NHS
London Ambulance Service
NHS Trust

Annual Report & Accounts 2019/20

Our vision

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

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

on scene • on phone • online

Our purpose

We exist to:

Provide outstanding care for all of our **patients**

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

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

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

Our values & behaviours

Respectful

Caring for our patients and each other with compassion and empathy

Championing equality and diversity

Acting fairly

Professional

Acting with honesty and integrity

Aspiring to clinical, technical and managerial excellence

Leading by example

Being accountable and outcomes orientated

Innovative

Thinking creatively

Driving value and sustainable change

Harnessing technology and new ways of working

Taking courageous decisions

Collaborative

Listening and learning from each other

Working with partners

Being open and transparent

Building trust

Contents

Photography: Some photography contained within this report was taken prior to the Covid-19 pandemic.

Chair and Chief Executive's Foreword

Over the last few years, London has experienced some devastating events: from the tragic fire at Grenfell to deadly terror attacks. And in the last month of this financial year, the coronavirus.

As providers of both urgent and emergency care, we have been at the forefront of the response to these events, which have affected the lives of so many. It is important, therefore, to begin this foreword by paying tribute to all our people who have shown selflessness and stoicism in the face of danger.

They have embraced new ways of working to enable us to care for Londoners; adapting and learning; saving lives.

Over a series of days in March calls to our 999 emergency control rooms doubled and calls to our NHS111 services trebled. The impact of this was compounded by a third of staff either sick with COVID-19 or self-isolating.

Our innovative way of working must not be lost and as the only health trust to serve the whole of London we will work with our NHS partners to ensure we are able to fully integrate many of our changes.

We are driving forward with our strategy which sets out an integrated approach for ensuring the best possible care and outcomes for our patients.

We tested what this approach was capable of achieving one Monday in September when we devised "Perfect Day". By working closely with community health services, social services and GPs, we were able to treat more patients at home. What we learned that day helped to influence our winter planning and continues to shape our Service.

Celebrating our people

It was this kind of innovation and initiative that was praised by the Care Quality Commission, citing the leading role of London Ambulance Service in integrating care services as "outstanding" practice. We are pleased to have retained an overall rating of "good" after an inspection in September.

An area of focus for us going forward is how to harness the positivity and enthusiasm of our staff – whether day-in, day-out or in a crisis – and use that to continue to transform our culture.

We have had excellent engagement with Freedom to Speak Up and have been able to resolve issues without the need for more formal processes.

This unprecedented volume of calls required a rapid rethink of how we operate and with teams working around the clock we were able to:

- Build a dedicated COVID-19 999 call-handling centre
- Open an extra 111 facility with more clinicians to respond to COVID-19 calls
- Coordinate bringing in 900 volunteers, student paramedics and former members of staff to help
- Train hundreds of London firefighters to drive ambulances and support our crews
- Acquire 200 extra ambulances
- Develop partnerships with the military and other organisations like the AA to help us keep more ambulances on the road
- Help design the NHS Nightingale London hospital and create the transfer service

We begin by paying tribute to all our people who have shown selflessness and stoicism in the face of danger.

We are proud of the progress we have made in our aim to be more inclusive and representative of the population we serve with particular success in recruiting executives and non-executives from a BAME background. But there is much more to do. We need to listen to the views of our people. We have set up a new Staff and Volunteer Advisory group to ensure this happens. We are also establishing a new Public and Patients Council.

We need to embrace technological change where we can. The use of secure iPads for all frontline crews means our busy teams can get the most up-to-date information about their patients at their fingertips.

Our move to electronic medical records will allow us to make better use of patient data and provide more opportunities for integration across the health system, which will lead to improved outcomes. We will also better understand patients' needs and wishes.

We would like to thank all of our staff including emergency voluntary responders and all those who came to assist us with responding to COVID-19. We do mean everyone: every single person, in every single department is appreciated.

We said farewell to John Jones and Theo de Pencier, Non-Executive Directors (NED) who had both served two terms helping us govern the organisation. We welcomed Rommel Pereira, as a NED and chair of the Audit Committee and Amit Khutti who is taking a lead role on strategy development and was previously an associate NED. We also said farewell to Paul Woodrow OBE, Director of Operations, Patricia Grealish, Director of People and Culture and Benita Mehra, Director of Strategic Assets, whilst welcoming Khadir Meer, Chief Operating Officer and Ali Layne-Smith as Director of People & Culture.

Finally, we also said farewell to Philippa Harding our Director of Corporate Governance and welcomed Syma Dawson in to that role.

The purpose of the overview is to provide a short summary which explains our organisational structure; our purpose and activities. It should also include our objectives and strategies as well as any risks.

Heather Lawrence OBE
Chair

Garrett Emmerson
Chief executive

About London Ambulance Service

Who we are

We are respectful

We are professional

We are innovators

We collaborate

We are NHS

We are London

We save lives

We answer over three million 999 and 111 calls a year, more than any other ambulance service in the country. We go to more than 3,000 emergencies a day.

We are the only NHS provider trust to serve the whole of London – one of the world's most dynamic and diverse cities. Demand for our services increases every year as do the challenges and complexities of our mission.

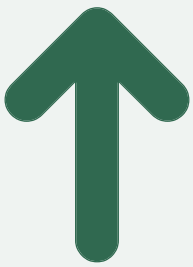
We directly employ 6,130 people – but with contractors; agency and bank staff, students, and volunteers – there are 7,670 people working for us. Together we are striving to be a world-class ambulance service for a world-class city.

We are governed by a Trust Board made up of 13 members: a Non-Executive Chair, seven Non-Executive Directors, and five Executive Directors, including the Chief Executive.

We are constantly evolving to meet the changing needs of the nearly nine million people who live and work in London.

2,084,306

999 calls



1,221,834

111 calls

1,181,050

Incidents attended

London Ambulance Service was awarded Ambulance Trust of the Year in the 2019 Health Business Awards.

Our core work:

- Answer, prioritise and allocate 999 calls across London
- Respond to emergency and urgent 999 calls by sending clinicians to the scene or by treating over the phone
- Provide 111 integrated urgent care (IUC) services for over 2.5 million people in south east and north east London
- Take eligible patients to medical appointments and treatment with our non-emergency transport service

Other work includes:

- Provide paramedics to work for London's Air Ambulance and decide when to dispatch the helicopter.
- Plan for, and respond to, major and significant incidents with London's other emergency services.
- Educate the public in life-saving skills and campaign for the widespread use of public access defibrillators
- Engage with NHS partners, local authorities and the Mayor to encourage a healthier population and a safer London.

6mins 51secs

Average response time to most serious calls

7,670

People working for us

Our Response to COVID-19

London Ambulance Service has had to adapt and respond quickly to help save lives.

When COVID-19 hit, we experienced an extraordinary increase in demand. By February, our 111 services were already feeling the impact from callers worried about whether they had COVID-19. By March, our 999 services felt the pressure with over 11,000 people calling 999 on some days, as we responded to the growing numbers of infected patients. Demand remained very high throughout March as the pandemic reached its peak.

In response, we rapidly implemented a range of measures to boost our capacity to help these patients. Many of these are listed in the Chair and Chief Executive's Foreword.

At unprecedented speed, we recruited call handlers and clinicians specially trained to deal with coronavirus concerns.

We also entered a number of new partnerships with public and private sector organisations to support operations at this exceptionally busy time.

Together with other London IUC/111 services we were also able to assess and refer certain Category 3, 4 and 5 calls from the 999 system, thereby protecting our response to our sickest patients.

To support our own people through the crisis we:

- **shipped millions of pieces of Personal Protective Equipment to the frontline through a new logistics hub**
- **arranged accommodation and transport for staff where needed**
- **tested staff with COVID-like symptoms**
- **provided access to a range of welfare and wellbeing services**
- **monitored national medical updates and developed guidance for staff.**

The COVID-19 pandemic hit the capital city before the rest of the UK, putting London Ambulance Service at the forefront of responding to this national emergency.

Our Patients

More than 9,000 people call 999 and 111 every day in need of our help.

We aim to provide the best possible care or advice for each and every one of them.

Our patients can include anyone who lives, works or socialises in London: some will have a life-threatening illness or injury; many will be in distress or pain; some may not need an ambulance at all.

Our 999 and 111 services are becoming more integrated, so regardless of which number a patient calls, the most appropriate clinical pathways are available.

Whatever a patient's needs – they can expect to be treated with respect and compassion and for us to deliver excellent care.

Cardiac Arrest

We continue to have some of the best outcomes for cardiac arrest patients among UK ambulance services. For the first time ever, more than one in ten people who suffered an out-of-hospital cardiac arrest in London survived to leave hospital (10.8%). The number of patients who received bystander cardiopulmonary resuscitation (CPR) remains high and will have contributed to these improved outcomes.

When a public access defibrillator is used to deliver a shock, the outcome is even better, at 57.1%.

Two thirds of the 999 calls assessed were for life threatening or serious medical emergencies which required a Category 1 or 2 response.

Heart Attack

Patients treated for a heart attack (STEMI) continue to receive a high standard of care and almost all (99.7%) were conveyed to an appropriate hospital. For patients whose STEMI diagnosis was confirmed at hospital, 89% went on to receive emergency surgery to unblock an artery in their heart, and the vast majority (92%) survived to be discharged from hospital.

Stroke

Stroke patients have also been well cared for. Nearly all (99.7%) were conveyed to an appropriate hospital, which was usually a hyper acute stroke unit (HASU) capable of providing specialised diagnostics, treatment and rehabilitation services.

Major trauma

We have been at the heart of the London Trauma system since its inception 10 years ago. Patients are taken directly to a major trauma centre which has led to a 50 per cent reduction in deaths.

Urgent calls

Urgent care patients now make up a significant proportion of our workload. We manage these patients through our IUC/111 services, 999 Clinical Hub and a range of core and bespoke frontline responders who provide a face-to-face assessment.

Patient Timothy Sheehan with the medics who saved his life.

Andreas Kallis, 68, and his family visited Walthamstow ambulance station to thank all those who saved his life.

Our Clinical Hub deals with 999 calls which do not need an emergency ambulance. Instead a clinician will further assess the patient to work out the best way to help them. **More than eight per cent of 999 calls are handled by the Clinical Hub team, which is one of the highest "hear and treat" rates in the country.**

Our two IUC/111 sites in north east and south east London operate 24-hours-a-day, making it easier for patients to access services when their GP surgery is closed. Patients are assessed by a range of clinicians, including paramedics, nurses, GPs and pharmacists.

Our clinicians can access medical records and care plans to better inform their decisions; they can book appointments directly into local services; and they can prescribe medication over the telephone when required.

The integrated urgent care model we have pioneered has led to more patients being helped without requiring referrals to other services, which simplifies the experience for the patient and relieves pressure on the wider NHS. Our IUC services consistently refer the fewest patients into the 999 system across London, which helps to protect our response to those patients with life-threatening conditions.

Advanced Paramedic Practitioners: Urgent Care

We have been committed to increasing the skills, knowledge and range of treatment options available to our advanced paramedics to provide the best patient care with fewer onward referrals or hospital conveyance.

These specially-trained paramedics are now able to close wounds and carry out blood tests, in a patient's home. In a newly launched pilot, some advanced paramedics are now being trained to prescribe medication on scene.

Measuring how well we respond to patients

Calls to 999

This table shows our performance for 2019/20 compared to the previous year but also shows the impact of COVID-19 in March.

Measure	2018/19	2019/20	2019/20 (Apr to Feb)	March 2020 Only
Total 999 calls	1,937,210	2,084,306	1,870,664	213,642
90th Centile Call Answering (secs)	24	88	48	595
Call Answering within 5 Secs (%)	86.4%	77.6%	82.2%	37.8%
Incidents attended (Face to Face)	1,141,704	1,181,050	1,082,168	98,882
Average Response time Category 1 (Mean)	00:06:28	00:06:51	00:06:35	00:09:51

As explained in the previous section, calls to 999 spiked in March and we have separated out data for this month to illustrate the impact of the coronavirus outbreak. The Trust saw 2% more patients than the previous year, attending a total of 1,181,050 patients face-to-face. We continued to achieve the National Performance Standard for Category 1 patients which means we got to our sickest patients within seven minutes. This has partly been achieved by putting more ambulances on the road than ever before as well as the work we have done in urgent care which has left more ambulances available for Category 1 and 2 calls.

Our preparations for winter pressures in 2019/20 were some of the most detailed we have ever done and helped to ensure that our performance remained strong despite very heavy demand on our services and the wider NHS.

We provided each London hospital with ambulance forecasting data for the period so that each hospital understood how many ambulances would be arriving each day, each hour. We also worked closely with NHS England and NHS Improvement, our commissioners and other providers.

Calls to 111

These tables show our performance for the year 2019/20 compared to the previous year but also show the impact of COVID-19 in February and March.

		Apr 2018 – Mar 2019		Apr 2019 – Mar 2020	
Measure	**National target**	**SEL**	**NEL**	**SEL**	**NEL**
Total number of calls	-	415,175	357,087	544,555	677,279
Average calls per day	-	1,141	1,380	1,488	1,850
Calls answered within 60 seconds	95%	84.0%	75.3%	70.2%	70.1%
Calls abandoned after 30 seconds	<5%	1.9%	4.4%	11.7%	13.4%
Calls referred to 999 system	<10%	9.0%	7.3%	7.9%	7.9%

		Apr 2019 – Jan 2020		Feb 2020 – Mar 2020	
Measure	**National target**	**SEL**	**NEL**	**SEL**	**NEL**
Total number of calls	-	395,341	504,136	149,214	173,143
Average calls per day	-	1,292	1,648	2,487	2,886
Calls answered within 60 seconds	95%	79.1%	79.0%	33.7%	25.5%
Calls abandoned after 30 seconds	<5%	3.4%	3.6%	33.9%	41.9%
Calls referred to 999 system	<10%	8.2%	8.0%	6.5%	7.8%

While our 999 services felt the impact of COVID-19 in March, enquiries to our 111 services about the disease were high throughout February and March. For that reason, the second table has the data for these two months separated to illustrate the impact on our overall performance.

Neither of our IUC sites met the calls answered within 60 seconds target, however both sites saw an increase in calls received each day, particularly in north east London. We were meeting our target for the percentage of calls abandoned before being answered, until the rise in demand due to coronavirus. We are continuing to work to improve our performance against these targets.

Our Consult and Complete rates – the number of patients who get to speak to a clinician without needing to be transferred elsewhere – are high: around 25 per cent of all calls, which means patients' needs are being resolved quickly.

Our Priorities

Our vision is to become a world-class ambulance service at the heart of urgent and emergency care in London.

Strategic Themes

Theme 1

Comprehensive urgent and emergency care, coordination, access, triage and treatment, with multichannel access for patients

Theme 2

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

Theme 3

Collaboration with NHS, emergency services and London system partners to provide more consistent and equitable services to Londoners

The COVID-19 pandemic has changed London; it has changed the NHS; it has changed London Ambulance Service.

Our priorities and our organisational strategy must also adapt as we look towards recovery.

We still believe the fundamental elements of our strategy are sound and these have underpinned and enabled our response to COVID-19. These elements include:

- Integrating 111 and 999 services so the public receives the right information from the right sources in a timely way
- Working with One London Health Information Exchange for seamless access to medical records
- Streaming video from callers in our 111 and 999 control rooms so clinicians to provide the most accurate advice
- Strengthening our partnerships with others providing healthcare across London
- Continuing our mental health pioneer service at a hugely challenging and anxiety-provoking time
- Developing remote working applications and network capability to support home-based and remote office clinicians

Over the coming months we will refresh our strategy to ensure that it aligns with our recovery phase as we emerge from the COVID-19 crisis.

Our refreshed strategy will identify the ways in which the NHS is changing and the opportunities and challenges that presents us with.

Successes to build on

Mental Health Pioneer Service

We piloted this service in 2018/19 with just a single response car in south east London but have this year expanded to six cars operating across the capital. In 2019/20 we went to nearly 2,000 patients with mental health needs and were able to treat 80 per cent of them in their own home without needing to take them to hospital.

Reduction in conveyances to emergency departments

One of our key strategic aims is to reduce avoidable emergency department conveyances. Work over the past two years has led to a reduction from 61.6% from April 2017 when our strategy was signed off, to 57.5% by the end of February 2020. This reduction equates to 50,000 fewer emergency department conveyances per year which is significant progress against our ambition of 120,000 fewer conveyances per year by the end of 2023.

Clinical Hub transformation to support winter initiatives

We implemented a number of initiatives within our 999 clinical hub to improve effectiveness and reduce demand on the NHS system. This includes close working with commissioners, providers and the wider system to test the

referral of low acuity 999 callers to local integrated urgent care services. Through these initiatives we were able to increase 'hear & treat' and significantly reduced the number of 111 calls receiving an ambulance dispatch.

Exciting digital advances

Computer-Aided Dispatch (CAD)

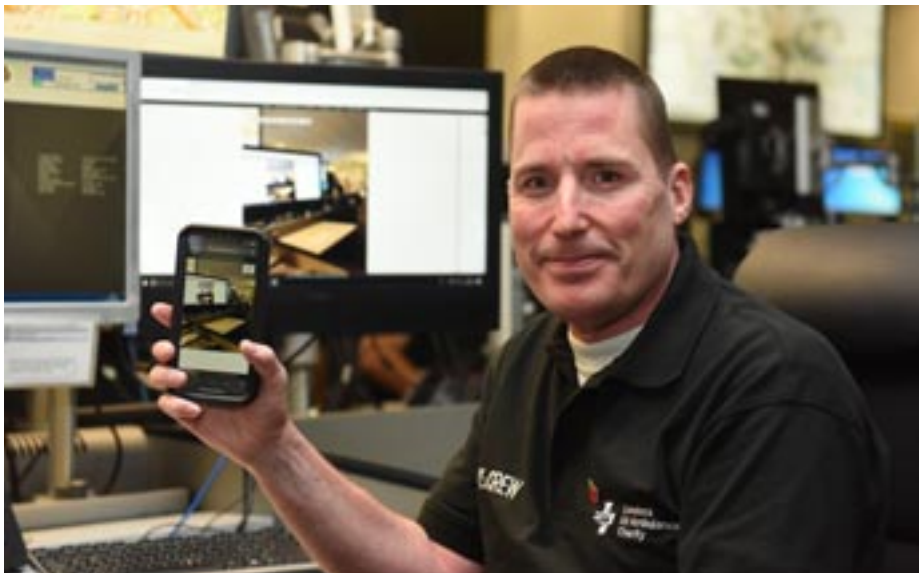
We are on track to complete the procurement of a new product that puts the patient right in the centre. Our staff will have immediate access to a caller's medical records, helping us to deliver better care and enable us to treat more people over the phone or in their own homes. The new software will be intrinsically linked to our electronic patient care record (ePCR) system allowing a seamless flow of clinical information.

Electronic Patient Care Records (ePCR)

We are switching from paper records to digital. This exciting development means our medics will have access to clinical and care data even before they reach a patient. Records can be updated on scene, so hospital clinicians can get up-to-the-minute information before we arrive with the patient. As a Service, we will have access to live clinical data to help with strategic planning and decision-making.

Live video calls

As mentioned above, our clinicians in all 111 and 999 centres can now stream video from a caller's mobile device, enabling safer and better quality care. This simple to use technology is available to us through our partnership with GoodSam. It was first used to assess which calls we should dispatch London's Air Ambulance to but is now being integrated into our clinical systems.



Paramedic Jason Morris explains how video streaming works.

Quality matters

London Ambulance Service remains committed to delivering safe and high quality care to the people of London. Our approach is outlined in our quality strategy, which is underpinned by the Care Quality Commission's (CQC) assessment framework.

In 2019/2020, our focus was on continuous learning, improvement and embedding achievements from the previous years while taking actions in the areas we identified as requiring further work.

The CQC inspected us in September 2019 and gave us an overall rating of 'good' in their final report. In addition to the overall rating, the sub-ratings for 'Effective', 'Responsive', Caring and 'Well-Led' – were rated as 'good'. However, the inspectors ranked 'Safe' as 'requires improvement' based on their assessment of security around vehicles and ambulance stations; restocking of equipment; and checking expiry dates on medicines. Work is underway to improve our practices in all these domains. The CQC highlighted areas of 'outstanding' practice citing the leading role of the Trust in integrating care services and in a 'ground-breaking' programme to deliver integrated patient records across all London providers.

Our Perfect Day

We spent a day putting our innovative clinical strategy to the test in north east London.

We found we could help almost half the people who dialled 999 get the care they needed but avoid an unnecessary trip to hospital.

By working closely with community health services, social services and GPs, we treated more patients at home which helps to ease pressure on busy emergency departments.

From 8am on Monday 30 September until midnight, our 999 and 111 call handlers were

Perfect Day

This ground-breaking trial was watched closely by health commissioners and trusts across the capital and beyond to see what we could make possible.

fully integrated and had a whole host of services they could direct patients to, or call upon. Ambulance crews were treating and discharging more patients in their homes than ever before.

To make this happen, a range of staff were involved in the trial:

- advanced paramedics who are specially trained to deal with urgent medical needs
- paramedics teamed with mental health nurses to respond to patients experiencing mental health problems
- an ambulance clinician working with a hospital doctor in a fast response car, in what is called a physician response unit
- senior clinicians providing support by phone to ambulance crews on the road

This could not have happened without the close involvement of other NHS partners. Partnership working meant we also had easier access to GPs and other local services as well as extra support to deal with terminally ill patients.

This model allowed us to send our category 5 (least serious) 999 calls straight to the 111 integrated urgent care hub and also provide a community response to our category 3 and 4 patients to better meet their needs.

As a result, for all the patients making emergency calls that day, **only 49 per cent were taken to hospital** – that's more than 10 per cent fewer than an average day.

That meant more ambulances were available for life-threatening emergencies. For the patients who did not need to be taken to hospital, it meant quicker and more comfortable treatment.

At the end of this pioneering trial, we found a high proportion of patients calling us could be treated over the phone by putting them through to doctors, nurses and paramedics working in our integrated urgent care centre. These clinicians could also find alternative pathways for patients.

The trial also led to us working collaboratively with trusts across London to expand the number of paramedic/mental health nurse teams we have working across the city. Lessons from Perfect Day informed our winter planning and continue to shape the Service.

Our Partnerships

Our collaborative approach allows us to provide the best possible care for the people who need us.

This means working with patient groups, stakeholders and our wider system partners to ensure communities are empowered to help shape the future of their health services.

Our community

We have continued to work with a range of patient and public groups to inform and influence our work, including the Patients' Forum.

We are setting up a new Public and Patients Council so we can spend more time engaging with local communities.

Through the work of our Public Engagement and Education team, we have a valuable opportunity to improve the health and wellbeing of Londoners. We give regular presentations in the community – often to children and young people, where our work can have the most impact.

We have the support of more than 1,300 people across the service who regularly give up their own time to attend community events.

Our events are so popular, we have had to recruit two new public education officers to boost the team.

Awareness sessions include the dangers of alcohol and other legal highs; careers in London Ambulance Service; and multi-agency road safety events. We regularly visit secondary schools across London for our award-winning presentations about the grim reality of carrying knives. We also use these opportunities to teach CPR and other life-saving skills.

This year, the team has developed a Community Education Volunteers (CEVs) training course for the staff. It aims to give participants the knowledge and confidence to deliver our presentations. We have already trained 87 CEVs.

Our NHS partners

As the only NHS provider trust to cover the whole of London, partnerships are vital. We work closely with NHS England, our commissioners, hospitals, specialist trusts and the five Sustainability and Transformation Partnerships (STP) and Integrated Care Systems (ICS) – from Trust Board level to day-to-day operations.

STPs encourage us to work together with local authorities and clinical commissioning groups to improve health outcomes for Londoners. ICSs are an advanced version of STPs but with the emphasis on even greater collaboration.

All STPs will become ICSs in due course and we have a central and potentially coordinating role in these system changes. Our challenge is to try to encourage consistency of pathways and services across London.

We now have Stakeholder Engagement Managers based in each of our five operational sectors working with acute hospitals, GPs, mental health trusts, patient forums, blue light partners, local authorities and community service.

Their hard work has helped to:

- establish electronic patient care records
- driven improvements in hospital handover performance
- promote best practice including with nursing care homes
- instigate new care pathways to reduce unnecessary trips to emergency departments.

We have worked with commissioners and STPs to boost investment in our pioneering services which include mental health, falls, urgent care, maternity and end of life care.

Our emergency services colleagues

Our response to COVID-19 saw a ground-breaking blue light collaboration with London Fire Brigade (LFB). The partnership saw around 300 firefighters driving ambulances and helping our crews to respond to the biggest public health challenge in our history.

We routinely work with both the Metropolitan Police Service and LFB responding to 999 calls. By working together, we are aiming to build a safer London; innovating the way we work; and improving the efficiency of our combined public service provision.

We hold regular meetings with the police to discuss any matters of concern and common themes in calls passed between each service. This has enabled us to be more aware of each other's operations and encourages collaborative working between the two services. We work together on violence reduction and tackling assaults on emergency service workers.

We are supporting the police in their review of clinical equipment that police officers can carry to enhance immediate lifesaving first aid interventions. A group has been set up so the ambulance and police services can work together to improve ways of dealing with patients with mental health issues. Together, we have supported the 'Safer Thames Campaign' and have backed the 'Safe Drive Stay Alive' partnership.

London's public services

We have a close relationship with the Mayor of London and the London Assembly and continue to liaise regularly on how we can work better together for the benefit of people who live in London. In particular we are working with the London Situational Awareness Team provide the Mayor's Office and London Assembly Members with accurate and timely information on our performance across London.

Charities

Partnerships have been a key factor in successfully realising our volunteering ambitions, and in helping us to establish and effectively run our volunteering schemes as part of our wider volunteering strategy.

Working with charities including St John Ambulance, British Red Cross and Macmillan has been invaluable in developing our strategy and we have used their expertise to gain greater 'pulling power' among volunteers.

Our Public Value

London Ambulance Service must provide the best possible value for the tax-paying public.

The COVID-19 pandemic led to the suspension of contracting and operational planning and the relaxation of normal financial constraints to allow maximum resource to be deployed to counter this threat. However, notwithstanding the financial impact of the pandemic, the Trust continued to focus on maximising available resources to provide the best possible value for the public, who ultimately fund the London Ambulance Service care and services.

At the outset of 2019/20, the Trust faced real challenges meeting our financial control total, particularly around delivery of the Ambulance Response Performance model and the beneficial, but substantial, increases in national Agenda for Change and banding pay-rises. Additionally, there was a nationally recognised funding pressure for 111 integrated urgent care services.

The Trust has managed such challenges well. In a cash-constrained environment for both capital and revenue, in 2019/20 we

Our Annual Public Meeting held in September

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

The Trust has sought to drive down costs and has carried out a comprehensive review of existing supplier contracts to ensure that savings have been delivered and efficiencies gained. We have built on the work of 2018/19 in further reducing agency and consultancy costs and reviewed widely areas that do not directly contribute to patient care to drive efficiencies. In addition, we expect to benefit from making permanent a number of transformation opportunities arising from the COVID-19 pandemic.

Efficiency achievements

To deliver a sustainable NHS, all providers are required to find efficiency savings: to allow the health service's budget to provide more care for more patients each year. The efficiency and productivity programme delivered £14.8m or 3.4 per cent of overall income and quality impact assessments were carried out in line with our policy to provide the necessary assurance to the Trust Board that efficiency savings were made without compromising quality and safety.

The Trust continued to use the findings in the Carter report on unwarranted variation 2018 to shape its efficiency programme as many of the recommendations in the Carter review matched those set out in our five-year strategy as well as identifying key challenges and actions for the Trust. We have embarked upon a range of initiatives which include reducing avoidable conveyances; upskilling the paramedic workforce to increase "see and treat" rates; increasing clinical effectiveness in clinical hubs; and increasing opportunities for patients to be conveyed to alternative care pathways. We continued our collaboration with South Central Ambulance Service.

Finances	2019/20	2018/19
Total Income	£438.7 million	£389.3 million
Year-end surplus	£0.2 million	£6.6 million

Investment	2019/20	2018/19
Capital Expenditure	£22.5 million	£21.5 million

Financial performance

Our financial performance in 2019/20 is detailed in the financial statements of this report. Overall, we finished the year with a small surplus of £0.2m. Surpluses generated are used to fund additional capital investment. During the year we invested £22.5m on capital to modernise our fleet, IM&T systems and Estate.

Our People

We aim to be the employer of choice in the capital.

We recruited more than 800 people across our core front line roles. With more than 400 new paramedics and 200 emergency ambulance crew (EAC) joiners we have cut our frontline vacancy levels from 14% to 3%.

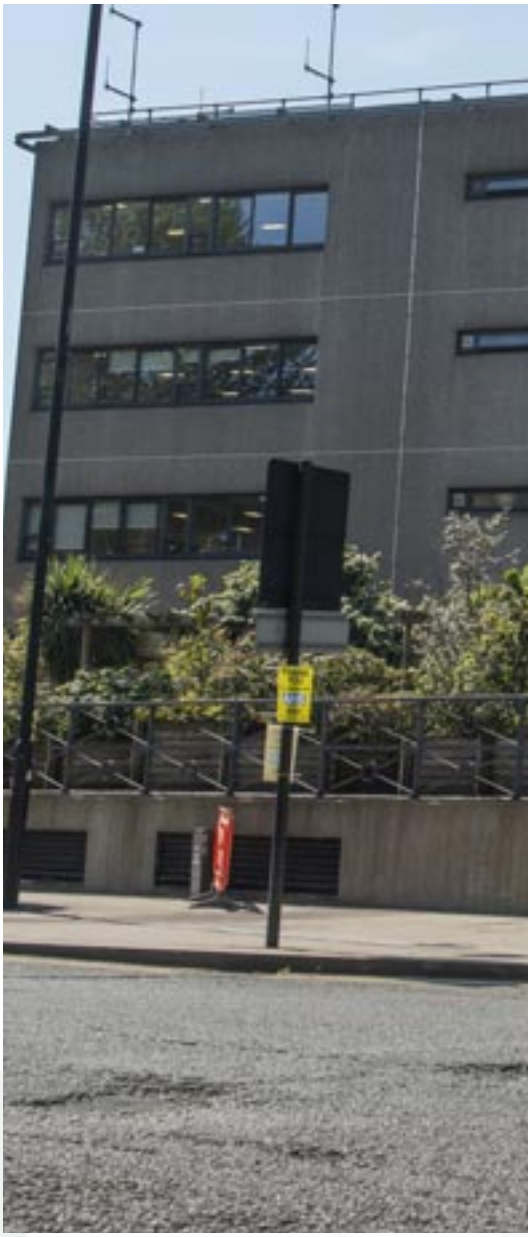
We have 6,130 people working for London Ambulance Service – which is an increase of more than 10 per cent in the last year to keep up with demand for our services. When you add all our contractors, agency and bank staff, students and volunteers to our headcount, we have 7,670 people caring for Londoners.

Most of our workforce has contact with patients – our ambulance crews and call handlers. They are supported by the considerable efforts of staff behind the scenes from those looking after our vehicles, equipment and buildings to our IT, finance, education teams and many more.

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

Behind the scenes

London Ambulance Service is the most visible part of the NHS in the capital. The sirens and flashing blue lights of an ambulance signify that help is on its way.



But it takes a whole team working behind the scenes to ensure all our patients get the right help at the right time. Not all our clinicians work on ambulances. They fulfil a range of roles including: treating patients over the phone; working as clinical tutors to maintain our highly skilled workforce; developing pioneering treatment; or advising the community on public health.

There are hundreds more people, without clinical or medical backgrounds, who support the efforts of those working on the frontline.

These include:

- Our People and Culture team looking after staff welfare and making sure we have the right HR policies to function effectively
- IM&T staff delivering innovative technological change to improve the quality of care we provide to patients;
- Fleet and logistics crews getting vehicles and equipment on the road to facilitate 800 front-line shifts a day;
- An estates team responsible for maintenance and capital programmes that create safe, secure offices or ambulance stations for corporate teams, call handlers and ambulance crews to work
- Communications staff engaging with our key NHS and public sector partners, our staff and the media to improve their understanding of our work
- Teams reviewing our governance, performance and the experience of patients so we are continuously improving patient safety and outcomes

What unites everyone working for London Ambulance Service, is being part of a mission to save lives, improve outcomes and make London a healthier place.

Recruiting and retaining our people

Our overall vacancy rate on 31 March 2020 was 2.7%. Our staff turnover rate has improved from 12.5% last year to 9.8% – meeting our 10% target.

We have recruited 120 call handlers to our 999 control rooms and more than 70 call handlers and clinicians across our north east and south east 111 services. We have filled all vacancies in our NETs team. We also had 254 apprenticeship joiners – most of these are working as EACs.

We have recruitment pipelines in place to address turnover in our control rooms and completed a restructure to ensure clarity of role; create clearer career paths; and to improve the terms and conditions of employment.

We are getting better at retaining our international paramedics by holding one-to-one interviews with them as they approach three years of working with us. We are also supporting international paramedics who apply for indefinite leave to remain in the UK, and meeting their costs.

New recruits: Our emergency call handlers soon after finishing their training

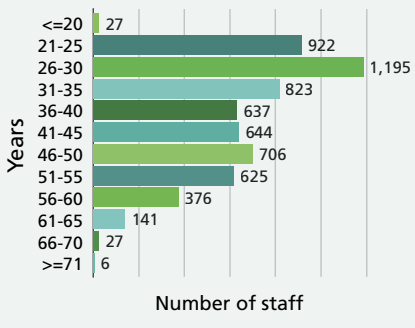
Volunteers

Our volunteer responders have committed almost 34,000 hours of their time to support our teams this year and we plan to increase that. As well as Emergency Responders, who are clinically trained, and Community First Responders, who are defibrillator-trained, we also have volunteers who are trained to use the 5,000 public access defibrillators we have in the community.

Headcount

6,130

Age band



Gender

51% 49%

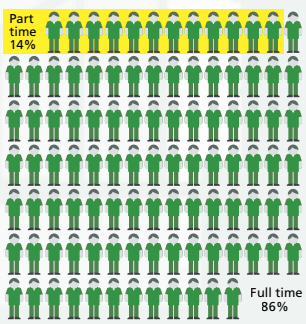
Our COVID-19 team

To help us respond to COVID-19, we had to rapidly recruit and train volunteers to help us. After a quick campaign to appeal for help from the public. We worked round the clock to bring more than 900 people on board in roles across the Trust.

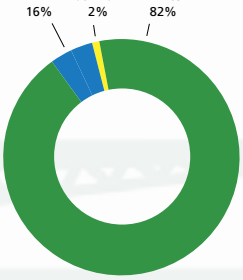
These included a number of former staff who were given refresher courses before returning to work in our control rooms and on ambulances. We also brought in skilled clinical volunteers from St John Ambulance and other ambulance services, and paramedic students from our university partners who could be on-boarded quickly. We upskilled several roles by extending the training for our Emergency Responders and Community First Responders.

More people came to us through our partnerships with the AA, the military and London Fire Brigade, and we had first-aid trained volunteers from airlines.

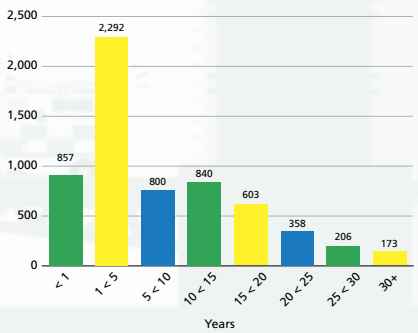
Full time vs Part time



Ethnicity



Length of service



Celebrating the Each for Equal campaign for International Women's Day 2020

Diversity and inclusion

We are working towards ensuring our workforce reflects the diversity of the population it serves in London. We end 2019/20 having recruited more than 250 BME staff, representing over 24% of all our new starters. We now have more than 1,000 BME staff which is 16% of us.

In December we launched a new Disability Network and we have developed an action plan to ensure people with a disability or long-term health condition are not discriminated against.

You can find more on our equality policies in the Annual Governance Statement.

Emotional and mental wellbeing

Working in a demanding environment like London Ambulance Service can be stressful and challenging. The current mental health provision is made up of an in-house psychotherapist and an external occupational health organisation and boosted by other initiatives including:

- trained volunteers in the trust to listen and support their peers
- practitioners trained to deal with the aftermath of traumatic event
- CBT appointments
- 24/7 support line with access to counsellors and clinicians

Staff survey results

We had the highest ever response rate to our 2019 staff survey with 72% of employees completing the online questionnaire. This compares to the national average response rate of 48%. However we have not made as much progress with positive responses as we would have hoped.

Our overall staff engagement score, which tells us how staff feel about working for us, has remained static at 6.1 (on a scale of 1-10). There is a fuller analysis of the results in our Staff Report.

Our people in numbers

4,957

Ambulance operations

1,655

999 and 111 call centres and control rooms

Recognising our people

We held our biggest ever celebration of service event in November by honouring a record 104 of our colleagues for a combined 2,550 years helping to care for people in the capital. Our annual VIP Awards are one of the highlights of the yearly calendar and the entire workforce is able to vote for the employee of the year – this year that honour went to Hollie Thomson-Young.

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

Freedom to Speak Up

Freedom to Speak Up (FTSU) continues to be at the forefront of our transformational culture, with more than 260 concerns received. We believe this increase is largely due to improved communication and engagement activities as FTSU continues to have a strong presence in the Trust and is respected and valued by the senior executive and management teams.

London Ambulance Service won an award from the National Guardians Office for having the most improved speaking up index across all NHS trusts.

There is a full report on our FTSU team in our Annual Governance Statement.

We are working towards ensuring our workforce reflects the diversity of the population it serves.

Our VIP Employee of the Year: Paramedic Hollie Thomson-Young

469
Corporate

127
Fleet and Logistics

462
Volunteers

Risks

As a Trust we are constantly evolving: adapting to a changing environment and a changing population. The challenges and risks we face evolve too, so we must regularly identify and assess these.

When evaluating risks we try to prioritise and manage the main risks which may prevent us from achieving our strategic objectives.

As of 31 March 2020, we identified the following strategic risks:

- Inability to deliver our control total value while maintaining quality of care as a result of cost pressures facing us and the wider NHS
- Inability to meet 111/IUC key performance indicators (KPIs) due to lack of skilled clinicians
- Opportunities for paramedics in other healthcare settings will affect our ability to recruit and retain registered clinicians
- System wide threat of cyber-attacks which could disrupt the Trust's ability to operate
- Out of date infrastructure could affect our ability to respond to patients

As we met our financial control, the first risk has now been proposed for closure. Due to the impact of COVID-19 on 111 providers, there has been a national decision to pause the KPI requirement so this risk has also been proposed for closure.

We have put in a mitigation plan for each of the other risks which include developing workforce planning and paramedic apprenticeships; tightening cyber security; and replacing or upgrading our hardware and software.

Garrett Emmerson 18 June 2020

Chief Executive

Accountability Report

Corporate Governance Report

1.1. Directors Report

The role of the NHS Trust Board

An NHS Trust Board leads in the development and delivery of the Trust's strategy and vision while ensuring it achieves value for money and acts in the best interests of patients and public. To carry out this role effectively, the Board must carefully monitor its strategic risks as well as engage with stakeholders to keep them informed on progress while seeking their input and feedback in relation to service delivery.

In order to achieve its purpose, the Board will delegate some of its powers to its Board Committees and the Executive Directors. Indeed every NHS Trust Board has Non-Executive Directors and Executive Directors.

The Chief Executive and the Executive Directors are deemed employees of the organisation and are responsible for the day-to-day management and running of the organisation.

Non-Executive Directors are not employees of the organisation as they are appointed to provide independent oversight and scrutiny on the Trust Board while contributing to the development of the Trust's strategy and monitoring its implementation. The Secretary of State for Health has delegated responsibility to the healthcare regulator NHS Improvement (NHSI) to appoint to the role of Trust Chair and Non-Executive Director, as well as responsibility for the removal and ongoing appraisal, support and mentoring of all non-executive directors. They are generally appointed to serve on the Trust Board for an initial period of two to four years, after which they may be eligible for reappointment. Their main responsibilities include:

- holding the Executive to account on matters of operational, financial and strategic delivery;
- helping to plan for the future growth and success of the organisation;
- ensuring effective governance arrangements are in place and being adhered to; and
- ensuring the Board operates in the best interest of patients and the public.

Our Board

The Trust Board meets every two months and holds both public and private meetings. The agenda, minutes and papers for the public meetings are available on the Trust website with members of the public invite to attend and observe the Board in progress. As of 31 March 2020, the Board was made up of 13 voting members: a non-executive Chair, seven other Non-Executive Directors, and five Executive Directors.

Non-Executive Directors

Trust Board members

Heather Lawrence OBE Chair

Heather joined us as Chair in April 2016, and has been a Non-Executive Director to The Royal Marsden Hospital since July 2017.

Heather has over 40 years' of frontline NHS experience and more than 20 years' experience running health trusts. She was Chief Executive at Chelsea and Westminster NHS Foundation Trust from 2000 to 2012. Before that, she was CEO of North Hertfordshire NHS Trust from 1996 to 2000; and Hounslow and Spelthorne Community and Mental Health Trust from 1989 to 1996.

She has also held a number of Non-Executive Director positions on UK Governmental Boards. In July 2012, the Secretary of State for Health, appointed her as a Non-Executive Director of Monitor, the NHS Regulator. At the same time, she was appointed to a FTSE 250 international health board.

She was awarded an OBE in the 2010 New Year Honors' List for her services to healthcare.

Theo De Pencier

Deputy Chairman
(01/04/19 – 29/02/20)

Theo took up his post in March 2014 and was the Trust's Deputy Chairman until 29 February 2020. He is a Board member of Transport Focus, the Government's independent watchdog for rail, bus and tram passengers and users of the strategic road network.

He has over 30 years' Board level experience in the logistics and supply chain industry working for DHL in the UK and abroad; and Bibby Line Group where he was Chief Executive of Bibby Distribution and a member of the Group Board.

From 2007 until retiring in 2015 he was Chief Executive of the Freight Transport Association (FTA) representing industry's freight interests by road, rail, sea and air. He has a degree in Economics and is a Fellow of the Chartered Institute of Logistics and Transport.

Rommel Pereira

Deputy Chairman,
(1/02/20 – present)

Rommel has a track record in finance, business transformation, technology, customer service, procurement and business development. Until recently, he was an Executive Director at the Bank of England attending the various committees of the Bank. Prior to this he was an Executive Director of the Financial Services Compensation Scheme after spending five years as Group Chief Operating Officer for the Metropolitan Housing Partnership. His earlier career included senior management roles at JP Morgan Chase.

His recent Non-Executive roles include the One Housing Group, the Shepherds Bush Housing Group and Homerton University Hospital NHS Foundation Trust. Rommel is the Chair of the Audit Committee.

John Jones

Senior Independent Director
(01/04/19 – 31/12/19)

John Jones started as an Associate Non-Executive Director in October 2011, and took up his substantive role on 1 January 2012.

He has 17 years' experience at board level in the NHS and has held a number of executive finance director positions. As a Director of Finance with Hertfordshire Partnership NHS Foundation Trust, John helped them to attain foundation trust status.

John is a member of the Chartered Institute of Management Accountants and the Chartered Institute of Public Finance and Accountancy and Fellow Chartered Director of the Institute of Directors. John held the role of Chair of the Audit Committee and Senior Independent Director for the Service.

Fergus Cass

Senior Independent Director

Fergus 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 Chair of the Finance and Investment Committee and Charitable Funds Committee and is our Freedom to Speak Up lead.

Professor Karim Brohi

Professor Brohi is a consultant Trauma Surgeon at Barts Health NHS Trust, Director of the London Trauma System at NHS England (London), and Director of the Centre for Trauma Sciences at Queen Mary University of London.

Sheila Doyle

Sheila joined the Service in February 2017 and has over 30 years' of experience at executive and board level in organisations including Norton Rose Fulbright, BP, Royal Mail, IBM and Deutsche Bank.

She specialises in delivering transformational change through the application of innovative technology solutions. She has managed international teams of 400 employees, delivered numerous complex change programmes and integrated diverse technology platforms in support of mergers and acquisitions. Sheila spent a number of years in Hong Kong, Singapore and Australia providing consulting services to the Financial Services and Manufacturing sector. She served as a non-executive director on the board of Companies House and was also a member of the Audit committee.

Sheila is currently the Chief Information Officer at Deloitte and is the Chair of the Logistics and Infrastructure Committee and Digital999 Programme Assurance Committee.

Jayne Mee

Jayne joined us in January 2017. She has spent more than 25 years in human resources and organisation development, working in executive roles with the Boots Company, Whitbread, Royal Mail, Punch Taverns and Barratt Developments.

Until June 2015 she was Director of People and Organisation Development at Imperial College Healthcare NHS Trust.

Through her work as an Executive Coach, Jayne supports executives and organisations in culture change, engagement and transformation. She is also a Non-Executive Director at University Hospitals Bristol and Weston NHS Foundation Trust and a trustee of St John Ambulance, where she chairs the People Committee and the Remuneration committee. She is also HR Counsel at Prezzo Restaurants.

Jayne is Chair of the People and Culture Committee.

Dr Mark Spencer

Dr Mark Spencer has been a GP for 40 years and continues to enjoy clinical work.

He is also Vice Chair of the London Clinical Senate – the clinical leadership for strategy and assurance for quality of service changes across the capital and has had various roles at NHS England (London), including Deputy Regional Medical Director and Medical Director for Quality and Service Design.

He has also worked in hospital inspection teams for the Care Quality Commission; has advised the National Institute for Health and Care Excellence (NICE) on commissioning guidelines; and has been part of the London Urgent and Emergency Care Clinical and Professional Leaders Group covering the whole of London for the past seven years.

As part of his new role at London Ambulance Service, Dr Spencer chairs the Service's Quality Assurance Committee, which monitors the quality of patient care as well as encouraging new improvements and innovations.

Amit Khutti

Associate Non-Executive Director (01/04/19 – 31/01/20)

Non-Executive Director (01/02/20 – present)

Amit is a technology entrepreneur, having co-founded Zava, one of Europe's largest online GP services in 2011.

Before becoming an entrepreneur, Amit led on strategy and planning for Chelsea and Westminster NHS Foundation Trust. Prior to joining the NHS, he was a senior civil servant delivering key health targets for then Prime Minister Tony Blair. Amit started his working life as a management consultant for McKinsey & Co, after studying English Literature at Oxford University.

Executive Directors

Trust Board members

Garrett Emmerson

Chief Executive Officer

Garrett was appointed Chief Executive in May 2017. Since then, he has led the Service through several major incidents including the 2017 and 2019 London terror attacks, the Grenfell Tower tragedy and, most recently, the Trust's response to the COVID-19 pandemic. In addition, in May 2018, the organisation moved from being in 'Special Measures', to achieving a Care Quality Commission (CQC) rating of "Good" overall; a rating that was sustained in 2019. Garrett is leading delivery of the Trust's vision to become London's primary integrator of access to urgent and emergency care.

Garrett was previously at Transport for London (TfL) where he was Chief Operating Officer for Surface Transport for eight years, and was responsible for implementing TfL's £4bn road investment programme. Before that, Garrett was Director of Strategy at TfL which followed his role as Director at transport consultancy, Steer Davies Gleave.

He is a former Head of Buckinghamshire County Council's Transportation Service and a former Member of the Government Commission for Integrated Transport and Motorists' Forum. He is also an independent advisor on the Office of Rail & Road (ORR) Highways Committee which monitors the performance and efficiency of Highways England, and a Non-Executive Director of Uno Bus Ltd.

Fenella Wrigley

Chief Medical Officer

Fenella was appointed the Chief Medical Officer for London Ambulance Service in March 2016 having been the interim Medical Director since January 2015. She has also been a consultant in emergency medicine since 2006.

She joined us as Assistant Medical Director for control services in 2008 and became Deputy Medical Director in 2010. Fenella has led on our development of urgent care, clinically overseeing the introduction of a Clinical Hub to provide clinical support and 'hear and treat'.

She is also the nominated officer responsible to oversee medication error incident reporting and is the Caldicott Guardian.

Paul Woodrow

Director of Operations (1/4/19 to 31/08/19)

Paul joined London Ambulance Service in 1991 and his clinical career has included time spent working on the frontline as a registered paramedic, he also worked as a flight paramedic on London's Air Ambulance, and was a clinical team leader.

He has since held a number of senior managerial positions with responsibility for operational delivery and performance.

As our Director of Operations, Paul was accountable for the day-to-day delivery of patient care, including frontline services, delivery, Emergency Preparedness, Resilience and Response, control services, our Hazardous Area Response Team, Patient Transport Services, Non-Emergency Transport Service and our NHS 111 arm in south east London.

Khadir Meer

Chief Operating Officer

Khadir joined us in September 2019 in the newly created role of Chief Operating Officer. Khadir oversees all aspects of our operating business, including integrated patient care (including both 111 and 999 call answering and clinical triage), emergency ambulance services, projects and programme delivery, technical services and asset and property management.

He has has more than 10 years' experience working in the NHS in London and before joining us was the Director of Performance and Improvement as well as the Chief Operating Officer for NHS England (London). During these roles he provided leadership during a period of significant change, including a number of major incidents.

Khadir will oversee our operational service delivery, and lead teams at the forefront of our pioneering work in delivering outstanding patient care.

Lorraine Bewes OBE

Chief Finance Officer

Lorraine joined us in July 2017 as the Interim Director of Finance and Performance, before becoming our Chief Finance Officer.

She has 25 years of NHS senior operational executive experience as well as in senior director roles at University College London Hospitals and Hammersmith and Charing Cross Hospitals.

Her last executive role was Chief Financial Officer of Chelsea and Westminster Hospital. She was also part of the management teams who took the trust to foundation trust status and negotiated the acquisition of West Middlesex hospital.

She has also held senior positions in FTSE 100 companies in the media and technology sectors including WH Smith Television Services and BT plc, and is a Non-Executive Director for a regulatory risk adviser to the financial services sector and a Foundation Governor of Lady Margaret School in Parsons Green.

Lorraine is a fellow of the ICAEW, a graduate of Trinity College, Oxford University and was awarded the OBE in the 2016 New Year Honors' List for her services to NHS Financial Management.

Dr Patricia Bain

Chief Quality Officer

Dr Trisha Bain joined us in January 2017 as Chief Quality Officer. She has more than 20 years' experience in quality improvement, patient safety and implementing system wide improvement programmes within NHS healthcare services.

Most recently Trisha was the Chief Quality Officer at Medway NHS Foundation Trust, and her career has also included roles with the former Commission for Healthcare Improvement and the National Patient Safety Agency.

Trisha is accountable for public and patient involvement and learning, safeguarding, health and safety, clinical governance, Serious Incidents, liaison with the Clinical Quality Commission, patient experiences and complaints, mental health, end of life care, frequent callers, nursing and risk management.

Board Register of Interests

The Board Register of Interests can be accessed via the Trust website using the following link: www.londonambulance.nhs.uk/about-us/our-publications/

A copy can also be requested from the Corporate Governance Team by emailing: committeesecretary@lond-amb.nhs.uk

Board attendance

Member		Trust Board	Audit Committee	Finance and Investment Committee	Logistics and Infrastructure Committee	People and Culture Committee	Quality Assurance Committee
Heather Lawrence	Trust Chair	11/11					6/6
Karim Brohi	Non-Executive Director	8/11				6/6	3/6
Fergus Cass	Non-Executive Director	11/11	6/6	6/6	5/6		5/6
Sheila Doyle	Non-Executive Director	10/11	5/6		5/6		
John Jones	Non-Executive Director	6/8	5/5	3/4			
Amit Khutti	Non-Executive Director	10/11		5/6			
Jayne Mee	Non-Executive Director	10/11		4/6		6/6	
Theo de Pencier	Non-Executive Director	8/10	5/6	3/5	5/5		
Rommel Pereira	Non-Executive Director	2/2					
Mark Spencer	Non-Executive Director	11/11				6/6	6/6
Garrett Emmerson	Chief Executive Officer	11/11		5/6			
Trisha Bain	Chief Quality Officer	11/11				4/6	5/6
Lorraine Bewes	Chief Finance Officer	10/11		6/6	4/6	1/6	
Khadir Meer	Chief Operating Officer	7/7			4/4	3/4	3/4
Paul Woodrow	Director of Operations	5/7				1/2	1/2
Fenella Wrigley	Chief Medical Officer	11/11					6/6

* Values shown are number of attendances against number of meetings during the year depending on when the Board member joined / left the Trust Board. Where there is no entry this means the Director is not a member of that committee.

Information Governance

In 2019/20, three information governance incidents were notified to the NHS Digital's Data Security and Protection Toolkit (DSPT) and two reported to the healthcare regulator the Information Commissioners Office. One incident was reported in August 2019 and related to staff member's personal information accidentally being made available to internal colleagues internally; no further action was taken by the regulator. In September 2019, an email containing an individual's personal information was sent in error to an external individual; no further action was taken by the regulator. In March 2020, pseudonymised sensitive health information was sent to 781 senior managers; no further action was taken by the regulator. It is important to note that the Trust investigates all breaches of Information Governance to identify the root cause of the incident and lessons to be learned.

Statement of Disclosure to Auditors

The Directors confirm that so far as they are aware:

- There is no relevant audit information of which the London Ambulance Service NHS Trust's auditor is unaware.
- They have taken all the steps they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the London Ambulance Service NHS Trust's auditors are aware of that information.
- Made such enquiries of his/her fellow Directors and of the Trust's auditors for that purpose; and
- Taken such other steps (if any) for that purpose, as are required by his/her duty as a Director of the Trust to exercise reasonable care, skill and diligence.

1.2. Statement of Accountable Officer's Responsibility

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

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

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 entity's auditors are aware of that information.

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.

Garrett Emmerson 18 June 2020

Chief Executive

1.3. Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

2. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of London Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in London Ambulance Service for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

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

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

5. The Director of Corporate Governance supports Executive Committee (ExCo) members and Non-Executive Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Trust Board, for maintaining the Board Assurance Framework (BAF). The BAF defines the principal risks to achieving the Trust's strategic objectives, together with associated controls, sources of assurance and action plans. The Chief Quality Officer is the quality governance lead for the Trust. She is responsible for the Trust's Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. She is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet requirements in relation to clinical governance and risk, up to and including the Trust's Corporate Risk Register. The holders of these two positions have continued to drive forward a significant workplan in 2019/20 to strengthen the Trust's risk management processes, at all levels of the organisation, from Board to station-level.

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

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

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

organisation with the identification and management of risk.

9. The Risk Management Strategy and Policy was reviewed to highlight clearly defined roles and responsibilities for the senior leadership team and the risk register levels further strengthened by a clear definition of the Corporate (Trust Wide) Risk Register and process for inclusion. This ensures that the right risks have been identified and prioritised for action. The structure of the Trust's Risk Compliance and Assurance Group (RCAG) was reviewed with an update to the Terms of Reference to include the Chief Quality Officer as Co-Chair of the meeting, due to their overall responsibility for risk management requirements up to and including the Corporate (Trust Wide) Risk Register, and to detail a clear purpose of the Group in relation to the BAF risks. The Trust Risk Manager has continued to improve, strengthen and embed Risk Management systems and processes across the Trust by increased engagement (both operational and corporate) to raise, review and mitigate risk. This has been evaluated by measuring compliance with the Trust KPI for risk review which has increased from 52.3% to 92.7% (target 90%) during the year. The effectiveness and maturity of the risk management process has also been measured by the internal auditors and areas for improvement have been identified including recommended updates of the Risk Management Procedure.

Staff – Training

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

11. The Trust's Risk Management Strategy and Policy sets out the approach that it takes to the provision of training in relation to risk management. An e-learning package 'Risk Awareness' is in development and will be available to all staff through ESR in Q1/2. Currently this course is offered by the Trust Risk Manager face to face in small groups. All managers that are responsible for implementing the risk management procedure locally receive more specialist training to enable them to fulfil their responsibilities. This training is generally offered on a one to one basis and tailored to be relevant to suit the responsibilities and risks associated with their role. All risk management training is recorded centrally in ESR. Staff have access to comprehensive risk guidance and advice via Risk Management Leads in the Quality Directorate, information embedded in the Risk Management page on the Trust intranet and by referring to the Risk Management Procedure. The Trust Risk Manager also supports staff in risk reviews and escalation through monthly quality governance meetings. The recent internal audit of Risk Management indicated that overall key risk management personnel have a good understanding of the risk management process. Risk management training is provided to Executive Committee and Board members every two years, in respect to high level awareness of risk management and to ensure that risks aligned to their remit are reviewed. The Trust Board last received such training in December 2018.

12. The Trust's mandatory and statutory training programme is regularly reviewed to ensure that it remains responsive to the needs of Trust staff. There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which includes elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. Despite significant operational pressures, the Trust has been able to achieve target levels of compliance with mandatory and statutory training requirements and this focus continues into 2020/21. Monitoring and escalation arrangements are in place to ensure that the Trust maintains its current good performance and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

The risk and control framework

Risk Management Strategy and Policy

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

14. The Risk Management Strategy and Policy, which was reviewed and amended in March 2020,

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

15. The Trust's Risk Management Strategy and Policy is an integral part of the Trust's approach to continuous quality improvement and is intended to support the Trust in delivering the key objectives within the Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements.

Identifying and reporting risk

16. Risks are identified routinely from a range of reactive & pro-active and internal & external sources including workplace risk assessments, analysis of incidents, complaints / PALS, claims, external safety alerts and other standards, targets and indicators etc. These are appropriately graded and ranked and included on the Trust's Corporate Risk Register and Board Assurance Framework (BAF). A Risk, Compliance and Assurance Group (RCAG) exists to review and monitor risks added to the Risk Register and regular reports from the Corporate Risk Register and the BAF are submitted to the relevant Board Assurance Committees and Trust Board. The Audit Committee has the delegated authority on behalf of the Trust Board for ensuring these arrangements are in place and remain appropriate. The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process. The BAF and Corporate Risk Register have continued to be kept under review and amendment during 2019/20 and the agenda of the Trust Board and Board Assurance Committees are closely aligned to these as a result.

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

Managing risk

18. Risk management is embedded in the activity of the organisation by virtue of robust organisational and committee structures which are reviewed and amended as necessary on an annual basis.

19. Of fundamental importance to the early identification, escalation and control of risk is the Trust's commitment to the ongoing development of a culture where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong', and a progressively 'risk aware' workforce. In addition to its standard incident reporting processes, Katy Crichton has been our substantive full time Freedom To Speak Up (FTSU) guardian since 2018/19. Concerns raised through FTSU are all investigated and many have led to improvements in processes in a number of different parts of the service. At Board level, Fergus Cass is the Non-Executive Director lead for FTSU.

Key events for FTSU:

- In September 2019, paramedic Erica Greene was appointed as part-time FTSU coordinator to support the guardian, liaise with the advocates and provide an alternative pathway for staff to raise concerns if a conflict of interest occurs with the guardian. We are recruiting a second part-time coordinator role due to the high demand on the team.
- The number of Freedom to Speak Up advocates grew from a team of 20 to 32. All of whom have received training in how to promote the work of FTSU and support staff to raise concerns.
- London Ambulance Service won an award from the National Guardians Office for having the most improved speaking up Index across all NHS trusts.
- London Ambulance Service won the Health Business Award 2019 for being The Ambulance Trust of the year. Special recognition was given to the FTSU team.

- Katy and Erica are both allies of the BME forum and the LGBT network. Katy gave a presentation at an International Women's day event held at HQ where she spoke about the work of Freedom to Speak Up.
- The FTSU team have a regular presence in the LAS intranet pages, internal weekly update and on the service's closed Facebook group. The FTSU page on the intranet is frequently updated with information about the advocates, how to speak up, and a news section. Katy and Erica attended a large number of the CEO Roadshows giving further visibility of FTSU to staff.
- The development of an e-learning package to educate staff and managers about the importance of speaking up is underway in line with the strategy.
- The FTSU Guardian has been part of the CEO's staff survey review group and is leading a 'speaking up' session at the sector leadership conferences in order to promote positive cultural change and empower local management teams.
- Freedom to Speak Up Month took place in October 2019. Staff engagement events took place and saw the guardian, coordinator and advocates reach out to staff across the service.
- The FTSU team rolled out a survey that collected valuable data from 168 members of staff about the current speaking up culture within the service.

20. Business Planning and Service Development proposals do not proceed without an appropriate assessment of and therefore recognition / acceptance of the risks involved and the involvement of the relevant expertise. The Trust's ExCo reviewed and agreed the approach to be taken to quality impact assessments (including equality and data protection assessments) in December 2017. This has continued to be used in the Trust's Business Planning activities for 2019/20.

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

22. The Trust Board last considered its approach to risk management and its risk appetite at a Board development session in December 2019. Work is being undertaken to further develop the Trust's Risk Appetite Statement in 2020/21; until this work has been completed, the Trust Board has agreed that the Risk Appetite Statement approved on 29 January 2019, which forms part of the BAF, remains appropriate.

23. Risks associated with data security and protection have been a focus of the Trust Board in 2019/20, particularly following a Trust Board Development session prompted by an internal audit report on cyber security. The Director of Corporate Governance took on the role of Senior Information Risk Officer (SIRO) in May 2020, together with responsibility for the oversight of information security as well as information governance. An action plan for the improvement of both of these aspects of the Trust's activities is being developed and will be a focus of the Logistics and Infrastructure Committee in 2020/21.

24. Towards the end of 2019/20, the Trust faced unprecedented levels of demand associated with the COVID-19 pandemic. The Board agreed to add a number of BAF-level risks in relation to this pandemic and work continues to understand and mitigate these. Significant amounts of work were undertaken to enable changes to governance and assurance frameworks to ensure a prompt response to the pandemic and reduce burden at a time of significant operational pressure. Use of existing business continuity and GOLD structures for decision-making as well as amended executive decision-making and Board Assurance structures has enabled the Trust to maintain control over its decision-making during this period. In order to ensure that all decisions were recorded appropriately, the Trust implemented a formal decision log.

25. In order to ensure the maintenance of an appropriate control environment, existing controls were adapted to ensure that they maintained appropriate rigor, whilst recognising the significant operational pressures facing the organisation. These amendments included changes to the Standing Financial Instructions with regard to COVID-19-related expenditure. Furthermore, these COVID-19 risk will be integrated into our new ways of working as part of the "new normal".

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

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

27. The key performance indicators reported to the Trust Board are being rated for data quality as part of the Data Quality Reviews (further information available below). Clear actions with lead person(s) timescales have been developed to implement the recommendations from the reviews to improve data quality of the systems and performance information.

28. London Ambulance Service is in the process of establishing an updated patient and public engagement strategy and, as part of this, the Trust Board has agreed to establish a Public and Patients Council. This will become fully operational in 2020/21.

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

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

30. In 2019/20 the Trust increased its focus on the strategic risks associated with workforce, through the BAF and through the People and Culture Committee. The People and Culture Committee has had a specific focus upon the development of a workforce planning model, providing assurance to the Board on this. The ExCo has also met as a Strategic Workforce Planning Group in 2019/20 and regularly received reports on strategic workforce planning activities, to provide additional oversight in this area.

Quality Strategy

31. The Trust has a clear quality strategy to direct quality governance and assurance from station to Trust Board. The Quality strategy aims to put patients and staff at the centre of everything we do and is underpinned by the Care Quality Commission's definition of quality. Alongside this, is a commitment to a just culture where reporting of both clinical and non-clinical incidents is central to continuous learning and improvement.

32. Quality Governance and assurance is supported by reliable information systems including Datix and Health Assure. These systems are a rich source of data which informs the Trust of its performance against various quality indicators. Each Sector has a dedicated Quality Governance and Assurance manager (QGAM) to oversee Patient safety and the quality of service at Sector level. Their work is overseen by a central quality Governance.

33. Every year, the Trust sets specific quality priorities which are reported in the annual Quality Account. These priorities are identified in

consultation with both internal and external stakeholder to ensure they are relevant and robust for the coming year. The Trust routinely reviews its performance against its quality priorities and this is reported through the governance structures which include, sector governance meetings, the Quality Oversight Group, the Quality Assurance Committee and the Trust Board. There are processes in place to review performance regularly across the year to ensure that gains are consolidated and any learning is utilised as part of the wider quality improvement plan. These processes include a series of Sector peer reviews and quality performance reviews which are designed to test how well the Trust is doing against the CQC's key lines of enquiry. The outcome of these reviews are reported to relevant teams and meetings to guide decisions and actions.

CQC registration and compliance with the NHS provider licence

1. The Trust is fully compliant with the registration requirements of the Care Quality Commission.
2. During 2019/20, CQC inspection activities at the Trust included:
   - Inspection of the Urgent and Emergency Care (U&EC) and the Emergency Operations Centres, (EOC).
   - Inspection of the NHS 111 services operated by the LAS, which are part of its two Integrated Urgent Care (IUC) services.
   - An annual well-led review.
3. The Trust's ratings for its EOC went down "requires improvements" overall. The rating for U&EC remained as "good". The rating for the Trust's NHS 111 was "good" overall. The well led inspection was also rated as "good".
4. The CQC's overall rating of the Trust remains "Good".
5. The Trust Board has assessed itself in compliance with the relevant aspects of the NHS provider licence at its meeting in May 2019. This assessment was reached following an internal review of the Trust's corporate governance framework.
6. With respect to condition FT4 (NHS Foundation Trust governance arrangements), the Board reviews the terms of reference of its Assurance Committees on an annual basis to ensure their effectiveness and last did so in March 2020. The Trust has an Audit Committee consisting of Non-Executive Directors. The Audit Committee regularly meets with the internal and external auditors without the presence of executive directors or staff. In addition, the Local Counter Fraud specialist presents a report to every meeting of the Audit Committee on measures to tackle Fraud, Bribery and Corruption and also the importance of reporting concerns as appropriate. The Trust also has a Remuneration and Nominations Committee consisting of the Non-Executive Directors, joined when appropriate, by the Chief Executive, the Director of People and Culture and the Director of Corporate Governance. In addition, the Board has established a Quality Assurance Committee, a People and Culture Committee, a Finance and Investment Committee and a Logistics and Infrastructure Committee. Each Committee is chaired by a Non-Executive Director. All Committees and sub Groups undertake an annual self-assessment of their effectiveness, which is reported to the Board (or the appointing Committee in the case of sub groups). The Audit Committee also submits an Annual Report to the Trust Board and regularly reviews the Standing Financial Instructions and Scheme of Delegation.
7. The terms of reference also serve to define the responsibilities, accountabilities and reporting lines of each Assurance Committee. The Board receives a report following each Assurance Committee meeting, written or approved by the Non-Executive Director Chair, and is therefore able to both receive assurance but also challenge any of the decisions made. Each Assurance Committee also has one identified lead Executive Director. The responsibilities of the Board and its Directors are defined in the Trust's Standing Orders and Standing Financial Instructions, which were reviewed in November 2019.
8. The Board has an annual schedule of business, which is reviewed at each formal meeting of the Board. The schedule defines when reports will be submitted, ensuring that the Board can operate timely and effective scrutiny of its operations. Key performance reports covering corporate, clinical, quality, workforce, finance and operational performance are received at each formal meeting of the Board and are made available on the Trust's website.
9. The Remuneration and Nominations Committee reviews, when necessary, the directorate

portfolios, and there is a clear organisational structure with staff and managers identified within each directorate, who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. Elsewhere within this report can be found the Trust's duty to operate efficiently, economically and effectively.

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

11. The Trust is compliant with health care standards that are binding which is demonstrated by the Trust being rated as "Good" overall following the CQC inspection in 2019. As part of gaining assurance Board and ExCo members are encouraged to visit staff in the sectors with each director allocated to a particular sector. In addition, at each meeting of the Board there is an opportunity to hear either a staff or patient story.

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

13. The Audit Committee discussed going concern assurance with the Trust's external auditor at its meeting in April 2020 and considered how this could be concluded without knowing the financial position for the following year. Audit Committee members agreed that fundamental changes related to the Trust's response to the COVID-19 pandemic had impacted on the operational cost base but that, whilst the national funding framework for the rest of 2020/21 and potentially 2021/22 was still under discussion, they were persuaded by the view that COVID-19 arrangements were likely to be more enduring than current guidance suggested and block arrangements were likely to apply for the majority of 2020/21. Therefore the Board is expected to approve the view that going concern will not be an issue. Management will prepare its cash flow projection to end June 2021 in support of this.

Roles and Responsibilities

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

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

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

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

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

18. There were a number of changes to the Trust's senior personnel in 2019/20:

- Patricia Grealish left the role of Director of People and Culture in June 2019 and was replaced by Ali Layne-Smith at the beginning of September 2019. Tina Ivanov undertook the role on an interim basis until Ali Layne-Smith joined the organisation.
- Paul Woodrow left the role of Director of Operations at the end of August 2019.
- Antony Tiernan took on the role of Director of Communication and Engagement at the beginning of September 2019.
- Khadir Meer took on the role of Chief Operating Officer at the beginning of September 2019.
- Ross Fullerton took on the interim role of Director of Strategy, Technology and Development at the beginning of November 2019.
- Benita Mehra left the role of Director of Strategic Assets and Property in November 2019.
- John Jones' term of appointment as Non-Executive Director and Chair of the Trust's Audit Committee came to an end at the end of January 2020, at which point he left the Trust and was replaced by Rommel Pereira at the beginning of February 2020.
- Theo de Pencier's term of appointment as Non-Executive Director and Deputy Chairman came to an end at the end of February 2020 and he left the Trust.
- Amit Khutti (previously Associate Non-Executive Director) was appointed as a Non-Executive Director with effect from the beginning of March 2020.
- Philippa Harding left the role of Director of Corporate Governance at the end of March 2020 and was replaced by Syma Dawson at the beginning of April 2020.

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

19. The purpose of the Executive Committee (ExCo) is to lead and manage the performance of the Trust within the strategic framework established by the Trust Board. The ExCo makes proposals to the Trust Board on key policy and service issues for Trust Board decision. The ExCo meets in a number of different forms throughout each month to focus on different aspects of the Trust's operations. As the Portfolio Management Board, it manages the portfolio of programmes and projects in place to deliver the Trust's Business Plan; as the Strategic Workforce Planning Group, it focuses on the actions required to ensure that the Trust will have the resources it requires to deliver its Strategy; and as the Performance Review Meeting, it retains detailed oversight of every aspect of the Trust's performance.

20. The ExCo has also established the following sub-groups:

    - the Risk Compliance and Assurance Group (RCAG) – to oversee the governance of the risk management process and management of risks rated greater than 15;
    - the Information Governance Group (IGG) - to ensure that the London Ambulance Service NHS Trust has clear direction of and management support for the activities required to comply with data quality principles; Caldicott principles; Information Security Management (ISO/IEC 17799 / ISO/IEC 27001); data protection legislation; the Freedom of Information Act 2000; the Data Security and Protection Toolkit; records management as defined by the Care Quality Commission (CQC); the Public Records Act; and the Information Governance Alliance Records Management Code of Practice for Health and Social Care.

21. The Audit Committee works closely with the Finance and Investment Committee in monitoring financial risks, but also balances assurance from the 2nd line of defence functions (principally the Director of Corporate Governance, Chief Financial Officer and Chief Quality Officer) with an independent 3rd line of internal and external audit programmes aligned to the Board's risk appetite and tolerances, and will be seeking to increase its assurances from 1st line functions over the coming year. It critically reviews and reports on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

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

23. The Quality Assurance Committee has responsibility for providing the Trust Board with assurance on the achievement of strategic objectives in relation to the provision of a high quality, safe, and effective service. The Trust's definition of quality encompasses three equally important elements:
    - Care that is safe – working with patients and their families to reduce avoidable harm and improve outcomes.
    - Care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients and their families.
    - Care that provides a positive experience – to patients and their families.

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

25. The Logistics and Infrastructure Committee has responsibility for providing the Trust Board with assurance on and overseeing strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate. At the end of 2019/20, the Board also decided to establish the time-limited Digital 999 Programme Assurance Committee, to provide assurance on the delivery of the Trust's Digital 999 Programme (replacement of the Computer Aided Dispatch system and implementation of the Electronic Patient Record Form).

Public Stakeholder involvement

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

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

28. The LAS is in the process of establishing an updated patient and public engagement strategy and, as part of this, the Trust Board has agreed to establish a Public and Patients Council. This will become fully operational in 2020/21.

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

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

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

Corporate Governance Statement

32. The Trust, under Condition FT4 of its Licence, is required to submit to NHS Improvement a Corporate Governance Statement by and on behalf of the Board of Directors confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. The Statement was drafted and approved by the Trust Board and submitted to the Regulator within the prescribed timescales. The Regulator received the statement and did not require a statement from its auditors either:
    - confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or;
    - setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

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

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

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

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

37. The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

NHS Pension Scheme

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

Equality, diversity and inclusion

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

40. We are committed to actively promoting equality and inclusivity and human rights among our organisation and ensuring equal and fair access to our services for all our patients and their families. We embrace diversity and recognise our responsibility to eliminate discrimination and harassment while supporting and empowering all our people.

    COVID-19 has put a spotlight of opportunity to create something different for the equality and diversity and inclusion work-stream moving forward. Lessons we have learned and changes we have made in response to the pandemic will help to inform our Inclusion and Diversity Strategy which we are aiming to publish in 2020/21.

    We are working towards ensuring our workforce reflects the diversity of the population it serves in London. We end 2019/20 having recruited more than 250 BME staff, representing over 24% of all our new starters. We now have more than 1,000 BME staff which is 16% representation. There is still more to do to increase these numbers and we will continue to put time effort and attention into this work.

    The biggest change has been in our leadership with 19% of senior managers 8c and above from a BME background, rising to 33% for Trust Board members as of March 31st 2020. We have also worked hard to increase gender diversity and 47% of our senior leadership team – including the Trust Board – is female.

    We are working with the College of Paramedics to improve BME admissions onto paramedic science degree courses across the country.

    We are now in the second year of our Workforce Race Equality Action Plan to address our ongoing challenges in this area. The WRES Action Plan Group, which is chaired by the CEO, meets quarterly to focus on driving this work forward.

    In December we launched a new staff Disability Network – called ENABLE - and we have developed an action plan to ensure people with a disability or long-term health condition get access to support to carry out the roles in the trust. The launch was timed to coincide with the promotion of Purple Light Up – a global movement designed to draw attention to the economic empowerment of disabled people.

Other key events for 2019/20 include:

- The National BME Forum is now hosted at London Ambulance Service every quarter and members of our BME forum attend.
- We held a series of well attended women's breakfasts with guest speakers from within and outside our organisation.
- We held our first Black History Month event in October to celebrate BME staff who contribute to the Trust's work on a day-to-day basis.
- Delegates from London Ambulance Service attended the second National Ambulance BME Conference in Brighton.
- Delegates from our LGBT Network attended the National Ambulance LGBT conference in Birmingham.

We celebrated International Women's Day in March by looking at how women contribute to the ambulance sector and how the role of female leaders has changed at London Ambulance Service over the last 20 years.

Carbon Reduction

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

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

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

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

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

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

45. The Trust's response to the COVID-19 pandemic in March 2020 involved the suspension of some of these measures; however it is content that an appropriate level of control was retained during this period (see paragraphs 25 & 26)

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

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

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

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

Information governance

50. The Trust continues to strengthen its arrangements for Information Governance. It has a robust programme of information governance improvements and awareness and a governance framework to monitor and assure the security of its information. An executive-led Information Governance Group exists as well as an Information Governance Strategy and Policy, along with a dedicated Information Security Policy.

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

52. Dependent on the nature of the incident, the information provided on the DSPT is sent to the Information Commissioner's Office, the Department of Health and Social Care, NHS England and the National Cyber Security Centre. In 2019/20, three information governance incidents were notified via the DSPT. Two of these were reported to the ICO. No action was taken by the ICO as a result of these.

53. Due to the outbreak of Covid-19, NHS Digital who have responsibility for the DSPT assessment have extended its submission deadline to 30 September 2020. Work is underway for LAS' final DSPT submission on 30 September 2020

Data quality and governance

54. In 2018/19, the Trust took steps to establish Data Quality Assurance, primarily through the establishment of a Data Quality Assurance team which was recruited and operational by July 2019, a new Integrated Performance Report and the approval of a new Data Quality Strategy (including a governance structure, policy and implementation plan).

55. Further significant progress was made in 2019/20 in implementing the Data Quality Strategy. A rigorous methodology has been developed and implemented for Data Quality Reviews of 11 key Information Systems and reporting arrangements used by the Trust. The Reviews identified data quality issues, recognised best practices or possible solutions to the issues and recommended how to adopt them.

Review of effectiveness

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

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

achieving its principal objectives have been reviewed.

58. The Trust received the following Head of Internal Audit Opinion for 2019/20:

"Significant assurance with some improvements"

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

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

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

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

Conclusion

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

Garrett Emmerson 18 June 2020

Chief Executive

Remuneration and Staff Report

Remuneration

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

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

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

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

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

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 47 to 50.

Banded Remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2019/20 was in the range of £215,001 to £220,000 on an annualised basis. The pay multiplier in 2019/20, based on annualised salary, was 5.98 times the median remuneration of the workforce, which was £36,399. In 2018/19, the banded remuneration of the highest paid director £210,001 to £215,000. The pay multiplier in 2018/19, based on annualised salary, was 5.92 times the median remuneration of the workforce, which was £35,865.

In 2019/20, one (2018/19, one) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £260,001 to £265,000 (2018/19 £285,001 to £290,000).

The range of staff remuneration is £20,001 to £265,000 (2018/19 £20,001 to £290,000).

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

The 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 2019/20

Name and Title	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Heather Lawrence, Chairman	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Rommel Pereira, Non-Executive Director (from 1st February 2020)	£0-£5,000	£0	£0	£0	£0	£0-£5,000
John Jones, Non-Executive Director (from 1st April 2019 to 31 December 2019)	£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 (from 1st April 2019 to 29th February 2020)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Sheila Doyle, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Jayne Mee, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Amit Khutti, Associate Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Karim Brohi, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Mark Spencer, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Garrett Emmerson, Chief Executive Officer	£210,001-£215,000	£0	£5,000-£10,000	£0	£0	£215,001-£220,000
Lorraine Bewes, Chief Finance Officer	£130,001-£135,000	£0	£5,000-£10,000	£0	£0	£140,001-£145,000
Paul Woodrow, Director of Operations (from 1st April to 31 August 2019)	£50,001-£55,000	£2,700	£5,000-£10,000	£0	£65,001-£67,500	£125,001-£130,000
Fenella Wrigley, Chief Medical Officer	£115,001-£120,000	£4,700	£0	£0	£82,501-£85,000	£200,001-£205,000
Patricia Bain, Chief Quality Officer	£125,001-£130,000	£0	£0	£0	£0	£125,001-£130,000
Khadir Meer, Chief Operating Officer (from 2nd September 2019)	£85,001-£90,000	£0	£0	£0	£40,001-£42,500	£130,001-£135,000

Paul Woodrow received £160,000 redundancy payment and a salary of £25,001 to £30,000 for the period 1st September to 29th November 2019 when he left the Trust.
The performance related bonus payments relate to the financial year 2018/19.

Salary and pension entitlements of senior managers (continued)

A) Remuneration 2018/19

Name and Title	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Heather Lawrence, Chairman	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Jessica Cecil, Non-Executive Director (from 1st April 2018 to 28Th February 2019)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director (from 1st April 2018 to 28th February 2019)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Sheila Doyle, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Jayne Mee, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Amit Khutti, Associate Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Karim Brohi, Non-Executive Director (from the 1st March 2019)	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Mark Spencer, Non-Executive Director (from the 1st March 2019)	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Garrett Emmerson, Chief Executive	£200,001-£205,000	£0	£5,001-£10,000	£0	£0	£210,001-£215,000
Lorraine Bewes, Director of Finance and Performance	£130,001-£135,000	£0	£0	£0	£0	£130,001-£135,000
Paul Woodrow, Director of Operations	£125,001-£130,000	£7,100	£0	£0	£10,001-£12,500	£135,001-£140,000
Fenella Wrigley, Medical Director	£110,001-£150,000	£4,700	£0	£0	£0	£115,001-£120,000
Patricia Bain, Chief Quality Officer	£125,001-£130,000	£0	£5,001-£10,000	£0	£0	£130,001-£135,000

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020
Heather Lawrence, Chairman	**	**	**	**	**	**	**
John Jones, Non-Executive Director (from 1st April 2019 to 31st December 2019)	**	**	**	**	**	**	**
Fergus Cass, Non-Executive Director	**	**	**	**	**	**	**
Theo de Pencier, Non-Executive Director (from 1st April 2019 to 29th February 2020)	**	**	**	**	**	**	**
Sheila Doyle, Non-Executive Director	**	**	**	**	**	**	**
Jayne Mee, Non-Executive Director	**	**	**	**	**	**	**
Amit Khutti, Associate Non-Executive Director	**	**	**	**	**	**	**
Karim Brohi, Non-Executive Director	**	**	**	**	**	**	**
Mark Spencer, Non-Executive Director	**	**	**	**	**	**	**
Rommel Pereira, Non-Executive Director (from 1st February 2020)	**	**	**	**	**	**	**
Garrett Emmerson, Chief Executive Officer	*	*	*	*	*	*	*
Lorraine Bewes, Chief Finance Officer	*	*	*	*	*	*	*
Fenella Wrigley, Chief Medical Officer	£2,501-£5,000	£5,001-£7,500	£45,001-£50,000	£105,001-£110,000	£773,592	£73,608	£882,333
Paul Woodrow, Director of Operations (from 1st April 2019 to 31st August 2019)	£0-£2,500	£0-£2,500	£45,001-£50,000	£115,001-£120,000	£888,971	£26,841	£992,655
Patricia Bain, Chief Quality Officer	*	*	*	*	*	*	*
Khadir Meer, Chief Operating Officer (from 2nd September 2019)	£0-£2,500	£0-£2,500	£25,001-£30,000	£50,001-£55,000	£351,006	£5,804	£391,380

*Garrett Emmerson, Lorraine Bewes and Patricia Bain are not members of the NHS Pension Scheme.
**Non-executive directors do not receive pensionable remuneration; there are no disclosures in respect of pensions for non-executive directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (23).

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

Table 1: Exit packages

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000s	Number of other departures agreed	Cost of other departures agreed £000s	Total number of exit packages	Total cost of exit packages £000s	Number of departures where special payments have been made	Cost of special payment element included in exit packages £000s
£10,000 - £25,000			2	36	2	36		
£50,001 - £100,000			1	58	1	58		
£150,001 - £200,000	1	160			1	160		
Totals	1	160	3	94	4	254	Nil	Nil

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

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

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

Reporting of other compensation schemes – Exit packages	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirements contractual cost	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	3	94
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring MHT approval	0	0
Total	3	94

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

Off-Payroll engagements

Table 1: Off-Payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	0
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	0
No. that have existed for between two and three years at the time of reporting.	0
No. that have existed for between three and four years at the time of reporting.	0
No. that have existed for four or more years at the time of reporting.	0

Table 2: New Off-Payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll.	0
Number of engagements reassessed for consistency/ assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review.	0

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

For any off-payroll engagements of board member, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

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

Staff report

Average Staff Numbers
The average number of staff has increased over last year 5,797 (2018/19 5,493) as the trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	12	5	7
Ambulance Service	2,853	2,816	37
Administration and estates	1,617	1,571	46
Healthcare assistants and other support staff	1,267	1,262	5
Nursing, midwifery and heath visiting staff	45	28	17
Scientific, therapeutic and technical	3	3	0
Total	**5,797**	**5,685**	**112**

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 2020, we had a workforce of 6,130 staff, made up of 3,150 men and 2,980 women. This was broken down as follows:

	Total	Female	Male
Directors	20	11	9
Senior Managers	263	113	150
Employees	5,847	2,856	2,991
Total	**6,130**	**2,980**	**3,150**

Over the course of the year, a total of 550 people left the service – a turnover rate of 9.5 per cent, compared to 12.4 per cent in 2018/19.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 205 paramedics left during 2019/20.

Staff Sickness

Information on sickness can be found on the NHS Digital site.

Staff Policies

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

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

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

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

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

As an employer, we are focusing on:

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

Staff Survey

We had the highest ever response rate to our 2019 NHS Staff Survey which was sent to everyone to complete online. The number of completed questionnaires was 72% – a Trust record and an increase of nearly 30% over the last three years. This compares exceptionally well to the average response rate nationally of 48%. Overall, 4,215 staff completed the survey, which is 651 more than last year.

We have seen statistically positive movement in 11 questions, but have gone backwards in 8. In the remainder of the survey questions (71), we've stayed about the same, which means we haven't made as much progress as we would have hoped overall. Our overall staff engagement score, which tells us how staff feel about the organisation generally, has remained static at 6.1 (on a scale of 1-10), comparing to a score of 7 for all trusts and 6.3 for ambulance trusts.

- 74% of us would be happy with the standard of care provided if a friend or relative needed treatment (compared to 71% across all trusts and 73% for ambulance trusts);
- 87% of us feel that the organisation encourages reporting of errors/near misses/incidents (compared to 88% across all trusts and 85% for ambulance trusts); and
- 70% of us feel that the organisation acts fairly in respect of career progression; an increase of 4% since last year (but comparing to 84% across all trusts and 73% for ambulance trusts).

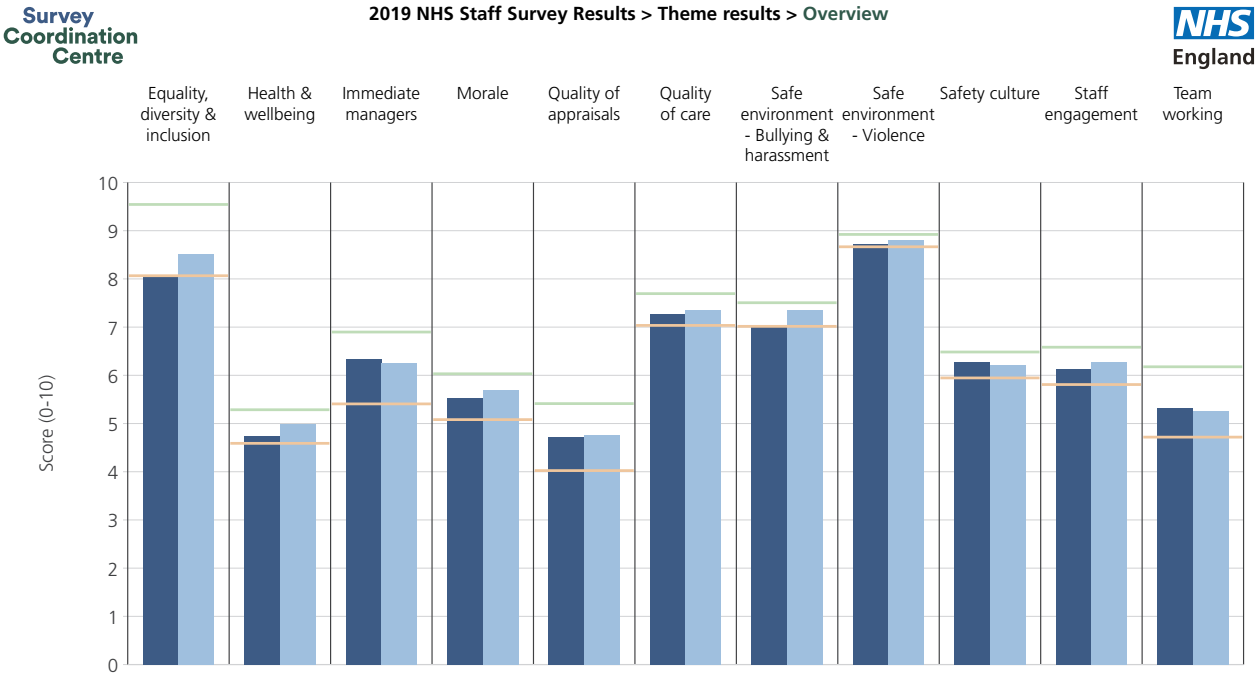
However, only 25% of us feel involved in changes that affect our work (compared to 52% across all trusts and 28% across ambulance trusts); 69% of us know who the senior managers are at LAS (compared to 83% nationally and 76% across ambulance trusts); and only 23% of us feel that senior managers involve us in important decisions (compared to 36% nationally and 25% in ambulance trusts). Sadly, over 20% of us have personally experienced discrimination at work from patients/service users or other members of the public, which is much higher than at other trusts (comparing to 7% across all trusts and 13% for ambulance trusts).

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

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

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

Analysis of feedback through ten key themes shows we are above average or average in three areas. The graph below sets out the analysis which shows there is still significant work to do if we want to be an employer of choice in the ambulance sector



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	5.3	6.9	6.0	5.4	7.7	7.5	8.9	6.5	6.6	6.2
Your org	8.1	4.7	6.3	5.5	4.7	7.3	7.0	8.7	6.3	6.1	5.3
Average	8.5	5.0	6.3	5.7	4.8	7.4	7.4	8.8	6.2	6.3	5.3
Worst	8.1	4.6	5.4	5.1	4.0	7.0	7.0	8.7	5.9	5.8	4.7
Responses	4,143	4,179	4,178	4,123	3,040	3,890	4,137	4,135	4,146	4,209	4,179

Following the results of the 2019 Staff Survey, our CEO is leading a programme of work to 'Build a World-class Workplace'. Based on feedback from staff, including the outcomes from the staff survey, the programme aims to turn shared priorities into real actions that deliver tangible change for everyone.

Discussions began at the Extended Leadership Group at the end of January and identified the key areas to focus on, including:

- **Getting the basics right** – from broken shutters through to overcomplicated HR processes, we are determined to make improvements that solve the 'small problems' that frustrate us
- **Communicating better** – making sure you know what we're doing to improve things … and supporting managers to do the same at a local level
- **Empowering our managers** – making sure local managers are empowered to make the changes they need, to cut through unnecessary bureaucracy and red tape, take ownership and lead in their own areas.

The first step with this initiative was to hold Sector-based events, the first of which was held in February. At these sessions there were discussions with key stakeholders where the organisation is currently, identifying the opportunities and blockers and begin to develop action plans to make improvements.

Expenditure on Consultancy

In 2019/20 the trust spent £0.4m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer:
Garrett Emmerson, Chief Executive

Organisation: London Ambulance Service NHS Trust

Signed:

Garrett Emmerson 18 June 2020

Chief Executive

2019/20 Introduction to the Annual Accounts

Financial Performance

For the financial year 2019/20 the Trust reported a surplus of £0.194m. The Trust had planned to report a £0.024m surplus. The improvement was due to in year non recurrent savings. The following table summarises the key elements of the financial performance of the Trust in 2019/20.

	Plan £m	Actual £m	Variance £m
Income	404.4	438.7	34.3
Expenditure	(404.4)	(438.5)	(34.1)
Surplus	0.024	0.194	0.17
EBITDA Surplus	20.9	16.4	(4.5)
Capital Resourcing Limit (CRL)	22.7	22.4	0.3
External Financing Limit (EFL)	8.4	(2.5)	10.9
Cash	15.1	26.0	10.9

In line with all NHS organisations LAS was required to identify efficiencies. In total £14.8m was identified and delivered in 2019/20.

The Trust continued to invest in new equipment, spending in excess of £22.5m on new vehicles to help improve the age profile of the fleet, IM&T system renewal and improvement, and additional clinical equipment.

	£m
Capital Expenditure	22.5
Less:	
NBV of Disposals	(0.1)
Capital Resourcing Limit (CRL)	22.4

Towards the end of the financial year the Trust incurred significant expenditure in relation to its response to the COVID-19 pandemic. Additional income of £6.8m was recognised in respect of expenses related to COVID-19 in respect of equivalent levels of cost and lost income reported to NHSI. It was also estimated that around £1.4m of additional costs were incurred in relation to increased annual leave accruals as a result of COVID-19. Given the non-cash nature of this expense however, the NHSI approach to this was to adjust Trust control totals to allow these increases in cost, thus no income was received or recognised in respect of this aspect.

NHS Trusts have a number of financial duties they must adhere to. The following section of the annual report outlines the performance of the Trust against those duties for the financial year ended 31 March 2020. The results outlined in this section relate to the full 12 month period of 1 April 2019 to 31 March 2020. A copy of the full statutory audited accounts is included in this annual report together with a glossary of terms to assist the reader in interpreting the accounts.

Financial Duties Review

Break-even duty

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

External Financial Limit

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

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

The original planned EFL was (£2.5m). The Trust had an under spend on its EFL of £10.9m due to higher than planned year-end cash balances. The Trust is permitted to under spend its EFL.

Capital Cost Absorption Duty

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

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

Capital Resourcing Limit

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

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

The Trust spent £22.4m on a range of projects, including ambulances and other vehicles including fast response cars and other vehicles, new technology projects and a range of projects to improve clinical equipment and the Trust's estate. Overall, the Trust underspent by £0.3m against its capital resource limit, which it is permitted to do. The capital programme was primarily funded internally, but was augmented with £1.8m of external support from the Department of Health and Social Care. The under spend on the capital programme will be carried forward into the 2019-20 financial year's capital programme.

Apply the Better Payment Practice Code

This regulatory duty requires NHS Trusts to pay all supplier invoices within 30 days. The Trust paid 89% of its trade invoices by volume within 30 days. This is below the 95% target set by the Department of Health and Social Care.

Pension costs

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

Financial plan 2020/21

Due to COVID-19 the Department of Health and Social Care has asked organisations to defer their financial planning for 2020/21. In line with this, NHSE/I have introduced temporary funding arrangements to ensure liquidity of NHS organisations in 2020/21. The arrangements involve advance payment of block centrally calculated funding amounts, along with retrospective top ups to breakeven monthly positions based on actual expenditure to take into account amounts spent on COVID-19 response initiatives. The Trust understands and is working under the assumption that the current or a similar regime will remain in force until the end of the year.

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. 2009/10 was the first year the Trust prepared its 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 2020 for all land and buildings. The net gain on revaluation was £3.4 million and the total impairments were £0.3 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 £5.7 million for the current financial year (£4.7 million in 2018/19).

Subsequent events after the balance sheet date

COVID-19 will have a material effect on the 2020/21 financial statements. The Department of Health and Social Care is currently reimbursing NHS organisations for the additional costs associated with responding to COVID-19 through the temporary funding mechanisms noted above in the Financial plan 2020/21 section.

Other information

Ernst and Young LLP were the Trust's external auditor for the year ended 31st March 2020. The Trust paid £86,000 (£83,000 in 2018/19) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our Audit Committee. Ernst and Young LLP have not undertaken any non-audit work for the Trust during the year ended 31st March 2020.

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 an NHS Trust established under the National Health Service Act 2006. The Secretary of State for Health has directed that the financial statements of 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 2019/20 Group Accounting Manual issued by the Department of Health and Social Care.

The financial statements for the year follow.

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

The Chief Executive of the NHS Improvement, in exercise of powers conferred on 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 NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

As far as I am aware, there is no relevant audit information of which the trust's auditors are aware, 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 entity's auditors are aware of that information.

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.

Garrett Emmerson 18 June 2020

Chief Executive

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 HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

By order of the Board

Garrett Emmerson
Chief Executive

Lorraine Bewes
Chief Finance Officer

18 June 2020

1.4. Audit Report

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

Opinion
We have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2020 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 33. 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 2019/20 HM Treasury's Financial Reporting Manual (the 2019/20 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2019/20 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:
- give a true and fair view of the financial position of London Ambulance Service NHS Trust as at 31 March 2020 and of its expenditure and income for the year then ended: and
- have been prepared property in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGNO1 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

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

Emphasis of matter — Property Plant and Equipment valuation
We draw attention to Note 1.23 Sources of estimation uncertainty and Note 15 Revaluations of property, plant and equipment of the financial statements, which describes the valuation uncertainty the Trust is facing as a result of COVID-19 in relation to property valuations. Our opinion is not modified in respect of this matter.

Emphasis of matter — Disclosures in relation to the effects of COVID-19
We draw attention to Note 1.2 of the financial statements, which describes the Financial and operational consequences the Trust is facing as a result of COVID-19 which is impacting patient demand, personnel available for work and being able to access offices. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern
We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:
- the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information
The other information comprises the information included in the annual report on pages 1 to 60 and 113 to 115, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.
We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006
In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2008 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception
We are required to report to you if:
- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014: or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in these respects

Responsibilities of the Directors and Accountable Officer
As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 60, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

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

Auditor's responsibility for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not 3 guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, 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 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we

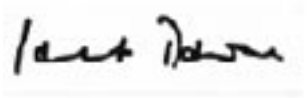
undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

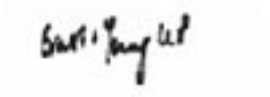
We are required under section 21{3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit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

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

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

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





Janet Daveson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
24 June 2020

Annual Accounts 2019/20

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	428,408	377,005
Other operating income	4	10,151	11,973
Operating expenses	5, 7	(433,604)	(378,154)
Operating surplus/(deficit) from continuing operations		**4,955**	**10,824**
Finance income	10	189	173
Finance expenses	11	(45)	(24)
PDC dividends payable		(4,846)	(4,482)
Net finance costs		**(4,702)**	**(4,333)**
Other gains / (losses)	12	(59)	131
Surplus / (deficit) for the year		**194**	**6,622**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	297	(2,027)
Revaluations	15	3,112	215
Total comprehensive income / (expense) for the period		**3,603**	**4,810**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		194	6,622
Remove net impairments not scoring to the Departmental expenditure limit		(55)	298
Remove I&E impact of capital grants and donations		35	38
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(125)	
Adjusted financial performance surplus / (deficit)		**49**	**6,958**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	13	8,183	5,746
Property, plant and equipment	14	177,183	165,304
Total non-current assets		**185,366**	**171,050**
Current assets			
Inventories	16	4,508	2,637
Receivables	17	22,270	27,057
Non-current assets for sale and assets in disposal groups		-	-
Cash and cash equivalents	18	25,964	21,718
Total current assets		**52,742**	**51,412**
Current liabilities			
Trade and other payables	19	(46,815)	(37,947)
Provisions	22	(6,584)	(5,533)
Other liabilities	20	(193)	(218)
Total current liabilities		**(53,592)**	**(43,698)**
Total assets less current liabilities		**184,515**	**178,764**
Non-current liabilities			
Borrowings	21	(107)	(107)
Provisions	22	(8,436)	(8,110)
Total non-current liabilities		**(8,543)**	**(8,217)**
Total assets employed		**175,972**	**170,547**
Financed by			
Public dividend capital		66,178	64,356
Revaluation reserve		55,620	54,070
Other reserves		(419)	(419)
Income and expenditure reserve		54,593	52,540
Total taxpayers' equity		**175,972**	**170,547**

The notes on pages 72 to 112 form part of these accounts.

Garrett Emmerson 18 June 2020

Chief Executive

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**64,356**	**54,070**	**(419)**	**52,540**	**170,547**
Surplus/(deficit) for the year	-	-	-	194	**194**
Other transfers between reserves	-	(1,859)	-	1,859	**-**
Impairments	-	297	-	-	**297**
Revaluations	-	3,112	-	-	**3,112**
Public dividend capital received	1,822	-	-	-	**1,822**
Taxpayers' and others' equity at 31 March 2020	**66,178**	**55,620**	**(419)**	**54,593**	**175,972**

Statement of Changes in Equity for the year ended 31 March 2019

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

Information on reserves

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

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

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

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

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,955	10,824
Non-cash income and expense:			
Depreciation and amortisation	5.1	11,535	15,205
Net impairments	6	(55)	298
(Increase) / decrease in receivables and other assets		4,643	(3,183)
(Increase) / decrease in inventories		(1,871)	109
Increase / (decrease) in payables and other liabilities		4,054	(177)
Increase / (decrease) in provisions		1,352	(4,202)
Net cash flows from / (used in) operating activities		**24,613**	**18,874**
Cash flows from investing activities			
Interest received		199	165
Purchase of intangible assets		(1,755)	(2,974)
Purchase of PPE and investment property		(16,039)	(25,224)
Sales of PPE and investment property		46	165
Net cash flows from / (used in) investing activities		**(17,550)**	**(27,868)**
Cash flows from financing activities			
Public dividend capital received		1,822	4,662
Other interest		(20)	(14)
PDC dividend (paid) / refunded		(4,620)	(4,236)
Net cash flows from / (used in) financing activities		**(2,818)**	**412**
Increase / (decrease) in cash and cash equivalents		**4,246**	**(8,582)**
Cash and cash equivalents at 1 April - brought forward		**21,718**	**30,300**
Cash and cash equivalents at 31 March	18	**25,964**	**21,718**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.
The London Ambulance Service NHS Trust Charitable Funds' Trust Deed established the London Ambualnce Service NHS Trust as a corporate Trustee. The Trust does not consider this charity fund, Charity Registration Number 1061191, is material therefore this has not been consolidated in the results of the Trust.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The key factors supporting this assumption are set out below.

In line with NHS specific considerations for going concern, all the operations of the Trust are considered to be continuing operations with no plans made or directions received for the provisions of service derived from operational activities of the Trust to either cease or be transferred to another organisation.

At the time of preparation of the financial statements the COVID-19 pandemic is ongoing and has resulted in the temporary suspension of contracting arrangements for 2020/21 between CCGs and the Trust, with funding for the Trust's services being settled by a block contract paid monthly and in advance at a sustainable value determined by NHS England. As a key provider of front line emergency health care services significant additional expenditure is being incurred by the Trust on resources in staffing, temporary staffing, patient transport and consumable supplies, such as personal protective equipment. In the financial year 20/21 where these levels of expenditure exceed the block contract values, further funding has been received by NHS England under a "top-up" regime to ensure Trusts break even. As such assurance is taken that national NHS arrangements are in place to ensure expenditure incurred in the financial year ended 31 March 2021 and beyond in relation to the COVID-19 response will be funded and not result in financial distress or risks to going concern. In addition the Trust has commenced discussions with funders on concluding the post COVID-19 revenue settlement via the NWL HCP accountable officers.

The Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 setting out that NHS Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. While there is uncertainty on the duration of the COVID-19 pandemic, arrangements in place across the NHS and as described here are believed to ensure the Trust remains both sustainably funded and a going concern for the foreseeable future.

Financial Governance arrangements in place within the Trust support the appropriate planning, forecasting and management of finances, as established through the Standing Orders, the Standing Financial Instructions and Scheme of Delegation, all of which have been reviewed and approved by the Trust board in March 2020. These along with the financial and operating policies of the Trust such as the Treasury Management Policy, provide the framework for financial decision making and support the preparedness and flexibility for overcoming financial challenge.

Detailed cashflow forecasting has been performed reflecting scenarios for the expected duration and values of the block contract arrangements during 2020/21 with a return to NHS Provider and CCG contracting at values in draft plans. The key assumptions in these scenarios are that the existing arrangements of block contract with central top up (excluding retrospective top up) continue for the remainder of the financial year and next year. Inflationary cost factors after March 2021 on pay and non-pay costs are anticipated to be matched by inflatory increases to funding in the 2021/22 financial year. The Trust will be able to maintain a positive cashflow until at least September 2021, not require any long term financial support to achieve a positive cashflow and be able to pay its creditors as they fall due during this period.

DHSC has made available Public Dividend Capital funding streams for support in the short-term and long-term for NHS Providers with exceptional needs or who are in financial distress. While the Trust is not forecast to require this support, assurance is to be taken from its availability that adverse financial challenges could be endured.

Note 1.3 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract

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

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

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.4 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

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

Measurement

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

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

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

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

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

Note 1.7 Property, plant and equipment cont'd

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

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

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

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

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

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

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

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

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

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

Note 1.7 Property, plant and equipment cont'd

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

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

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

Note 1.8 Intangible assets

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

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

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Useful lives of intangible assets

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

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

Note 1.9 Inventories

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

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

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

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

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

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

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

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

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

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

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

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

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

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

Note 1.12 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 a lessee

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

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

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 22 but is not recognised in the Trust's accounts.

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

Note 1.14 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 23, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Note 1.15 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.16 Value added tax

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

Note 1.17 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.18 Gifts

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

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

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

IFRS 16 Leases
IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust is working with Real Asset Management to develop an electronic lease register that will automate the accounting entries for leasing under the new standard. Financial procedures and controls are being modified to incorporate the changes arising from the new standard.
HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation .

Other standards, amendments and interpretations
The following list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2019-20.
- IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of iFRS after 1 January 2016. Therefore not applicable to DHSC group bodies. Not EU-endorsed.
- IFRS 17 Insurance Contracts - Application required for accounting periods begining on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 1.21 Critical judgements in applying accounting policies
There were no critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies.

Note 1.22 Sources of estimation uncertainty

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

Asset Valuations

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

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. The estimated economic lives are disclosed in note 1.7 and the carrying values of property, plant and equipment and intangible assets in notes 14.1 and 13.1 respectively.

The Trust have considered the 31 March 2020 valuation for material uncertainty arising from the developing economic impact of the COVID-19 pandemic as relevant to property valuation inputs. While we note this as a factor that reduces certainty in property valuations, we do not consider this to be a material uncertainty at 31 March 2020. An explanation of this assessment is provided in note 15.

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 22.

Annual Leave Accrual

The accrual is based on management's estimation of untaken leave as at 31 March 2020. The carrying value of the accrual is £5.74m within note 19 under accruals.

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 receivable is £3.57m within note 17 under prepayments and accrued income.

PPE and Intangible Assets

The Trust has carried out a review of the useful lives of its PPE (except land and Buildings) and intangible assets during the year. The result of the review has led to some changes in estimated useful lives of the following classes of assets.

Double Crew Ambulances

The previous useful life of these assets was 7 years. This has now been changed to 10 years.

Defibrillators & Stretchers

The previous useful life of these assets was 7 years. This has now been changed to 10 years.

Computer Software

The previous useful life of these assets was 3 years. This has now been changed to 5 years.

Information Technology

The previous useful life of these assets was 3 years. This has now been changed to 5 years.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	**2019/20**	**2018/19**
	£000	**£000**
A & E income	415,053	371,589
Patient transport services income	(11)	42
Other income	1,203	1,447
Agenda for Change pay award central funding*		3,927
Additional pension contribution central funding**	12,163	
Total income from activities	**428,408**	**377,005**

Additional income of £6.8m has been recognised in respect of expenses related to COVID-19. It has been included in A&E income above.

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2019/20	**2018/19**
Income from patient care activities received from:	**£000**	**£000**
NHS England	26,296	6,766
Clinical commissioning groups	397,514	362,608
Department of Health and Social Care	39	3,944
Other NHS providers	113	191
NHS other	194	-
Local authorities	(11)	-
Injury cost recovery scheme	1,203	1,447
Non NHS: other	3,060	2,049
Total income from activities	**428,408**	**377,005**
Of which:		
Related to continuing operations	428,408	377,005
Related to discontinued operations	-	-

Additional income of £6.8m has been recognised in respect of expenses related to COVID-19. It has been included in income received from NHS England above.

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	213	-	**213**	205	-	**205**
Education and training	4,671	-	**4,671**	2,167	-	**2,167**
Non-patient care services to other bodies	-		**-**	15		**15**
Provider sustainability fund (PSF)	3,143		**3,143**	9,310		**9,310**
Financial recovery fund (FRF)	1,591		**1,591**			
Income in respect of employee benefits accounted on a gross basis	533		**533**	276		**276**
Total other operating income	**10,151**	**-**	**10,151**	**11,973**	**-**	**11,973**
Of which:						
Related to continuing operations			**10,151**			**11,973**
Related to discontinued operations			**-**			**-**

Note 5 Expenses

Note 5.1 Operating expenses

	2019/20 £000	2018/19 £000
Staff and executive directors costs	312,595	266,604
Remuneration of non-executive directors	109	93
Supplies and services - clinical (excluding drugs costs)	17,580	7,685
Supplies and services - general	16,707	15,625
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	708	741
Inventories written down	(25)	(89)
Consultancy costs	385	436
Establishment	11,153	8,480
Premises	9,485	9,422
Transport (including patient travel)	28,723	28,313
Depreciation on property, plant and equipment	10,411	12,545
Amortisation on intangible assets	1,124	2,660
Net impairments	(55)	298
Movement in credit loss allowance: contract receivables / contract assets	18	4,821
Increase/(decrease) in other provisions	377	(626)
Change in provisions discount rate(s)	671	(168)
Audit fees payable to the external auditor		
audit services- statutory audit	86	83
other auditor remuneration (external auditor only)	-	-
Internal audit costs	109	119
Clinical negligence	3,711	3,621
Legal fees	1,302	662
Insurance	564	1,065
Research and development	941	771
Education and training	7,733	8,074
Rentals under operating leases	4,724	4,814
Redundancy	13	(198)
Car parking & security	1,190	282
Hospitality	2	-
Other	3,263	2,021
Total	**433,604**	**378,154**
Of which:		
Related to continuing operations	433,604	378,154
Related to discontinued operations	-	-

Additional expenditure has been incurred in relation to the Trust's response to COVID-19. Significant items include £4.36m incorporated in Staff and executive directors costs, £2.33m incorporated in Supplies and services - clinical (excluding drugs costs) and £0.85m incorporated in Transport (including patient travel) above.

Note 5.2 Other auditor remuneration

There was no other auditor remuneration in 2019/20 (2018/19 nil).

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 6 Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(55)	298
Total net impairments charged to operating surplus / deficit	**(55)**	**298**
Impairments charged to the revaluation reserve	(297)	2,027
Total net impairments	**(352)**	**2,325**

Note 7 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	243,662	216,011
Social security costs	27,216	24,191
Apprenticeship levy	1,216	1,085
Employer's contributions to NHS pensions *	39,998	24,714
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	13	(198)
Temporary staff (including agency)	8,521	10,690
Total gross staff costs	**320,626**	**276,493**
Recoveries in respect of seconded staff	-	-
Total staff costs	**320,626**	**276,493**
Of which		
Costs capitalised as part of assets	1,314	4,104

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have however been recognised in these accounts.

Note 7.1 Retirements due to ill-health

During 2019/20 there were 3 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £202k (£54k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The employer contribution rate for 2019/20 is 20.6%.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 9 Operating leases

Note 9.1 London Ambulance Service NHS Trust as a lessee

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

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

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	4,724	4,814
Total	**4,724**	**4,814**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	3,804	4,032
- later than one year and not later than five years;	7,354	9,520
- later than five years.	2,356	4,027
Total	**13,514**	**17,579**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2019/20 £000	2018/19 £000
Interest on bank accounts	186	170
Interest on other investments / financial assets	-	-
Other finance income	3	3
Total finance income	**189**	**173**

Note 11 Finance expenditure

Note 11.1 Finance expenditure

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

	2019/20 £000	2018/19 £000
Interest expense:		
Interest on late payment of commercial debt	20	14
Total interest expense	**20**	**14**
Unwinding of discount on provisions	25	10
Other finance costs	-	-
Total finance costs	**45**	**24**

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

	2019/20 £000	2018/19 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	20	14
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains / (losses)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	-	131
Losses on disposal of assets	(59)	-
Total gains / (losses) on disposal of assets	**(59)**	**131**

Note 13 Intangible Assets

Note 13.1 Intangible assets - 2019/20

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**2,984**	**-**	**-**	**17,794**	**-**	**-**	**-**	**3,336**	**-**	**24,114**
Additions	16	-	-	21	-	-	-	3,538	-	**3,575**
Reclassifications	361	-	-	884	-	-	-	(1,259)	-	**(14)**
Disposals / derecognition	-	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2020	**3,361**	**-**	**-**	**18,699**	**-**	**-**	**-**	**5,615**	**-**	**27,675**
Amortisation at 1 April 2019 - brought forward	**2,337**	**-**	**-**	**16,031**	**-**	**-**	**-**	**-**	**-**	**18,368**
Provided during the year	232	-	-	892	-	-	-	-	-	**1,124**
Reclassifications	-	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	-	**-**
Amortisation at 31 March 2020	**2,569**	**-**	**-**	**16,923**	**-**	**-**	**-**	**-**	**-**	**19,492**
Net book value at 31 March 2020	**792**	**-**	**-**	**1,776**	**-**	**-**	**-**	**5,615**	**-**	**8,183**
Net book value at 1 April 2019	**647**	**-**	**-**	**1,763**	**-**	**-**	**-**	**3,336**	**-**	**5,746**

Note 13.2 Intangible assets - 2018/19

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

Note 14 Property, Plant and Equipment

Note 14.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**52,154**	**61,613**	**-**	**15,921**	**18,833**	**54,387**	**16,716**	**319**	**219,943**
Additions	-	2,182	-	13,099	668	1,687	478	842	**18,956**
Impairments	-	(1,942)	-	-	-	-	-	-	**(1,942)**
Reversals of impairments	-	702	-	-	-	-	-	-	**702**
Revaluations	78	1,679	-	-	-	-	-	-	**1,757**
Reclassifications	-	265	-	(7,138)	928	2,829	3,126	4	**14**
Disposals / derecognition	-	(137)	-	-	-	(1,983)	(256)	-	**(2,376)**
Valuation/gross cost at 31 March 2020	**52,232**	**64,362**	**-**	**21,883**	**20,429**	**56,920**	**20,064**	**1,165**	**237,055**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**7**	**-**	**-**	**14,847**	**27,602**	**12,100**	**83**	**54,639**
Provided during the year	-	3,049	-	-	1,033	4,594	1,676	59	**10,411**
Impairments	-	(533)	-	-	-	-	-	-	**(533)**
Reversals of impairments	-	(1,059)	-	-	-	-	-	-	**(1,059)**
Revaluations	-	(1,355)	-	-	-	-	-	-	**(1,355)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(102)	-	-	-	(1,876)	(253)	-	**(2,231)**
Accumulated depreciation at 31 March 2020	**-**	**7**	**-**	**-**	**15,880**	**30,320**	**13,523**	**142**	**59,872**
Net book value at 31 March 2020	**52,232**	**64,355**	**-**	**21,883**	**4,549**	**26,600**	**6,541**	**1,023**	**177,183**
Net book value at 1 April 2019	**52,154**	**61,606**	**-**	**15,921**	**3,986**	**26,785**	**4,616**	**236**	**165,304**

Note 14.2 Property, plant and equipment - 2018/19

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

Note 14.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	52,232	64,355	-	21,883	4,549	26,561	6,541	1,023	**177,144**
Owned - donated	-	-	-	-	-	39	-	-	**39**
NBV total at 31 March 2020	**52,232**	**64,355**	**-**	**21,883**	**4,549**	**26,600**	**6,541**	**1,023**	**177,183**

Note 14.4 Property, plant and equipment financing - 2018/19

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

Note 15 Revaluations of property, plant and equipment

A professional revaluation was undertaken on all land and buildings at 31 March 2020.

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 valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on 11 March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries.

Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.

The Trust's valuation are therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we will keep the valuation of this these properties under frequent review.

a) Specialised In Use (Operational) assets - buildings valued using depreciated replacement cost

The majority of the trust buildings are valued using the depreciated replacement cost basis. There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. BCIS cost indices are used in determing the valuation of the buildings, at the present time, BCIS have advised and the District Valuers have agreed that it is too early for COVID-19 related issues to impact on BCIS indices published and adopted in our valuations.

b) Non - Specialised In Use (Operational) assets including the land element of the depreciated replacement cost valuation of specialised assets

The trust has a few non-specialised in use buildings. There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. Their basis of valuation is however current value in existing use, having regard to comparable market evidence and early commentary as it exists regarding direction of travel tends to suggest and support a downward movement in value. In our view, it is too early at this stage to evidence this impact accurately and it is our opinion at the date of valuation on the information then avaliable that the assessed impact falls within normal valuation tolerances.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

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

a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously;
b) in the respect of the Market Value of non-operational asset only the NHS is assumed not to be in the market for the property interest; and
c) regard has been had to appropriate lotting to achieve the best price.

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

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

GROSS CARRYING VALUE OF ASSETS IN USE

	2019/20 £000
Furniture & fittings	56
Transport equipment	11,083
Plant & machinery	11,353
Information technology	9,789
Total	**32,281**

Note 16 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	150	46
Consumables	4,358	2,591
Total inventories	**4,508**	**2,637**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £9,834k (2018/19: £10,542k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Due to COVID-19 a full count of the stock was unable to take place as at 31 March 2020. Where a count was not able to be performed the Trust has made an estimate of the stock value using the last performed stock count in January 2020. Stock has been estimated at the following sites; Deptford Stores, the majority of the ambulance stations and fleet workshops. The total value of stock estimated at 31 March 2020 is £3.8m.

Note 17 Receivables

Note 17.1 Contract and other receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	17,419	27,354
Capital receivables	51	11
Allowance for impaired contract receivables / assets	(920)	(5,668)
Prepayments (non-PFI)	4,805	4,561
Interest receivable	10	20
PDC dividend receivable	-	174
VAT receivable	468	15
Other receivables	437	590
Total current receivables	**22,270**	**27,057**
Non-current		
Contract receivables	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Prepayments (non-PFI)	-	-
Interest receivable	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current receivables	**-**	**-**
Of which receivable from NHS and DHSC group bodies:		
Current	12,614	18,116
Non-current	-	-

Note 17.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**5,668**	**-**	**-**	**853**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**5,668**	**-**	**-**	**853**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			853	(853)
New allowances arising	58	-	4,850	-
Reversals of allowances	(40)	-	(29)	-
Utilisation of allowances (write offs)	(4,766)	-	(6)	-
Allowances as at 31 Mar 2020	**920**	**-**	**5,668**	**-**

Note 18 Cash and cash equivalents movements

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

	2019/20 £000	2018/19 £000
At 1 April	**21,718**	**30,300**
Prior period adjustments		-
At 1 April (restated)	**21,718**	**30,300**
Net change in year	4,246	(8,582)
At 31 March	**25,964**	**21,718**
Broken down into:		
Cash at commercial banks and in hand	8	7
Cash with the Government Banking Service	25,956	21,711
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**25,964**	**21,718**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**25,964**	**21,718**

Note 19 Payables

Note 19.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	6,807	7,540
Capital payables	8,786	4,049
Accruals	20,125	16,483
Social security costs	3,998	3,563
Other taxes payable	2,939	2,718
PDC dividend payable	52	-
Other payables	4,108	3,594
Total current trade and other payables	**46,815**	**37,947**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	969	1,769
Non-current	-	-

Note 20 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	193	218
Total other current liabilities	**193**	**218**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 21 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Bank overdrafts	-	-
Other loans	-	-
Total current borrowings	**-**	**-**
Non-current		
Other loans	107	107
Total non-current borrowings	**107**	**107**

Note 21.1 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**-**	**107**	**-**	**-**	**107**
Cash movements:					
Financing cash flows - payments and receipts of principal	-	-	-	-	**-**
Financing cash flows - payments of interest	-	-	-	-	**-**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	-	-	-	-	**-**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2020	**-**	**107**	**-**	**-**	**107**

Note 21.2 Reconciliation of liabilities arising from financing activities - 2018/19

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

Note 22 Provisions

Note 22.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2019	**1,291**	**7,386**	**372**	**-**	**-**	**150**	**4,444**	**13,643**
Change in the discount rate	**46**	**625**	**-**	**-**	**-**	**-**	**-**	**671**
Arising during the year	**50**	**574**	**366**	**-**	**-**	**-**	**4,681**	**5,671**
Utilised during the year	(157)	(493)	(149)	-	-	(150)	(2,409)	**(3,358)**
Reversed unused	**-**	**(342)**	**(269)**	**-**		**-**	**(1,021)**	**(1,632)**
Unwinding of discount	**4**	**21**	**-**	**-**	**-**	**-**	**-**	**25**
At 31 March 2020	**1,234**	**7,771**	**320**	**-**	**-**	**-**	**5,695**	**15,020**
Expected timing of cash flows:								
- not later than one year;	155	414	320	-	-	-	**5,695**	**6,584**
- later than one year and not later than five years;	621	1,668	-	-	-	-	**-**	**2,289**
- later than five years.	458	5,689	-	-	-	-	**-**	**6,147**
Total	**1,234**	**7,771**	**320**	**-**	**-**	**-**	**5,695**	**15,020**

Injury Benefits provision of £7,771k (2018/19 £7,387k) relates to staff injured at work, whilst the Early Departure Costs provision of £1,234k (2018/19 £1,291k) relates to staff who have taken early retirement. Both amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of -0.50% is applied.

The Legal Claims provision of £320k (2018/19 £372k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

There is not currently a redundancy provision, however the prior year provision (2018/19 £150k) relates to management restructures within the Trust.

Other provisions of £5,695k (2018/19 £4,444k) includes £3,970k in relation to pending legal cases affecting calculation of holiday pay, £1,187k for pending employment tribunals, £306k in relation to whether team leader allowances are pensionable and £232k in relation to relocation costs for recruitment of overseas paramedics.

Note 22.2 Clinical negligence liabilities

At 31 March 2020, £64,277k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of London Ambulance Service NHS Trust (31 March 2019: £54,231k).

Note 23 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(170)	(156)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(170)**	**(156)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(170)**	**(156)**
Net value of contingent assets	**-**	**-**

Note 24 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	3,765	8,095
Intangible assets	279	3
Total	**4,044**	**8,098**

Note 25 Financial instruments

Note 25.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 25.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	16,992	-	-	**16,992**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	25,964	-	-	**25,964**
Total at 31 March 2020	**42,956**	**-**	**-**	**42,956**

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

Note 25.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Other borrowings	107	-	**107**
Trade and other payables excluding non financial liabilities	39,826	-	**39,826**
Total at 31 March 2020	**39,933**	**-**	**39,933**

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

Note 25.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	39,826	31,665
In more than one year but not more than two years	-	-
In more than two years but not more than five years	107	107
In more than five years	-	-
Total	**39,933**	**31,772**

Note 25.5 Fair values of financial assets and liabilities

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

Note 26 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	5	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	12	12	11	7
Stores losses and damage to property	2,320	927	2,366	1,360
Total losses	**2,333**	**944**	**2,377**	**1,367**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	19	584	25	472
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**19**	**584**	**25**	**472**
Total losses and special payments	**2,352**	**1,528**	**2,402**	**1,839**
Compensation payments received		-		-

Note 27 Related parties

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

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

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

	Payments to Related Party £000s	Receipts from Related Party £000s	Amounts owed to Related Party £000s	Amounts due from Related Party £000s
NHS Barking and Dagenham CCG	-	11,056	16	155
NHS Barnet CCG	-	14,964	-	117
NHS Bexley CCG	-	11,657	-	82
NHS Brent CCG	-	15,010	-	329
NHS Bromley CCG	-	15,271	-	158
NHS Camden CCG	-	12,167	-	98
NHS Central London (Westminster) CCG	-	13,159	-	88
NHS City And Hackney CCG	-	13,988	14	87
NHS Croydon CCG	-	17,111	-	116
NHS Ealing CCG	-	14,800	-	100
NHS Enfield CCG	-	13,624	-	124
NHS England	-	18,949	-	8,958
NHS Greenwich CCG	-	13,750	-	90
NHS Haringey CCG	-	11,215	-	84
NHS Havering CCG	-	13,559	21	243
NHS Hillingdon CCG	-	14,326	-	103
NHS Hounslow CCG	-	11,686	-	87
NHS Islington CCG	-	10,770	-	98
NHS Lambeth CCG	-	16,413	-	112
NHS Lewisham CCG	-	13,556	-	89
NHS Newham CCG	-	15,440	18	105
NHS Redbridge CCG	-	13,344	20	141
NHS Southwark CCG	-	15,987	-	105
NHS Tower Hamlets CCG	-	13,645	17	130
NHS Waltham Forest CCG	-	11,888	17	88
NHS Wandsworth CCG	-	11,998	-	76
NHS West London (KandC And QPP) CCG	-	10,329	-	70

The Trust has a number of staff who also work for St John Ambulance Service. Transactions with St John Ambulance Service during the year comprised expenditure of £1,858k (2018/19 £1,678k), income of £Nil (2018/19 £3k) and the amount payable by the Trust as at 31 March 2020 was £115k (31 March 2019 £36k).

Fenella Wrigley has worked for the following organisations that have had transactions with the Trust during 2019/20. Receipts from related parties Home Office £128k (2018/19 £49k), All England Lawn Tennis Club £104k (2018/19 £nil) and Barts Hospital £60k (2018/19 £66k). Payments to Barts Hospital was £120k (2018/19 £83k). Amounts due from Barts Hospital is £45k (2018/19 £Nil) and Home Office is £35k (2018/19 £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 2019/20.

Note 28 Events after the reporting date

At the time of preparation of the financial statements the COVID-19 pandemic is ongoing and has resulted in the temporary suspension of contracting arrangements between CCGs and the Trust, with funding for the Trust's services being settled by a block contract paid monthly and in advance at a sustainable value. As a key provider of front line emergency health care services significant additional expenditure is being incurred by the Trust on resources in staffing, temporary staffing, patient transport and consumable supplies, such as personal protective equipment. The expenditure arising in March 2020 and recognised in the year to 31 March 2020 on this pandemic was £6.8m, and was fully funded by NHS England. NHS arrangements are in place to ensure expenditure incurred in the financial year ended 31 March 2021 and beyond in relation to the COVID-19 response will be funded. While there is uncertainty on the duration of the COVID-19 pandemic, arrangements in place across the NHS and as described here are believed to ensure the Trust remains sustainably funded and a going concern for the foreseeable future.

Note 29 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	53,149	191,362	57,760	117,567
Total non-NHS trade invoices paid within target	47,325	176,414	47,952	93,303
Percentage of non-NHS trade invoices paid within target	89.0%	92.2%	83.0%	79.4%
NHS Payables				
Total NHS trade invoices paid in the year	380	2,506	253	2,455
Total NHS trade invoices paid within target	333	1,998	223	1,404
Percentage of NHS trade invoices paid within target	87.6%	79.7%	88.1%	57.2%

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

Note 30 External financing limit

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

	2019/20 £000	2018/19 £000
Cash flow financing	(2,511)	13,244
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**(2,511)**	**13,244**
External financing limit (EFL)	8,395	20,350
Under / (over) spend against EFL	**10,906**	**7,106**

Note 31 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	22,532	21,532
Less: Disposals	(145)	(48)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**22,387**	**21,484**
Capital Resource Limit	22,675	21,788
Under / (over) spend against CRL	**288**	**304**

Note 32 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	49
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2018/19 post-accounts PSF reallocation	125
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**174**

Note 33 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,425	1,002	2,751	262	262
Breakeven duty cumulative position	2,569	3,994	4,996	7,747	8,009	8,271
Operating income		279,864	283,617	281,731	303,109	303,827
Cumulative breakeven position as a percentage of operating income		1.4%	1.8%	2.7%	2.6%	2.7%

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	6,048	(4,405)	6,143	5,758	6,958	174
Breakeven duty cumulative position	14,319	9,914	16,057	21,815	28,773	28,947
Operating income	324,052	319,992	355,507	364,598	388,978	438,559
Cumulative breakeven position as a percentage of operating income	4.4%	3.1%	4.5%	6.0%	7.4%	6.6%

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty assessment should be 2009/10. Periods prior to 2009/10 have been consolidated to provide the cumulative breakeven position. The Trust is subject to a three year period for recovery of any deficit incurred. The application of breakeven duty means that if a cumulative surplus or deficit is reported (greater than a materiality threshold of 0.5% of operating income), it should be recovered within the subsequent two financial years.

Appendix – Glossary of Terms

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

STATEMENT OF COMPREHENSIVE INCOME

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

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

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

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

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

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

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

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

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

STATEMENT OF FINANCIAL POSITION

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

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

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

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

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

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

NOTES TO THE ACCOUNTS

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

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

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

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

Prepayments
Where the Trust has paid in advance for goods or services – for example, quarterly payment in advance for telephone rentals.
Deferred Income
Income received in the financial year but deferred to a subsequent accounting period because the relevant services will be provided in that future accounting period.

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

TERMINOLOGY

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

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

Revenue Expenditure
Expenditure on the day to day operations of the Trust whose benefit is used in that accounting period such as pay expenditure, payment for services etc, as opposed to capital expenditure which generates economic benefits in future accounting periods as the asset created is used over time.

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

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

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

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

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

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

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

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

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

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

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

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

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

Annual Report & Accounts 2019/20

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