x	x	x	x	x	x	Appointed to substantive role on 16th March 2016
Non-voting							
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	x	x	x	
Karen Broughton (Director of Transformation, Strategy and Workforce)	x	x	x	x	x	x	
Paul Beal (Interim Director of HR)					x		Interim. Left the Trust in March 2016
Charlotte Gawne (Director of Strategic Communications)							Attending by invitation
Jill Patterson (Interim Director of Performance)				x	x	x	Appointed as interim in September 2015
Mark Whitbread (Director of Paramedic Education and Development)	x	x	x	x			Left the Trust in December 2015
Paul Woodrow (Director of Performance)	x	x	x				Appointed to acting Director of Operations from 28th September 2015
Andrew Watson (Chief Information Officer)						x	Appointed to the role on 14th March 2016

Peter McKenna (Deputy Director of Operations, South)						x	Deputising for the Director of Operations

ANNEX 4: ATTENDANCE AT QUALITY GOVERNANCE COMMITTEE MEETINGS 2015/16

x = attended a = apologies	14th April 2015	7th May 2015	14th July 2015	22nd September 2015	17th November 15	12th January 2016	15th March 2016	Comments
Quality Governance Committee members								
Bob McFarland (Non-Executive Chair)	x	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	x	x	x	x	a	x	
Nick Martin (Non-Executive Director)	x	a	x	x	a	a	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	x	x	
Fionna Moore (Chief Executive)	x		x			x	X	Attending by invitation
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	x	x	x	X	
Zoe Packman (Director of Nursing and Quality)	x	x	x	x	a	x	X	
Jason Killens (Director of Operations)	x							Left the Trust in September 15
Kevin Brown (Deputy Director of Operations)			x	x	x			Attending for Director of Operations
Paul Woodrow (Director of Performance)							x	Attending by invitation
Mark Whitbread (Director of Paramedic Education and Development)			x					Left the Trust in December 2015
Fenella Wrigley (Acting Medical Director)	x	x	x	x	x	x	x	
Jane Thomas	x					x		Attending for Director of Paramedic Education and Development
Briony Sloper					x	x	x	Attends for the Quality Report; deputised for ZP on 17th November 2015 and 12th January 2016
Tina Ivanov Deputy Director of Clinical Education and standards						x	x	Joined the Trust on 5th January 2016
Andrew Grimshaw Director of Finance and Performance							x	Attending by invitation

ANNEX 5: ATTENDANCE AT AUDIT COMMITTEE MEETINGS 2015/16

x = attended a = apologies	17th April 2015	21st May 2015	1st June 2015	7th September 2015	9th November 2015	15th February 2016	Comments
Audit Committee members							
John Jones (Non-Executive Director)	x	x	x	x	x	x	
Fergus Cass (Non- Executive Director)	x	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	x	x	x	x	
Attending							
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	x	x	a	
Fionna Moore (Chief Executive)						x	By invitation
Bob McFarland (Non-Executive director)		x			x	x	By invitation

ANNEX 6: ATTENDANCE AT STRATEGY REVIEW AND PLANNING COMMITTEE MEETINGS 2015/16

x = attended a = apologies	23rd April 2015	30th June 2015	27th October 2015	15th December 2015	23rd February 2016	Comments
Trust Board members (voting)						
Richard Hunt (Non-Executive Chair)	x	x	x	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	a	x	x	x	x	
John Jones (Non-Executive Director)	x	x	x	x	x	
Nick Martin (Non-Executive Director)	a	x	x		x	
Bob McFarland (Non-Executive Director)	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	x	x	
Jason Killens (Director of Operations)	x					Left in September 2015
Fionna Moore (Chief Executive)	x	x	x	x	X	
Paul Woodrow (Acting Director of Operations)			a	x	X	
Zoe Packman (Director Nursing and Quality)	x	x	x	x	a	
Fenella Wrigley (Acting Medical Director)	X	a	a	x	X	
Non-voting						
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	a	x	x	x	
Karen Broughton (Director of Transformation and Strategy)	x	x	x	x	x	
Charlotte Gawne (Director of Strategic Communications)	x	a	a	x	x	

Mark Whitbread (Director of Paramedic Education and Development)	a	x	x	a	x	
Paul Woodrow (Director of Performance)	x	x			x	Appointed as acting Director of Operations in September 15
Jill Patterson (Interim Director of Performance)					x	

ANNEX 7: ATTENDANCE AT FINANCE AND INVESTMENT COMMITTEE MEETINGS 2015/16

X = attended a = apologies	21st May 2015	23rd July 2015	24th September 2015	20th November 2015	21st January 2016	24th March 2016	Comments
Finance and Investment Committee members							
Nick Martin (Non-Executive Director)	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	a	a	x	x	a	x	
John Jones (Non-Executive Director)	x	x	x	x	a	x	
Theo de Pencier (Non-Executive Director)	x	x	x	x	x	a	
Attending							
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	a	x	a	x	x	
Andrew Grimshaw (Director of Finance and Performance)	x	x	x	x	x	x	
Paul Woodrow (Director of Performance*)	x	x	x				By invitation

*appointed as Acting Director of Operations in September 2015

ANNEX 8: NEW RISKS ADDED TO THE TRUST RISK REGISTER IN THE PERIOD 2015 /2016

Risk ID	Headline Risk
441	There is a risk that there may be insufficient vehicle numbers to meet demands. Impacting on the Trust's ability to provide adequate vehicle numbers to support operational demand impacting on operational performance for the Trust
442	There is a risk that there may be insufficient range and volume of equipment to meet demands. Staff will not have equipment required to provide appropriate patient care
443	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care
444	There is a risk that the equipment for frontline vehicles may not be in an effective condition. Staff will not have equipment required to provide appropriate patient care
445	Risk of exposure to Category 4 infectious disease organisms as well as other infectious diseases of high consequence, resulting in potential adverse consequence to the health of LAS staff and that of the general public to whom they are responding.
446	There is a risk that support service staff may not receive statutory and mandatory training appropriate to their role, required to comply with legislation, meet CQC compliance and the Trust‟s TNA policy.
447	There is a risk that the operational management restructure will create prolonged uncertainty amongst managers, potentially destabilising the operational and clinical environment which is already under pressure due to other organisational factors.
448	There is a risk that the Trust IT networks are unsecure and that parties outside of LA could gain access to data, compromise data or systems or affect the performance of the Trust.
449	There is a risk that the Trusts IT infrastructure and applications would be severely compromised by external parties undertaking a cyber-attack on LAS.
450	Duty AOM shifts will remain uncovered due to the decline in numbers of suitably trained Managers being available to work on the AOM Rota
451	There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient‟s safety whilst calls are being held.
452	There is a risk that the 2015/16 Improvement Programme does not achieve the agreed delivery milestones or the anticipated impact on A8 performance. This may result in the delayed release of funding as agreed in the transformation business case, which will have an impact on: * the delivery of improvement activity; * reputational damage to the Trust; and * activity to improve experiences for the workforce.
453	There is a risk that funding for the improvement programme activities is delayed or reduced as a result not achieving the agreed commissioner performance trajectories or gateways (overall programme or projects).
454	There is a risk that the Improvement Programme objectives may not fully achieve the agreed levels within the expected timescales. This may be seen across a number of the relevant projects This will put at risk achievement of the Trust A8 performance trajectory
455	There is a risk that we may not be able to convey all patients detained under section 136 MHA (1983). This leads to a lack of physical health screening for these patients leading which may affect the care they receive
456	There is a risk that staff may fail to identify physical health and/ or organic causes of mental health presentations which may lead to a delay in patients receiving the right care at the right time.
457	There is a risk that there may be insufficient staff to manage the three key functions of the clinical hub (1. hear and treat 2. crew queries 3. surge level). Impact will be increased demand on operational frontline with likely increase to ED departments.
458	There is a risk that due to our inability to link safeguarding referrals and identify previous referrals made to Social Services, this will impact on our ability to escalate any continued safeguarding concerns identified, which will impact on patient care.
459	There is a risk that the Trust is unable to meet statutory requirements of providing safeguarding supervision, by trained professionals. This will result in an impact on staff

	performance and welfare and the Trust will not be compliant with the Children Act and Care Act pertaining to safeguarding.
460	The TDA expects all NHS trusts to achieve financial balance in 2016/17, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.
461	Significant time lag (in excess of six months) in the reporting of medicines usage data captured by Management Information during the data entry and validation of PRFs may lead to LAS not being able to track usage of medicines by complex stations/ sectors/ practitioner group, call signs etc.
462	There is a risk that the organisation does not accurately and effectively report incidents that have resulted in moderate, severe harm or death to the patient. A failure to do so will prevent the organisation accurately reporting to the NRLS.
463	Safeguarding referrals will suffer. They will be delayed, mis-referred etc; also information governance will be impacted, because EBS is unable to offer a timely and secure onward referral process. The risk impacts those patients and others who are the subject of referrals and to whom we owe statutory duties of care.

REMUNERATION AND STAFF REPORT

Remuneration

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

The Remuneration and Nominations 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 2 to 5**.**

Banded Remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2015/16 was in the range of £145,001 to £150,000. The pay multiplier, based on annualised salary, was 5.36 times the median remuneration of the workforce, which was £40,589. In 2014/15, the banded remuneration of the highest paid director £130,000 to £135,000. The pay multiplier, based on annualised salary, was 5.08 times the median remuneration of the workforce, which was £40,102.

In 2015/16, 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:

- Substantive appointment of CEO in 2015/16
- Limited growth in average cost of frontline staff due to high levels of recruitment of newly qualified staff.

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 2015/16

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Richard Hunt, Chairman	£20,001-£25,000	£0	£0	£0	£0	£20,001-£25,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
*** Fionna Moore, Chief Executive (Acting to 23 July 2015)	£145,001-£150,000	£4,700	£0	£0	£0-£2,500	£150,001-£155,000
Andrew Grimshaw, Finance Director	£125,001-£130,000	£0	£0	£0	£20,001-£22,500	£150,001-£155,000
Jason Killens, Director of Operations (to the 25 September 2015)	£50,001-£55,000	£1,900	£0	£0	£0-£2,500	£55,001-£60,000
Paul Woodrow, Director of Operations (Acting Director of Operations from 28 September 2015)	£50,001-£55,000	£4,900	£0	£0	£22,501-£25,000	£80,001-£85,000
** Fenella Wrigley, Medical Director (Acting to 29 February 2016)	£95,001-£100,000	£4,000	£0	£0	£77,501-£80,000	£175,001-£180,000
** Zoe Packman, Director of Nursing and Quality (Acting)	£75,001-£80,000	£0	£0	£0	£10,001-£12,500	£85,001-£90,000

The figures shown under the heading „expense payments" refer to the provision of lease car.
* The following director left the Trust: Jason Killens on 25th September 2015.
** The following director Zoe Packman was on secondment from Croydon Health Services NHS Trust until November 2015. Fenella Wrigley was on secondment from Barts Healthcare NHS Hospital until February 2016.
*** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works full-time for the London Ambulance Service as Medical Director until December 2015.

Remuneration 2014/15

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
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fionna Moore, Acting Chief Executive (from 24 January 2015)	£120,001-£125,000	£0	£0	£0	£0-£2,500	£120,001-£125,000
Andrew Grimshaw, Finance Director	£130,001-£135,000	£0	£0	£0	£2,501-£5,000	£135,001-£140,000
Jason Killens, Director of Operations	£110,001-£115,000	£2,000	£0	£0	£32,501-£35,000	£145,001-£150,000
Fenella Wrigley, Acting Medical Director (from 29 January 2015)	£10,001-£15,000	£0	£0	£0	£57,501-£60,000	£65,001-£70,000
Zoe Packman, Acting Director of Nursing And Quality (from 24 November 2014)	£20,001-£25,000	£0	£0	£0	£20,001-£22,500	£45,001-£50,000

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase as at pension age (bands of £2,500)	Lump sum as at pension aged related to real increase in pension (bands of £2,500)	Total accrued pension as pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension as at pension age as related to accrued pension at 31 March 2016 (bands of £5,000)	Cash equivalent transfer value at 31 March 2016	Cash equivalent transfer value at 31 March 2015	Real increase in cash equivalent transfer value	Employers contribution to stakeholder pension To nearest £100
Richard Hunt, Chairman	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Robert McFarland, Non-Executive Director	**	**	**	**	**	**	**	
Nicholas Martin, Non-Executive Director	**	**	**	**	**	**	**	
John Jones, Non-Executive Director	**	**	**	**	**	**	**	
Fergus Cass, Non-Executive Director	**	**	**	**	**	**	**	
Theo de Pencier, Non-Executive Director	**	**	**	**	**	**	**	
*Fionna Moore, Chief Executive (Acting to 23 July 2015)	*	*	*	*	*	*	*	
Andrew Grimshaw, Director of Finance	£0-£2,500	£0-£2,500	£30,001-£35,000	£95,001-£100,000	£579,079	£550,988	£21,479	
Jason Killens, Director of Operations (to the 25 September 2015)	£0-£2,500	£0-£2,500	£10,001-£15,000	£35,001-£40,000	£188,374	£359,360	£0	
Fenella Wrigley, Acting Medical Director (acting to 29 February 2016)	£2,501-£5,000	£5,001-£7,500	£25,001-£30,000	£80,001-£85,000	£454,318	£381,544	£68,195	
Zoe Packman, Acting Director of Nursing and Quality	£0-£2,500	£2,501-£5,000	£40,001-£45,000	£125,001-£130,000	£775,034	£741,296	£24,842	
Paul Woodrow, Acting Director Operations (from 28 September 2015)	£0-£2,500	£0-£2,500	£25,001-£30,000	£85,001-£90,000	£527,424	£479,643	£21,416	

* Fionna Moore has opted out of the NHS pension scheme.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's 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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, 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

	2015-16			2014-15		
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
Less than £10,000	0	0	0	1	1	2
£10,000-£25,000	0	1	1	0	1	1
£25,001-£50,000	0	0	0	3	1	4
£50,001-£100,000	0	0	0	0	1	1
£150,001-£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**0**	**1**	**1**	4	4	8
Total resource cost (£000s)	**0**	**21**	**21**	127	127	254

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

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Reporting of other compensation schemes – Exit packages

	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirements contractual costs	1	21
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring MHT approval	0	0
Total	**1**	**21**

As a single exit package 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 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

Off-Payroll engagements - Table 2

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, 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 2015 and 31 March 2016	1
Number of new engagements which include contractual clauses giving the London Ambulance Service NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number of new engagements for whom assurance has been requested	1
Of which:	
Assurance has been received	1
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	
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	0

STAFF REPORT

Average Staff Numbers

The average number of staff has increased over last year 4,756 (2014/15 4,531) as the trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	2	2	0
Ambulance Service	2,428	2,373	55
Administration and estates	1,346	1,243	103
Healthcare assistants and other support staff	944	944	0
Nursing, midwifery and heath visiting staff	36	13	23
Total	4,756	4,575	181

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

Staff Composition

At the end of March 2016, we had a workforce of 5,089 staff, made up of 2,821 men and 2,268 women. This was broken down as follows:

	Total	Female	Male
Directors	15	7	8
Senior Managers	453	157	296
Employees	4,621	2,104	2,517

Total	5,089	2,268	2,821

Over the course of the year, a total of 581 people left the service – a turnover rate of 12.2 per cent, compared to 14.3 per cent in 2014/15.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 198 paramedics left during 2015/16.

Staff Sickness

The average workings days lost in 2015/16 was 12.60 (2014/15 14.52). The data is based on calendar years January 2015 (2014) to December 2015 (2014).

Staff Policies

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

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

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

- patients and customers receive fair and equal access to our healthcare service
- everyone is treated with dignity and respect
- 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.

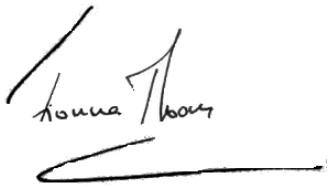
Expenditure on Consultancy

In 2015/16 the trust spent £1.7m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer: Fionna Moore, Chief Executive

Organisation: London Ambulance Service NHS Trust

Signature:



Date: 02 June 2016

2015/16 INTRODUCTION TO THE ANNUAL ACCOUNTS

Financial performance

2015/16 saw major recurrent investment in the London Ambulance Service by London Clinical Commissioning Groups (CCGs) in support of a programme of performance improvement. This investment was to increase capacity, recruit additional staff and improve operational working practices. This investment was designed to replace non-recurrent "resilience" funding that had been made available to the service on an annual basis over the last 4-5 years. The recurrent investment made, £20.7m was a significant commitment for CCGs at the start of 2015/16 given the wide range of demands across London.

For the financial year 2015/16 the Trust reported a deficit of £4.4m. The Trust had planned to report a £4.4m deficit following agreement with the TDA in quarter 4. The previous plan was a £9m deficit. The over spend was driven by non-recurrent costs associated with the performance improvement programme. The following table summarises the key elements of the financial performance of the Trust in 2015/16

	Plan £m	Actual £m	Variance £m
Income	316.4	320.0	3.6
Expenditure	308.1	307.5	0.6
EBITDA	8.3	12.5	4.2
Deficit	(9.0)	(4.4)	4.6
Capital Investment	10.2	9.2	1.0
External Financing Limit	8.6	(10.0)	18.6
Cash	11.8	20.2	8.4

In line with all NHS organisations LAS was required to identify efficiencies. In total £9m was identified and delivered in 2015/16. Key areas of improvement related to the cost of fuel, contract renegotiation and renewal and management of non-frontline staffing costs.

The Trust continued to invest in new equipment, spending in excess of £9.2m on new vehicles to help improve the age profile of the fleet, IMT system renewal and improvement and additional clinical equipment. The Trust also completed a business case for a further 140 new ambulances for delivery across 2016/17.

NHS Trusts have a number of financial duties. This section of the annual report outlines the financial performance of the Trust for the financial year ended 31 March 2016 and the results outlined in this section relate to the full 12 month period of 1 April 2015 to 31 March 2016. A copy of the full statutory audited accounts is included in this annual report together with a glossary of terms to assist the reader in interpreting the accounts.

Financial duties review

Break-even duty

NHS trusts have a regulatory duty to break-even in each and every financial year. The Trust had an agreed plan for a deficit of £4.4m in 2015/16. As this was an approved overspend this Trust is seen to have achieved the in-year breakeven duty.

Despite reporting a deficit in year the Trust‟s cumulative break-even performance remains in surplus, totalling £9.9m. While working to improve its financial position in 2016/17 it is planning for another deficit in 2016/17, although at a reduced level. While this will reduce the cumulative surplus further it will not take the Trust into a cumulative deficit.

External financial limit

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

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

The Trust was expected to spend £1.6m less than it generated in 2015/16. The trust achieved its EFL target of £10.0m.

Capital cost absorption duty

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

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

Capital Resourcing Limit (CRL)

The Capital Resourcing Limit (CRL) is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that resources allocated by the government for capital spending are used for capital, rather than to support revenue budgets. All NHS bodies have a capital resource limit.

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

The Trust spent £9.2million on a range of projects, including ambulances (54 delivered in year) and fast response cars (60 new cars are in procurement), new technology projects and a range of projects to improve clinical equipment and the estate. Overall, the Trust under spent by £1.0m against its capital resource limit, which it is permitted to do. The capital programme was funded internally (no loans or external support from the DH). The underspend on the capital programme will be carried forward into the new year capital programme.

Apply the Better Payment Practice Code

This regulatory duty requires NHS Trusts to pay all supplier invoices within 30 days. The Trust paid 87% of its NHS trade invoices respectively within 30 days; this is below the 95% target set by the Department of Health.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 8.6 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial plan 2016/17

The Trust has formally submitted a plan for the coming financial year, 2016/17 that takes into account planned contracted income levels and expenditure requirements. These plans have been set in line with guidance from the DH, TDA and Monitor as well as discussions with clinical commissioning groups across London. The plan is set to deliver a deficit of £5.5 million.

Financial risk

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

International Financial Reporting Standards (IFRS)

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

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2016 for all land and buildings. The net gain on revaluation was £10.1 million and the total impairments were £0.1 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 £5.4 million for the current financial year (£4.7 million in 2014/15).

Subsequent events after the balance sheet date

The Trust has not identified any important event occurring after the financial year end, 31st March 2016, that has a material effect on the 2015/16 financial statements as presented.

Other information

Ernst Young LLP were the Trusts external auditor for the year ended 31st March 2016. The Trust paid £59,466 (£66,000 in 2014/15) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our Audit Committee. Ernst Young LLP has not undertaken any non-audit work for the Trust during the year ended 31st March 2016.

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

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

The London Ambulance Service is a NHS trust established under the National Health Service Act 2006. The Secretary of State for Health has directed that the financial statements of the NHS trusts will meet the accounting requirements of the NHS Trusts Manual for Accounts, which will be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2015/16 NHS Manual for Accounts issued by the Department of Health.

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

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

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

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

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

NB: sign and date in any colour ink except black

Signed:

Chief Executive

Date: 02 June 2016

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.

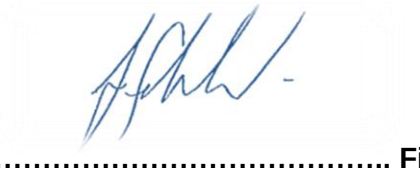
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They 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

nb: sign and date in any colour ink except black

……02 June 2016 ……Date ……Chief Executive



……02 June 2016 ……Date …….. Financial Director

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

Head of Financial Services
Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

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

We have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers" Equity, the Statement of Cash Flows and the related notes 1 to 34. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

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

- the table of salaries and allowances of senior managers and related narrative notes on page 54;
- the table of pension benefits of senior managers and related narrative notes on page 56;
- the tables of exit packages and related notes on page 58;
- the analysis of staff numbers and related notes on page 62; and
- the table of pay multiples and related narrative notes on page 52.

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors" Responsibilities in respect of the Accounts, set out on page 70, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board"s Ethical Standards for Auditors.

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

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

Scope of the audit of the financial statements

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

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of London Ambulance Service NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority"s guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in these respects

Certificate

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

Janet Dawson
for and on behalf of Ernst & Young LLP, London
2 June 2016

London Ambulance Service NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	8.1	**(230,771)**	(217,034)
Other operating costs	6	**(89,316)**	(97,284)
Revenue from patient care activities	4	**315,487**	313,925
Other operating revenue	5	**4,505**	10,127
Operating surplus/(deficit)		**(95)**	9,734
Investment revenue	10	**122**	178
Other gains and (losses)	11	**44**	40
Finance costs	12	**(139)**	(282)
Surplus/(deficit) for the financial year		**(68)**	9,670
Public dividend capital dividends payable		**(3,966)**	(3,390)
Transfers by absorption - gains		**0**	46
Net Gain/(loss) on transfers by absorption		**0**	46
Retained surplus/(deficit) for the year		**(4,034)**	6,326

Other Comprehensive Income

	2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve	**87**	199
Net gain/(loss) on revaluation of property, plant & equipment	**10,106**	8,179
Total Other Comprehensive Income	**10,193**	8,378
Total Comprehensive Income for the year	**6,159**	14,704

Financial performance for the year

Retained surplus/(deficit) for the year	**(4,034)**	6,326
Impairments (excluding IFRIC 12 impairments)	**(377)**	(237)
Adjustments in respect of donated gov't grant asset reserve	**6**	5
Adjustment re absorption accounting	**0**	(46)
Adjusted retained surplus/(deficit)	**(4,405)**	6,048

There is a statutory requirement for NHS trusts to break even taking one year with another. Details of the break even duty is given in note 33.1.

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(Deficit), but adjusted for the following-
a) impairments to land & buildings due to change in market prices. An impairment charge is not considered part of the organisation's operating position.
b) Donated assets are now shown as income and are not considered part of the organisation's operating position.

The notes on pages 79 to 107 form part of this account.

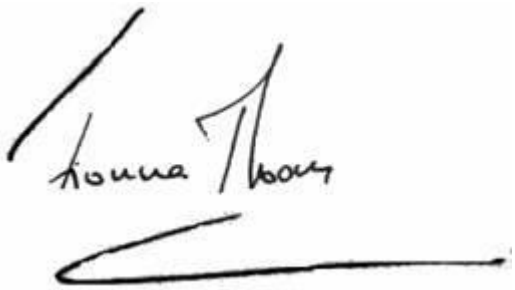
Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	13	**143,403**	134,668
Intangible assets	14	**8,704**	10,634
Total non-current assets		**152,107**	145,302
Current assets:			
Inventories	18	**2,999**	3,026
Trade and other receivables	19.1	**14,461**	33,813
Cash and cash equivalents	20	**20,209**	14,701
Sub-total current assets		**37,669**	51,540
Non-current assets held for sale	21	**101**	101
Total current assets		**37,770**	51,641
Total assets		**189,877**	196,943
Current liabilities			
Trade and other payables	22	**(33,495)**	(39,303)
Provisions	27	**(4,609)**	(7,357)
Borrowings	23	**0**	(2)
Total current liabilities		**(38,104)**	(46,662)
Net current assets/(liabilities)		**(334)**	4,979
Total assets less current liablilities		**151,773**	150,281
Non-current liabilities			
Provisions	27	**(9,796)**	(9,963)
Borrowings	23	**(107)**	(107)
Total non-current liabilities		**(9,903)**	(10,070)
Total assets employed:		**141,870**	140,211
FINANCED BY:			
Public Dividend Capital		**58,016**	62,516
Retained earnings		**28,120**	30,746
Revaluation reserve		**56,153**	47,368
Other reserves		**(419)**	(419)
Total Taxpayers' Equity:		**141,870**	140,211

The notes on pages 79 to 107 form part of this account.

The financial statements on pages 74 to 107 were approved by the Board on 31 May 2016 and signed on its behalf by:

Chief Executive: Date: 02 June 2016



Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**62,516**	**30,746**	**47,368**	**(419)**	**140,211**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(4,034)			**(4,034)**
Net gain / (loss) on revaluation of property, plant, equipment			10,106		**10,106**
Impairments and reversals			87		**87**
Transfers between reserves		1,408	(1,408)	0	**0**
Reclassification Adjustments					
Permanent PDC repaid in year	(4,500)				**(4,500)**
Net recognised revenue/(expense) for the year	**(4,500)**	**(2,626)**	**8,785**	**0**	**1,659**
Balance at 31 March 2016	**58,016**	**28,120**	**56,153**	**(419)**	**141,870**
Balance at 1 April 2014	**62,516**	**22,675**	**40,735**	**(419)**	**125,507**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		6,326			6,326
Net gain / (loss) on revaluation of property, plant, equipment			8,179		8,179
Impairments and reversals			199		199
Transfers between reserves		1,745	(1,745)	0	0
Net recognised revenue/(expense) for the year	**0**	**8,071**	**6,633**	**0**	**14,704**
Balance at 31 March 2015	**62,516**	**30,746**	**47,368**	**(419)**	**140,211**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(95)**	9,734
Depreciation and amortisation	6	**12,998**	12,101
Impairments and reversals	15	**(377)**	(237)
Interest paid		**0**	(108)
PDC Dividend (paid)/refunded		**(3,692)**	(3,556)
(Increase)/Decrease in Inventories		**27**	472
(Increase)/Decrease in Trade and Other Receivables		**19,183**	(10,985)
Increase/(Decrease) in Trade and Other Payables		**(1,806)**	11,466
Provisions utilised		**(2,098)**	(1,201)
Increase/(Decrease) in movement in non cash provisions		**(817)**	4,657
Net Cash Inflow/(Outflow) from Operating Activities		**23,323**	22,343
Cash Flows from Investing Activities			
Interest Received		**121**	199
(Payments) for Property, Plant and Equipment		**(12,553)**	(9,321)
(Payments) for Intangible Assets		**(927)**	(615)
Proceeds of disposal of assets held for sale (PPE)		**46**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(13,313)**	(9,737)
Net Cash Inform/(outflow) before Financing		**10,010**	12,606
Cash Flows from Financing Activities			
Permanent PDC Repaid		**(4,500)**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**0**	(4,343)
Net Cash Inflow/(Outflow) from Financing Activities		**(4,500)**	(4,343)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**5,510**	8,263
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**14,699**	6,436
Cash and Cash Equivalents (and Bank Overdraft) at year end		**20,209**	14,699

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

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

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust Charitable Funds are not considered material and therefore not consolidated with the Trust financial statements for 2015-16.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

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

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset Valuations

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

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. The estimated economic lives are disclosed in note 1.11 and the carrying values of property, plant and equipment and intangible assets in notes 13.1 and 14.1 respectively.

Provisions

Provisions are made for liabilities that are uncertain in amount. These include provisions for the cost of pensions relating to other staff, legal claims, restructuring and other provisions. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. The carrying values of provisions are shown in note 27.

NOTES TO THE ACCOUNTS

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

Annual Leave Accrual
The accrual is based on management's estimation of untaken leave as at 31 March 2016. The carrying value of the accrual is £5.37m within note 22 under Non-NHS accruals and deferred income.

Injury Cost Recovery Scheme Accrual
The Trust receives income from the NHS injury cost recovery scheme for the recovery of ambulance journey costs relating to road traffic accidents. Accruals are made for receivables that are uncertain in amount. The receivables are based on "management estimates supported by the number of cases" supplied by hospitals. The carrying value of the receivables is £3.1m within note 19.1 under non-NHS accrued income.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of *length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

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

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.8 Other expenses

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

1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to The Trust.
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

NOTES TO THE ACCOUNTS

Land and buildings used for The Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

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

1.10 Intangible assets

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

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

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

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

NOTES TO THE ACCOUNTS

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

The estimated lives are as follows:

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

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

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

1.12 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale

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

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

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

1.15 Leases

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

The trust as lessee

NOTES TO THE ACCOUNTS

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

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

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

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

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

1.16 Inventories

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

1.17 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.18 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of (1.55)% in real terms (1.37% for employee early departure obligations).

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

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

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 27.

1.20 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Contingencies

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

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

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

1.22 Financial assets

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

NOTES TO THE ACCOUNTS

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

NOTES TO THE ACCOUNTS

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

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

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

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

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

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

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

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

1.26 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

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

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

1.27 Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

NOTES TO THE ACCOUNTS

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had [NHS bodies] not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.28 Subsidiaries

The Trust Charitable Funds are not considered material and are therefore not consolidated with the Trust financial statements for 2015-16.

1.29 Other reserve

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

1.30 Heritage assets

The London Ambulance Service NHS Trust Museum has a collection of vintage radio equipment, memorabilia from both World Wars and a photographic and document archive. There is also a collection of more than 20 vintage vehicles. The museum is currently closed to members of the public. The value of these assets cannot be obtained at a cost commensurate with the benefits to the users of the financial statements and therefore have not been included in the Statement of Financial Position.

1.31 Research and Development

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

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

● IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating segments

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

3. Income generation activities

The Trust undertook income generation activities of £52k (2014/15 £54k) during the financial year.

4. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**72**	119
NHS England	**1,652**	9,918
Clinical Commissioning Groups	**303,970**	299,602
Foundation Trusts	**57**	76
Department of Health	**508**	0
NHS Other (including Public Health England and Prop Co)	**1,722**	4
Additional income for delivery of healthcare services	**4,500**	0
Non-NHS:		
Local Authorities	**77**	14
Injury costs recovery	**1,365**	1,391
Other	**1,564**	2,801
Total Revenue from patient care activities	**315,487**	313,925

5. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**346**	546
Patient transport services	**3,240**	5,953
Education, training and research	**867**	3,574
Income generation (Other fees and charges)	**52**	54
Total Other Operating Revenue	**4,505**	10,127
Total operating revenue	**319,992**	324,052

6. Operating expenses

	2015-16 £000s	2014-15 £000s
Trust Chair and Non-executive Directors	**60**	60
Supplies and services - clinical	**6,387**	8,039
Supplies and services - general	**2,103**	3,349
Consultancy services	**1,691**	4,316
Establishment	**11,028**	9,666
Transport	**32,380**	33,643
Business rates paid to local authorities	**2,205**	1,763
Premises	**14,813**	14,979
Hospitality	**1**	0
Insurance	**980**	812
Legal Fees	**(333)**	(71)
Impairments and Reversals of Receivables	**(1,279)**	881
Depreciation	**10,329**	9,533
Amortisation	**2,669**	2,568
Impairments and reversals of property, plant and equipment	**(377)**	(237)
Internal Audit Fees	**85**	81
Audit fees	**68**	66
Other auditor's remuneration	**0**	1
Clinical negligence	**1,413**	917
Research and development (excluding staff costs)	**58**	0
Education and Training	**2,438**	2,588
Change in Discount Rate	**(74)**	530
Other	**2,671**	3,800
Total Operating expenses (excluding employee benefits)	**89,316**	97,284
Employee Benefits		
Employee benefits excluding Board members	**230,083**	216,280
Board members	**688**	754
Total Employee Benefits	**230,771**	217,034
Total Operating Expenses	**320,087**	314,318

7. Operating Leases

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

7.1. London Ambulance Service NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**6,720**	6,642
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**6,720**	6,642
Payable:					
No later than one year	4	2,342	2,117	**4,463**	5,893
Between one and five years	2	6,901	4,106	**11,009**	8,511
After five years	0	4,872	547	**5,419**	4,755
Total	**6**	**14,115**	**6,770**	**20,891**	19,159
Total future sublease payments expected to be received:				0	0

8. Employee benefits and staff numbers

8.1. Employee benefits

	2015-16 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	195,172	184,645	10,527
Social security costs	15,837	15,837	0
Employer Contributions to NHS BSA - Pensions Division	21,602	21,602	0
Other pension costs	0	0	0
Termination benefits	(1,697)	(1,697)	0
Total employee benefits	**230,914**	**220,387**	**10,527**
Employee costs capitalised	**143**	**0**	**143**
Gross Employee Benefits excluding capitalised costs	**230,771**	**220,387**	**10,384**

Employee Benefits - Gross Expenditure 2014-15	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Salaries and wages	181,042	172,548	8,494
Social security costs	14,400	14,400	0
Employer Contributions to NHS BSA - Pensions Division	20,357	20,357	0
Termination benefits	1,235	1,235	0
TOTAL - including capitalised costs	217,034	208,540	8,494
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	217,034	208,540	8,494

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

8.2. Staff Numbers

	2015-16 Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	**2**	2	0	2
Ambulance staff	**2,428**	2,373	55	2,410
Administration and estates	**1,346**	1,243	103	1,244
Healthcare assistants and other support staff	**944**	944	0	846
Nursing, midwifery and health visiting staff	**36**	13	23	29
TOTAL	**4,756**	**4,575**	**181**	4,531
Of the above - staff engaged on capital projects	**1**	0	1	0

8.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	56,015	63,166
Total Staff Years	4,443	4,351
Average working Days Lost	12.61	14.52

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**7**	8
	£000s	£000s
Total additional pensions liabilities accrued in the year	**439**	704

8.4. Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	0	0	**0**	**0**	0	0
£10,000-£25,000	0	0	1	20,672	**1**	**20,672**	0	0
£25,001-£50,000	0	0	0	0	**0**	**0**	0	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**0**	**0**	**1**	**20,672**	**1**	**20,672**	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	8,931	1	9,311	**2**	**18,242**	0	0
£10,000-£25,000	0	0	1	16,544	**1**	**16,544**	0	0
£25,001-£50,000	3	118,083	1	40,723	**4**	**158,806**	0	0
£50,001-£100,000	0	0	1	60,000	**1**	**60,000**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**4**	**127,014**	**4**	**126,578**	**8**	**253,592**	**0**	**0**

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

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

8.5. Exit packages - Other Departures analysis

	2015-16		2014-15	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	1	21	0	0
Contractual payments in lieu of notice	0	0	3	86
Exit payments following Employment Tribunals or court orders	0	0	1	41
Total	1	21	4	127
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	1	35

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

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

8.6. Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

9. Better Payment Practice Code

9.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**59,493**	**87,324**	56,336	82,145
Total Non-NHS Trade Invoices Paid Within Target	**51,539**	**69,632**	50,905	73,348
Percentage of NHS Trade Invoices Paid Within Target	**86.63%**	**79.74%**	90.36%	89.29%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**434**	**3,563**	410	**3,263**
Total NHS Trade Invoices Paid Within Target	**310**	**2,308**	316	**2,165**
Percentage of NHS Trade Invoices Paid Within Target	**71.43%**	**64.78%**	77.07%	66.35%

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

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

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**1**	0
Total	**1**	0

10. Investment Revenue

	2015-16 £000s	2014-15 £000s
Interest revenue		
Bank interest	**105**	131
Other loans and receivables	**17**	47
Subtotal	**122**	178
Total investment revenue	**122**	178

11. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**44**	40
Total	**44**	40

12. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**0**	108
Interest on late payment of commercial debt	**1**	0
Total interest expense	**1**	108
Provisions - unwinding of discount	**138**	174
Total	**139**	282

13.1. Property, plant and equipment

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

Revaluation Reserve Balance for Property, Plant & Equipment

	Land Buildings		Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	26,667	20,701	0	0	0	0	0	0	**47,368**
Movements (specify)	4	8,781	0	0	0	0	0	0	**8,785**
At 31 March 2016	**26,671**	**29,482**	**0**	**0**	**0**	**0**	**0**	**0**	**56,153**

Additions to Assets Under Construction in 2015-16

Buildings excl Dwellings	0	0	0	17	0	0	0	0
Plant & Machinery - Transport Equipment & IT	0	0	0	2,000	0	0	0	0
Balance as at YTD	**0**	**0**	**0**	**2,017**	**0**	**0**	**0**	**0**

13.2. Property, plant and equipment prior-year

2014-15	Land Buildings	excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's		£000's	£000's		£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	47,371	50,330	0	3,762	17,340	37,415	15,905	66	**172,189**
Additions of Assets Under Construction	0	0	0	2,913	0	0	0	0	**2,913**
Additions Purchased	0	1,816	0	0	1,381	6,671	1,277	17	**11,162**
Reclassifications	0	121	0	(3,271)	564	2,333	231	0	**(22)**
Reclassifications as Held for Sale and Reversals	(63)	(39)	0	0	0	0	0	0	**(102)**
Disposals other than for sale	0	(49)	0	0	(4,628)	(3,894)	(4,939)	0	**(13,510)**
Revaluation	4,236	1,081	0	0	0	0	0	0	**5,317**
Impairments/negative indexation charged to reserves	0	(110)	0	0	0	0	0	0	**(110)**
Reversal of Impairments charged to reserves	192	117	0	0	0	0	0	0	**309**
At 31 March 2015	**51,736**	**53,267**	**0**	**3,404**	**14,657**	**42,525**	**12,474**	**83**	**178,146**
Depreciation									
At 1 April 2014	0	0	0	0	10,885	28,353	11,258	66	**50,562**
Reclassifications	0	0	0	0	22	(22)	(22)	0	**(22)**
Reclassifications as Held for Sale and Reversals	0	(1)	0	0	0	0	0	0	**(1)**
Disposals other than for sale	0	(49)	0	0	(4,614)	(3,894)	(4,938)	0	**(13,495)**
Revaluation	0	(2,862)	0	0	0	0	0	0	**(2,862)**
Impairments/negative indexation charged to operating expenses	0	38	0	0	0	0	0	0	**38**
Reversal of Impairments charged to operating expenses	(18)	(257)	0	0	0	0	0	0	**(275)**
Charged During the Year	0	3,135	0	0	1,816	2,529	2,053	0	**9,533**
At 31 March 2015	**(18)**	**4**	**0**	**0**	**8,109**	**26,966**	**8,351**	**66**	**43,478**
Net Book Value at 31 March 2015	**51,754**	**53,263**	**0**	**3,404**	**6,548**	**15,559**	**4,123**	**17**	**134,668**
Asset financing:									
Owned - Purchased	51,754	53,263	0	3,404	6,548	15,530	4,123	17	**134,639**
Owned - Donated	0	0	0	0	0	29	0	0	**29**
Total at 31 March 2015	**51,754**	**53,263**	**0**	**3,404**	**6,548**	**15,559**	**4,123**	**17**	**134,668**

13.3. (cont). Property, plant and equipment

A professional revaluation was undertaken on all land and buildings at 31 March 2016

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

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

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

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

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

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

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

13.4 Gross carrying value of fully depreciated assets still in use:

The gross carrying value of fully depreciated assets still in use:	**£m**
Furniture & fittings	0.1
Transport equipment	16.8
Plant and Machinery	2.1
Information technology	6.0
	25.0

14. Intangible non-current assets

14.1. Intangible non-current assets

2015-16

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

Revaluation reserve balance for intangible non-current assets

						£000's
At 1 April 2015	0	0	0	0	0	**0**
At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**

14.2. Intangible non-current assets prior year

2014-15

	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	15,892	2,366	0	0	316	18,574
Additions - purchased	160	181	0	0	519	860
Reclassifications	33	160	0	0	(171)	22
Disposals other than by sale	(172)	(250)	0	0	0	(422)
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	46	0	0	0	46
At 31 March 2015	15,913	2,503	0	0	664	19,080
Amortisation						
At 1 April 2014	4,596	1,682	0	0	0	6,278
Reclassifications	(8)	30	0	0	0	22
Disposals other than by sale	(172)	(250)	0	0	0	(422)
Charged during the year	2,230	338	0	0	0	2,568
At 31 March 2015	6,646	1,800	0	0	0	8,446
Net book value at 31 March 2015	9,267	703	0	0	664	10,634
Net book value at 31 March 2015 comprises:						
Purchased	9,267	703	0	0	664	10,634
Total at 31 March 2015	9,267	703	0	0	664	10,634

The Trust does not revalue its intangible assets.

Economic lives of intangible assets

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

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

The gross carrying value of fully depreciated intangible assets is £2.17 million.

15. Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Total charged to Departmental Expenditure Limit	0
Changes in market price	(377)
Total charged to Annually Managed Expenditure	**(377)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(377)**
Total Impairments charged to SoCI - AME	**(377)**
Overall Total Impairments	**(377)**

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI	0	0	0	0	
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Changes in market price	(377)	0	0	0	(377)
Total charged to Annually Managed Expenditure	**(377)**	**0**	**0**	**0**	**(377)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(377)**	**0**	**0**	**0**	**(377)**

16. Commitments

16.1. Capital commitments

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

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	**1,003**	3,045
Intangible assets	**153**	605
Total	**1,156**	3,650

17. Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	**£000s**	**£000s**	**£000s**
Balances with Other Central Government Bodies	0	0	4,620	0
Balances with Local Authorities	18	0	0	0
Balances with NHS bodies inside the Departmental Group	6,416	0	629	0
Balances with Bodies External to Government	8,027	0	28,246	107
At 31 March 2016	**14,461**	**0**	**33,495**	**107**
prior period:				
Balances with Other Central Government Bodies	2	0	4,385	0
Balances with NHS bodies inside the Departmental Group	25,902	0	883	0
Balances with Bodies External to Government	7,909	0	34,037	107
At 31 March 2015	**33,813**	**0**	**39,305**	**107**

18. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**65**	**2,961**	**0**	**0**	**0**	**0**	**3,026**	0
Additions	686	7,630	0	0	0	0	**8,316**	0
Inventories recognised as an expense in the period	(716)	(7,627)	0	0	0	0	**(8,343)**	0
Balance at 31 March 2016	**35**	**2,964**	**0**	**0**	**0**	**0**	**2,999**	**0**

19. Receivables

19.1. Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**4,420**	22,011	**0**	0
NHS prepayments and accrued income	**2,037**	3,718	**0**	0
Non-NHS receivables - revenue	**431**	831	**0**	0
Non-NHS receivables - capital	**6**	0	**0**	0
Non-NHS prepayments and accrued income	**7,343**	7,907	**0**	0
PDC Dividend prepaid to DH	**0**	175	**0**	0
Provision for the impairment of receivables	**(782)**	(2,062)	**0**	0
VAT	**672**	1,000	**0**	0
Interest receivables	**11**	9	**0**	0
Other receivables	**323**	224	**0**	0
Total	**14,461**	33,813	**0**	0
Total current and non current	**14,461**	33,813		
Included in NHS receivables are prepaid pension contributions:	**0**			

19.2. Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**3,824**	602
By three to six months	**47**	0
By more than six months	**76**	0
Total	**3,947**	602

19.3. Provision for impairment of receivables

	2015-16	2014-15
	£000s	£000s
Balance at 1 April 2015	**(2,062)**	(1,181)
Amount written off during the year	**1**	0
Amount recovered during the year	**0**	335
(Increase)/decrease in receivables impaired	**1,279**	(1,216)
Balance at 31 March 2016	**(782)**	(2,062)

20. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**14,701**	6,436
Net change in year	**5,508**	8,265
Closing balance	**20,209**	14,701
Made up of		
Cash with Government Banking Service	**20,199**	14,694
Commercial banks	**3**	0
Cash in hand	**7**	7
Cash and cash equivalents as in statement of financial position	**20,209**	14,701
Bank overdraft - Commercial banks	**0**	(2)
Cash and cash equivalents as in statement of cash flows	**20,209**	14,699

21. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	63	38	0	**101**
Balance at 31 March 2016	**63**	**38**	**0**	**101**
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**
Balance at 1 April 2014	0	0	0	**0**
Plus assets classified as held for sale in the year	63	38	0	**101**
Balance at 31 March 2015	**63**	**38**	**0**	**101**
Liabilities associated with assets held for sale at 31 March 2015	0	0	0	0

The assets comprise two radio transmitter sites which are surplus to requirements due to technology advances.
No sale had been agreed by 31 March 2016 but it is anticipated that the sites will be sold in April 2016 for £250k.

22. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**404**	791	**0**	0
NHS accruals and deferred income	**126**	92	**0**	0
Non-NHS payables - revenue	**5,905**	5,536	**0**	0
Non-NHS payables - capital	**1,615**	5,853	**0**	0
Non-NHS accruals and deferred income	**17,541**	19,802	**0**	0
Social security costs	**2,446**	2,311	**0**	**0**
PDC Dividend payable to DH	**99**	0	**0**	**0**
Tax	**2,174**	2,074	**0**	**0**
Other	**3,185**	2,844	**0**	0
Total	**33,495**	39,303	**0**	0
Total payables (current and non-current)	**33,495**	**39,303**		
Included above:				
Outstanding Pension Contributions at the year end	**3,124**	2,834		

23 Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Bank overdraft - commercial banks	**0**	2		
Loans from other entities	**0**	0	**107**	107
Total	**0**	**2**	**107**	**107**
Total borrowings (current and non-current)	**107**	**109**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	0	0	**0**
1 - 2 Years	0	0	**0**
2 - 5 Years	0	107	**107**
Over 5 Years	0	0	**0**
TOTAL	**0**	**107**	**107**

24. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**56**	56	**0**	0
Deferred revenue addition	**90**	56	**0**	0
Transfer of deferred revenue	**(56)**	(56)	**0**	0
Current deferred Income at 31 March 2016	**90**	56	**0**	0
Total deferred income (current and non-current)	**90**	56		

25. Finance lease obligations as lessee

The Trust had no finance leases at 31 March 2015, and has not entered into any new finance lease arrangements during the year.

26. Finance lease receivables as lessor

Not relevant for trust

27. Provisions

		Comprising:						
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Continuing Care**	**Equal Pay (incl. Agenda for Change**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**17,320**	8,972	846	0	0	0	5,781	1,721
Arising during the year	**4,839**	198	665	0	0	0	3,976	0
Utilised during the year	**(2,098)**	(416)	(271)	0	0	0	(1,384)	(27)
Reversed unused	**(5,720)**	0	(487)	0	0	0	(3,539)	(1,694)
Unwinding of discount	**138**	117	0	0	0	0	21	0
Change in discount rate	**(74)**	(68)	0	0	0	0	(6)	0
Balance at 31 March 2016	**14,405**	**8,803**	**753**	**0**	**0**	**0**	**4,849**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**4,609**	396	753	0	0	0	3,460	0
Later than One Year and not later than Five Years	**2,272**	1,584	0	0	0	0	688	0
Later than Five Years	**7,524**	6,823	0	0	0	0	701	0

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

As at 31 March 2016	50,351
As at 31 March 2015	21,456

The Early Departure Costs provision of £8,803k (2014/15 £8,972k) comprises pensions relating to claims for Personal Injury Benefits. The amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of 1.37% is applied.

The Legal Claims provision of £753k (2014/15 £846k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

The other provision of £4,849k (2014/15 £5,781k) includes £2,518k relocation costs for recruitment of overseas paramedics, £543k for changes in VAT rules, and £1,555k in respect of pension payments due to employees made redundant prior to 1995 as a result of the restructuring of the Trust. The provisions are calculated using actuarial tables and are payable quarterly over the life of the employees.

28. Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent Liabilities		
NHS Litigation Authority legal claims	**(218)**	(296)
Net value of contingent liabilities	**(218)**	(296)

29. Financial Instruments

29.1. Financial risk management

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

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

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

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

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

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

29.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS	0	6,416	0	**6,416**
Receivables - non-NHS	0	4,942	0	**4,942**
Cash at bank and in hand	0	20,209	0	**20,209**
Other financial assets	0	0	0	**0**
Total at 31 March 2016	**0**	**31,567**	**0**	**31,567**
Receivables - NHS	0	22,011	0	22,011
Receivables - non-NHS	0	831	0	831
Cash at bank and in hand	0	14,699	0	14,699
Other financial assets	0	7,066	0	7,066
Total at 31 March 2015	0	44,607	0	44,607

29.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
			£000s
NHS payables	0	629	**629**
Non-NHS payables	0	32,293	**32,293**
Other borrowings	0	107	**107**
Other financial liabilities	0	0	**0**
Total at 31 March 2016	**0**	**33,029**	**33,029**
NHS payables	0	791	791
Non-NHS payables	0	11,389	11,389
Other borrowings	0	109	109
Other financial liabilities	0	22,682	22,682
Total at 31 March 2015	0	34,971	34,971

30. Events after the end of the reporting period

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

31. Related party transactions

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

The Department of Health is regarded as a related party. It also had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below where receipts exceed £10m:

	2015/16 Payments to related party	2015/16 Receipts from related party	2015/16 Owed to related party	2015/16 Owed by related party
	£'000	£'000	£'000	£'000
Barnet CCG	0	11,486	0	271
Brent CCG	0	16,398	0	238
Bromley CCG	0	11,210	0	183
Central London (Westminster) CCG	0	10,550	0	238
City And Hackney CCG	0	10,445	0	225
Croydon CCG	0	13,429	0	81
Ealing CCG	0	11,007	0	64
Enfield CCG	0	10,808	0	243
Greenwich CCG	0	10,384	0	197
Hillingdon CCG	0	11,715	0	642
Lambeth CCG	0	12,608	0	67
Lewisham CCG	0	10,736	0	65
Newham CCG	0	11,190	0	269
Southwark CCG	0	12,388	0	65

	2014/15 Payments to related party	2014/15 Receipts from related party	2014/15 Owed to related party	2014/15 Owed by related party
	£'000	£'000	£'000	£'000
Barnet CCG	0	10,652	0	139
Brent CCG	1	14,289	0	3,617
Bromley CCG	0	10,538	0	152
Camden CCG	0	11,394	0	2,469
Central London CCG	0	14,015	0	3,965
City & Hackney CCG	0	10,404	0	644
Croydon CCG	0	13,101	0	785
Ealing CCG	0	10,561	0	128
Enfield CCG	0	10,012	0	136
Hillingdon CCG	0	10,897	0	130
Lambeth CCG	0	12,005	0	135
Lewisham CCG	0	10,112	0	113
Newham CCG	0	11,005	0	504
Southwark CCG	0	14,664	0	2,980

The Trust has a number of staff who do voluntary work for St John Ambulance Service. The transactions with St John Ambulance Service during the year comprised expenditure of £1,968k (2014/15 £1,521k) and the amount owed by the Trust as at 31 March 2016 was £360k (31 March 2015 £nil).

The London Ambulance Service NHS Trust acts as corporate trustee for the London Ambulance Service Charity. There were no financial transactions with the Charity in 2015/16.

32. Losses and special payments

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

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

There are no cases totalling over £300k individually.

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	1,783,364	1,016
Special payments	724,170	67
Total losses and special payments	2,507,534	1,083

33. Financial performance targets

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

33.1. Breakeven performance

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

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

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

33.2. Capital cost absorption rate

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

33.3. External financing

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

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**(10,010)**	(12,606)
Cash flow financing	**(10,010)**	(12,606)
External financing requirement	**(10,010)**	(12,606)
Under/(over) spend against EFL	**0**	0

33.4. Capital resource limit

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

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**9,241**	14,937
Less: book value of assets disposed of	**(8)**	(15)
Charge against the capital resource limit	**9,233**	14,922
Capital resource limit	**10,164**	15,900
(Over)/underspend against the capital resource limit	**931**	978

34. Third party assets

The Trust held cash and cash equivalents of £nil at 31 March 2016 (£nil at 31 March 2015) relating to monies held on behalf of patients or other parties.

APPENDIX - GLOSSARY OF TERMS

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

STATEMENT OF COMPREHENSIVE INCOME

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

Revenue From Patient Care
Activities Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

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

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

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

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

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

Amortisation
Where depreciation applies to tangible fixed assets, amortisation is the same process for non-tangible fixed assets, such as loans to the Trust.

Profit / (loss) on disposal of fixed assets
The difference between the value of an asset in the balance sheet and the actual sale price of the item. This could be equipment or buildings.

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

STATEMENT OF FINANCIAL POSITION

Fixed Asset / Non-Current Assets
An asset that has a life that extends beyond the current financial year and that will generate economic benefits in future accounting periods– as opposed to current assets, which are realisable immediately or in the next accounting period. Fixed assets are typically equipment or buildings.

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

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

Debtors / Receivables
Money owed to the Trust for services provided.

Creditors / Payables
Money owed by the Trust for goods and services received.

Total Taxpayers' Equity
See Public Dividend Capital

NOTES TO THE ACCOUNTS

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

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

Off Balance Sheet
Refers to fixed assets that are in use by the trust but which are not technically 'owned' by the organisation, and therefore do not appear in the balance sheet. An example of this would be operating leases, where equipment, such as vehicles, is leased by the organisation but never comes into our ownership.

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

Prepayment
Where the Trust has paid in advance for goods

or services – for example, quarterly payment in advance for telephone rentals.

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

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

TERMINOLOGY

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

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

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

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

CCGs - Clinical Commissioning Groups
New organisation established from 1st April 2013.

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

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

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

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

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

Risk Pooling Scheme
This is essentially the NHS insurance scheme,
where we pay an annual premium to cover any insurance claims that may arise during the year.
The scheme covers all the usual insurance risks around buildings, equipment, fire etc, as well as clinical negligence issues.

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

Losses and Special Payments

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

HART
Hazardous Area Response Team

RRV
Rapid Response Vehicle

PTS
Patient Transport Service.