London Ambulance Service
NHS Trust

Annual Report
2017/18

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1 Chair's foreword

The care our staff provide to patients was recognised as 'outstanding' by the Care Quality Commission (CQC) in 2015; however, at the same time significant failings were identified resulting in the Trust being placed in special measures by our regulators. The Board took this very seriously and since that time significant changes have occurred resulting in improved systems and processes, and in engaging with our staff.

I am delighted to be able to announce that the CQC re-inspected the Trust in March this year and has assessed the Trust as 'good' overall resulting in NHS Improvement's decision to take the Trust out of Special Measures. Whilst we are proud of this achievement, our work is far from done and we will not rest until the organisation is seen as 'outstanding' by all, and most importantly by patients and our staff.

As the demand for health services in London continues to grow the London Ambulance Service (LAS) has a significant and increasing role in working collaboratively with the rest of the health sector as well as the Metropolitan Police Service and London Fire Brigade to meet the needs of the population of London including those who visit and work in the capital. I am pleased to be able to report that over the last year the Trust has made significant progress in the quality of the services it provides, the range of services it provides and in meeting the new Ambulance Response Programme targets. This has been achieved under the leadership of our new Chief Executive, Garrett Emmerson and his executive team whom I am delighted to introduce to you through this report.

Alongside this, 2017/18 was a challenging year for the NHS and London's emergency services. Our people have had to cope with increased demand and the horrors of terrorism and the Grenfell Tower fire. I am extremely proud of how the Service and all our staff have risen to these challenges and on behalf of the Board offer our heartfelt thanks to them. We continue to work closely with London's other emergency services to make sure we can respond effectively to major incidents; as they occur.

One area of work we want to progress further is our efforts to build a workforce that more accurately reflects the diversity of the patients we serve. We have a detailed action plan to deliver on the Workforce Race Equality Standard and saw some important progress in the last year. I was delighted to welcome Amit Khutti to our non-executive team in January 2018, and through the year we have been running targeted recruitment in Black and Minority Ethnic (BME) publications; holding regular BME network sessions; and in October 2017 we re-established our equality committee. I'm also very excited to see a new sponsorship and mentoring pilot launch in May 2018. We hope it will support BME staff from bands 5-7 to develop their careers further within the Trust.

Alongside all these changes we have also developed new and exciting strategies to enable the Trust to develop our services and staff, and work with other providers to better meet the needs of the population we serve embracing both new technologies and roles for our staff.

Heather Lawrence OBE,
Chair

2 Chief Executive's foreword

I would like to echo Heather's thanks to all our people for their continued commitment. Since joining the Service in May 2017. I have become immensely proud of what we do and the amazing work our people do, day in and day out, for our patients and Londoners in general.

For most people, their only contact with our service is with the 999 and 111 call handlers and the paramedics responding to incidents. However, having been out and about meeting teams, I can assure you it is a huge collective effort. We could not do what we do without the commitment of all our support teams, from fleet and logistics teams who keep our vehicles on the road and equipped with all the kit the crews need, to estates, HR, IM&T and many others.

In 2017/18 we again saw increasing numbers of calls to 999 and 111. In addition, the winter pressures have been the toughest the NHS has experienced in many years. Despite these pressures we have performed well and have consistently ranked in the top three or four ambulance trusts across the country for our response times.

Our performance against quality indicators has also been strong, as our full Quality Account shows (available on our website). In 2017/18 we have established a strong grip on our quality performance and processes. We have addressed most of issues raised by our previous CQC inspection and have robust plans to continue improving. Alongside good performance in the care we provide we also finished the year in a strong financial position with a small surplus of £5.7m.

We have also established a clear direction for the future. We are clear that we have an essential role in improving the quality of emergency and urgent care services across London. Our strategy for the next five years identifies three themes which will improve patient care and value for money.

We want to develop an integrated clinical assessment and triage service to coordinate the flow of patients through urgent and emergency services; making it as easy as possible for people to get the help they need.

We will continue to provide high quality care to everyone who contacts us, especially those most critically ill and injured. However, we will place a stronger emphasis on assessment and enhanced treatment at scene and in community settings. Pilots have already proven effective and have shaped the commitments we are making in our new strategy.

Equally, as the only pan-London NHS provider, we will work with our partners to identify opportunities to provide more consistent, efficient and equitable services that benefit patients and the healthcare system.

Developing the strategy has been an important piece of work in 2017/18 and one which has involved many of our staff and external stakeholders. I would like to thank everyone who has helped to shape it and the future of our service. You can find out more in section 8 of this report and our full strategy we be available on our website.

Garrett Emmerson,
Chief Executive

3 About us

This section provides an overview of who we are and what we do. We summarise the services we provide; our vision, purpose and values; and performance in 2017/18. Some of the key risks and challenges we face are set out later in the report in section 7.6.

We are the largest and busiest ambulance service in the UK and the only London-wide NHS Trust. We have over 5,300 staff and over 1,100 vehicles providing a 24/7 service for Londoners, commuters and visitors to the capital. We cover around 620 square miles and work from 70 bases. Our fleet is being constantly developed and now includes: 446 ambulances, 208 cars, 21 motorbikes and 78 bicycles.

In 2017/18 we answered 1.9 million 999 calls and attended 1.2 million incidents. Our NHS 111 service answered 356,826 calls.

3.1 Our services

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

However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. We have a range of clinicians and vehicles to respond to less urgent situations and are providing an increasing amount to telephone only support.

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

- Taking and prioritising 999 calls
- 999 emergency and urgent care responses (*See and treat* support)
- Clinical telephone advice – (*Hear and treat* support; providing advice to people with less serious illnesses and injuries that don't need a paramedic to be sent to them)
- Dispatching and providing paramedics for London's Air Ambulance
- NHS 111 service for south east London
- Planning for, and responding to, large-scale events and major incidents

We provide a **non-emergency transport service**. This supports our core 999 service in transporting low priority patients to healthcare facilities when there is little or no clinical intervention required en route. The service helps free up paramedic crews to attend life-threatening calls and helps to minimise response times for lower priority patients. The service has continued to grow since being established in 2015 and at the end of 2017/18 was providing approximately 760 journeys a week.

In 2017/18 we also provided **patient transport services**, taking patients to and from their pre-arranged hospital or clinic appointments. We delivered seven contracts across London but have been in the process of handing these over to alternative providers. We stopped providing five of the services during the year and will transfer the final two contracts in April 2018.

3.2 Vision, purpose and values

Our vision, purpose and values for 2017/18 are set out below.

Vision To make the LAS great by delivering safe, high quality care that meets the needs of our patients and commissioners, and that make our staff proud.

Purpose To care for people in London: saving lives; providing care; and making sure they get the help they need.

Values

- **Clinical Excellence:** giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

- **Care**: helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

- **Commitment**: setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.

As part of developing a new five-year strategy (see section 8) we have worked with staff and partners to develop new vision and purpose statements. These will be in place from April 2018.

3.3 Performance summary

The table below gives a summary of our performance in key areas. There is more detail in section 7.

	Measure		2017/18	2016/17
Activity	Total 999 calls		1,892,660	1,826,842
	Incidents attended		1,128,348	1,114,099
	Average response time - Category 1 (most life threatening incidents) 1 Nov 17 - 31 Mar 18		7.17 mins	Reporting in this area changed mid-year so is not comparable with 2016/17.
	NHS 111 South East London	Total calls	356,826	319,078
		% answered within 60 seconds	90%	94.4%
		Referrals to 999	8.2%	7.6%
Money	Financial performance (year-end position)		£5.7m surplus	£6.0m surplus

Our Trust Board is made up of 14 members — our Chair, six non-executive directors, two associate non-executive directors and five executive directors (including our chief executive). The Board meets in public monthly. Dates, meeting papers and profiles of our board members are on our website: www.londonambulance.nhs.uk/about-us/how-we-are-run/trust-board/

Connect with us and find out more

To keep up-to-date with our work you can follow us on social media. We have accounts on Twitter (@Ldn_Ambulance) Facebook (@LondonAmbulance) Instagram (ldn_ambulance) and YouTube (londonambulance).

You can also find news, publications, details of public board meetings and more about what we do on our website at www.londonambulance.nhs.uk

4 Our patients

4.1 Who we care for

We care for patients with a wide range of critical and urgent conditions:

- Critical care patients are those who are most seriously ill or injured. They include cardiac arrest, heart attack, stroke, and major trauma patients.

- Urgent care covers all other conditions which need our help but are not immediately life-threatening. Examples include maternity, mental health, falls, and minor injuries

4.2 Responding to critical care patients

London has developed specialist centres to care for patients with the most critical illnesses and injuries. We now assess patients' conditions and take people directly to specialist units. Taking people directly to these centres of excellence allows them to get the best care faster; even if the travel time in an ambulance is longer than going to a local hospital.

Critical care patients include people suffering cardiac arrest, heart attacks, stroke and major trauma. They make up approximately 66% of all the incidents we attend. You can find out more about how we support these patients in our Quality Account.

4.3 Responding appropriately to urgent calls

With around 34% of the incidents we attend being urgent, rather than critical, it is essential that we provide an effective response for patients with non-life-threatening conditions. In doing so we must balance the needs of these patients with our need to prioritise ambulances attending critical incidents.

Through 2017/18 we have continued to develop our 'hear and treat' services, where urgent calls are transferred to clinicians to discuss options with the patient.

We also piloted a new service with advanced paramedic practitioners responding to urgent care calls in a car, rather than sending an ambulance with two staff. During 2017/18 the pilot service, based at Croydon, the vast majority of patients were cared for or referred to other services without needing to attend an emergency department. From April 2018 we are extending the service to two more areas of London.

The success of this service, and the growing need to offer an effective response to a wider range of non-critical incidents, has resulted in pilots of four additional pioneer clinical services being developed as part of our new five-year strategy. These will cover maternity, falls, mental health and end-of-life patients.

We have also supported a consultant paramedic to be a guideline committee member contributing to a NICE guideline recommending the establishment of further advanced paramedic practitioner programmes nationally.

4.4 Improving care

Throughout 2017/18 we have been working hard to improve both patient experience and quality of care. Below are a few examples and you can read more in the news section of our website.

Improving hospital handover times

We have worked extensively with hospitals across London to improve handovers between our crews and hospital teams. The work aims to ensure the safety of handovers whilst also reducing the time it takes our crews to be ready to respond to further calls.

The work includes ensuring we are taking patients to the right locations to avoid delays and identifying those patients who are well enough to wait in a chair once they arrive at an emergency department.

For the most seriously ill patients we began piloting a new system of monitoring their condition when handovers are delayed. The system involves a standard set of observations which are repeated at regular intervals until the handover is complete.

Our work on hospital handovers has been recognised as outstanding practice and has played a significant role in reducing waiting times for patients.

Improving our vehicle preparation

The quality of our vehicles and the equipment they carry is essential to providing high quality care to patients. We have made major improvements in this area and have been recognised with a national award in November 2017 for our Vehicle Preparation Gold Service.

The project has now rolled out with 14 hub sites with over 300 people working through the night to keep our fleet on the road. Every night up to 300 ambulances are cleaned inside and out then all 450+ items of medical consumables are checked and restocked as needed. Ambulances are then refuelled and returned to their bases for the start of the next shift.

The work has kept an average of 13 more ambulances on the road each day and has reduced the number of hours ambulances are out of service due to missing equipment by 72%.

Next steps for the programme including extending it to all vehicles including our fast response cars and non-emergency transport vehicles.

Connecting clinicians to essential information

We have now rolled out nearly 4,000 iPads to frontline staff, giving them better access to information whilst with patients. Three applications have been rolled out so far, with more planned for the future:

- **Coordinate my care** – a system that empowers patients to be at the centre of their care, documenting plans and wishes particularly around urgent care.

- **MiDOS** – a digital directory of local services commissioned by the 32 London clinical commissioning groups and tailored to our specific needs.

- **JRCALC** – a clinical guidelines application giving access to an intuitive system supporting clinical decision making with access to up-to-date and relevant clinical guidelines.

Being able to access information from a wide range of clinical systems used by hospitals, GPs, community and mental health services is key to allowing us to provide patients the best care and experience. We are working closely with NHS England, NHS Digital and the pan-London NHS community to develop an electronic patient care record. Our aim is to act as a beacon to promote interoperability across systems for collaboration and sharing of key data.

Cardiac Arrest trials

In January 2018 we began working on a trial supported by the British Heart Foundation. Currently, we transport patients who have had a cardiac arrest caused by a heart attack directly to specialist Heart Attack Centres. Those who suffer a cardiac arrest but who do not have any clear evidence of a heart attack are transported to the nearest Emergency Department. Some experts believe that all patients who have had a cardiac arrest might benefit from being taken directly to a Heart Attack Centre. This randomised trial is looking to answer that question. The trial will run until 2020 and will involve 860 patients.

Positive incident reporting

In early 2017 we launched positive incident reporting as a new way for staff to report good work. During 2017/18 we saw a steady rise in reports with over 50 received during the year. The reports have highlighted good practice in both clinical services and our support teams. We use the reports to identify why and how things go right and explore whether we can replicate it throughout the Service.

Physician Response Unit (PRU)

In 2017 we launched a pilot with London Air Ambulance and Barts Health NHS Trust which has a senior emergency doctor and an ambulance crew member responding to incidents in a car. The PRU carries advanced medication, equipment and treatments usually only found in hospital such as instant result blood tests, urine tests and sutures to stitch serious wounds. This means patients can be treated where they are, avoiding trips to hospital.

Of 652 patients treated by the PRU during its first 111 days of extended service 449 patients were treated in the community. Of these, 312 would otherwise have been taken to the emergency department at hospital. The pilot has shown overwhelmingly positive patient feedback, easing of pressure on busy emergency departments, and significant savings for health services; £411,000 was saved in the first 111 days.

4.5 Patient and public engagement

Insight project

In 2017/18 we continued to develop our Insight project which is working with patient groups to co-design service improvements. We have established and maintained positive relationships with patient groups for sickle cell disease, COPD/respiratory disease and personality disorders. A key success of the project is enabling patients to feel heard, in particular through patient involvement in staff training. All three groups have helped to develop training materials now in use across the Service. We have learnt valuable lessons about how to do this kind of patient engagement well and are now talking to NHS England about how we can share our learning with other parts of the NHS.

Patients' forum

The patients' forum is a body independent of London Ambulance Service which plays an important role in our work. Representatives from the forum sit on all of our governance committees and run their own monthly meetings; regularly attended by 20-30 members. Patients' Forum members also meet regularly with senior LAS colleagues, our commissioners and other key stakeholders such as the Care Quality Commission, to highlight areas of good practice and areas where development is required.

The forum has been directly involved in the development of the LAS Academy. Together with staff from the Academy, they have formed a Patient and Public Involvement Panel, and attend steering group meetings. They have developed a teaching programme detailing patient and public involvement in the Academy's syllabus and take part in assessment centres for the recruitment of students.

Community engagement events

We are committed to supporting a wide range of patient engagement and public education events. In 2017/18 we received 654 requested to attend events and were able to join 506 of those. This is thanks to the ongoing support of over 1,200 staff on our volunteers database, with over 300 individuals taking part in multiple events, often in their own time.

We also have four part-time Public Education Officers who continue to focus mostly on activities involving children and young people, such as awareness sessions on the dangers of carrying knives and of using alcohol and other legal highs; careers with us; and multi-agency road safety events such as Safe Drive Stay Alive and Biker Down.

One of the Public Education Officers led a pilot of a scheme which involved all the blue light services attending schools in the London Borough of Haringey. Pupils participated in a range of sessions, rotating between them during a school day. The London Ambulance Service sessions focused on the consequences of carrying knives, and CPR (basic life support) training. The pilot has been evaluated and shown to be highly effective. A bid is now being submitted, with the aim of rolling out the scheme to other London boroughs.

Friends and Family Test

We collect Friends & Family Test responses from Patient Transport Service and *See & Treat* patients. The total number of responses received in the year 2017/18 was 334. Although the response rate remains low, almost all patients said they would be “extremely likely” or “likely” to recommend our services to their friends and family if they needed similar care or treatment.

5 Our people

We employ over 5,300 staff in a wide range of roles. The majority, 89%, are patient facing including roles treating patients and taking 999 and 111 calls. We have several different emergency clinical roles including consultant paramedics, advanced practitioners, paramedics, trainees, and students. We have also expanded our clinical roles to include mental health nurses, increased numbers of Advanced Paramedics, GPs and pharmacists.

Our workforce is 55% male and 45% female with an average age of 40 for men and 37 for women. Approximately 13% are from Black and Minority Ethnic backgrounds and 1.9% have identified themselves as disabled. The average length of service is 9.4 years, though we have over 700 staff with more than 20 years’ service.

5.1 Diversity and equality

At the end of 2017/18 we had 13% of staff from BME backgrounds. This is the same as in 2016/17 and remains significantly below BME representation in the London population (45%) and the wider NHS workforce in London (41%). We are committed to improving this position in the years ahead and have a dedicated action plan linked to the Workforce Race Equality Standard (WRES).

Progress in 2017/18 includes:

- Co-designed a revised WRES action plan with staff in June 2017.
- Regular BME staff engagement events with focus groups and round table events to understand the experiences of our staff and inform our WRES action plan. In December 2017 we also launched a series of lunch and learn sessions looking at our equality challenges.
- Targeted recruitment work to increase the number of BME applications including specific advertising in BME publications and talking to BME communities about career opportunities.
- Recruited our first BME associate non-executive director, Amit Khutti, in January 2018 through the NEXT Director scheme.
- Developed a sponsorship and reverse mentoring programme to support the career development of BME staff at bands 5-7. The pilot begins in May 2018.
- Re-established an equality committee in October 2017.

Performance against WRES indicators:

In 2017/18 we reported against eight of the nine WRES indicators (up from seven the previous year). The position across all indicators remained largely static through 2017/18. The indicator we are not currently able to report on is “relative likelihood of staff accessing non-mandatory training and CPD”. We aim to have reporting in place for this during 2018/19.

During our Care Quality Commission (CQC) visit in March 2018 the inspectors spoke with members of the BME network to find out about their experiences working in the Service.

5.2 Recruiting new people

In 2017/18 we recruited over 600 frontline staff covering paramedic, emergency ambulance crew roles and our 999 and 111 call handlers. Our overall vacancy rate at 31 March 2018 was 6%; a slight increase from our year end position in 2016/17 (5.1%).

We have recruited over 100 UK graduate paramedics and continue to work with universities to make our service the employer of choice for students.

We also recruited over 100 emergency medical dispatchers (call handlers), and essential role where we have had significant vacancies in the past. Offering new part-time roles, increasing starting salaries and improving our assessment processes has helped to fill vacancies against an increased establishment for this role.

We have developed a 5-year workforce plan to manage staffing and protect against shortages. The plan includes: ensuring our talent search covers the expanding range of clinical roles we are developing; dynamic workforce modelling and planning across all roles; engaging with students and paramedic graduates across the UK and building stronger relationships with our four partner universities.

5.3 Retaining, developing and supporting our people

We want people to stay with us and develop their skills and careers. Our retention rate has been stable during the year with 10.8% turnover in 2017/18 and we have plans to reduce this further in the years ahead.

We are doing lots to improve our offer to staff with a wider range of non-pay benefits; introducing lease cars and cycle schemes and enhancing our occupational health service to improve the health and wellbeing of our staff. Other important work includes:

Appraisal

To ensure we remain focussed on continuous development for our people we have made sure we achieved out 85% appraisal target this year. Making sure people have an effective appraisal is key to identifying career aspirations and development opportunities. It is also part of ensuring we are a well-led organisation with line managers at all levels committed to supporting their teams to develop. Effective appraisals also help us to provide a training offer that meets the needs of all our people. We are carrying out an appraisal audit and will be identifying further improvement actions during 2018/19.

The LAS Academy

We launched our internal academy in 2016 to help more of our people develop their careers and become registered paramedics, and we have continued to provide access to this program by increasing the placement opportunities on the program and partnering with other providers to support several pathways.

The LAS bursary programme has resulted in 650 staff enrolled into further education programs, supported by Health Education England investing over a million pounds.

Coach to lead

To support our people strategy and encourage a coaching style of management we have piloted Coach to Lead, a two-day programme supported by action learning which gives staff practical coaching skills to develop their leadership style. Evaluation on this programme has been very positive.

Induction

Helping new staff to settle in is vital to ensuring people can succeed in their jobs. We have reviewed our induction programme and have an improvement plan focussed on locations and frequency. An internal stakeholder group has also been set up to review content to make sure everyone gets a timely and effective induction.

Emotional and mental wellbeing

The work our people do can be very stressful and emotionally challenging. We continue to work hard to provide support both to prevent and treat mental ill health. We have a network of peers trained to support colleagues through our LINC Worker scheme and have dedicated counselling available as part of our occupational health services. We also have access to the Mind Blue Light programme which offers confidential, independent and practical support, advice and signposting around mental health and wellbeing, for emergency service staff, volunteers and their families.

Freedom to Speak Up Guardians

Freedom to Speak Up Guardians have been introduced in each NHS Trust, as a result of the recommendations in the Francis Report. A Guardian was appointed at the LAS in October 2016, and undertook this role in addition to her core role as Head of Patient & Public Involvement and Public Education. She stepped down at the end of December 2017, to be replaced by a full-time interim Freedom to Speak Up Guardian, who was tasked with promoting the role in the Trust and facilitating the recruitment of a permanent Guardian.

Since the role was introduced the Trust has:

- Announced the role in the internal Routine Information Bulletin and produced a leaflet to be attached to staff payslips.
- Established a Freedom to Speak Up LAS group, with dates to meet quarterly.
- Agreed reporting arrangements to the Trust Board.
- Designed a secure recording and reporting module on Datix, which is only visible to the Freedom to Speak Up Guardian.

- Hosted a successful visit by colleagues from the National Guardian's Office.

- Had its Freedom to Speak Up arrangements audited by KPMG.

- The LAS was the first NHS organisation to have taken this action.

The LAS Guardian has attended the national launch and undertaken the Freedom to Speak Up training. He is a member of the London regional network and national ambulance network for Freedom to Speak Up Guardians.

During 2017/18, a total of 9 concerns have been reported. The majority of these have related to a bullying culture across a team or part of the organisation, two have related to trust processes, two to patient safety concerns, and the remaining three have been related to infrastructure, to seek advice, or to give ideas about possible improvements. Feedback has been very positive from staff who have used this method of raising concerns, indicating that is a method of engaging with staff that should be developed further over the coming year.

5.4 Recognising our people

Our annual staff VIP awards continues to recognise the great work of individuals and teams across the service. In 2017/18 there were over 350 nominations across the 11 categories. Throughout the year our staff have also received numerous external awards and praise for the fantastic work they do. Below are a few highlights from across the year.

April – June 2017

- Over 100 letters of thanks from the public, politicians and royalty plus a special mention in the Good Morning Britain Health Star awards; recognising the dedication of staff during the Westminster terrorist attack in March 2017.

- Paul Smith, Sector Delivery Manager, honoured by HM The Queen at Buckingham Palace and presented with the prestigious Queen's Ambulance Service Medal.

- Christina Long, Romford Senior Paramedic, named 'Employee of the Year' at our third VIP Awards ceremony. John Waugh, Homerton Clinical Team Leader, came second in the voting, and David Gordedo, Incident Response Officer, was third.

July – September 2017

- Our safeguarding team were shortlisted in the Education and Training Category at the Patient Safety Awards for their "Dementia Care matters in the Ambulance Service" project.

- We won in the "Best Staff Travel Benefits" category at the Employee Benefits Awards, recognising effective use of benefits for staff travel and car schemes.

- Our mental health nurses team, were shortlisted in the Emergency and Critical Care category of the Nursing Times Awards 2017 and the Innovation in Mental Health category of the HSJ Awards

October - December 2017

- Cycle paramedics recognised by metropolitan police for working with police officers on evening shifts treating revellers in the Christmas party season.

- Emergency Medical Dispatcher Emma Venosi shortlisted for the IAED Dispatcher of the Year award.

- Our Fleet and Logistics Team won the 'Supply Chain Strategy and Design' category of the Logistics and Supply Chain Excellence Awards for their work in our Vehicle Preparation Project

January – March 2018

- We were shortlisted with London South Bank University in the Student Nursing Times Awards for Student Placement of the Year: Community.

- Our Emergency Operations Centre was re-accredited as a Centre of Excellence (ACE), just one of three accredited centres in England, and was shortlisted for Team of the Year at the Control Room Awards 2018.

- We were recognised alongside colleagues from the Metropolitan Police and the London Fire Brigade at the Global Awards.

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 and long-service milestones.

5.5 Staff survey results

A total of 2,664 people completed the 2017 staff survey – which is 53.6% and our highest ever response rate. Overall, results are similar to 2016, despite a year full of challenges and significant change. They reflect a consolidation of lots of positive work over the last three years which has seen significant increases in staff satisfaction. Some key results are listed below. Our Quality Account 2017/18 provides a more detailed analysis and the full results are available online.

Significant improvements in 2017 include:

- Error reporting
- Positivity about work
- Mandatory training

Results which are lower than last year include:

- Staff involvement
- Recognition
- Senior manager visibility

Other areas for development include health and wellbeing, staff development and incidents of physical violence. To respond to the 2017 survey results, we have established a network of staff survey champions who are driving forward improvement actions. Champions met twice in February and March 2018 and will work as a group to support ongoing action.

Key commitments that we will follow through with include: improving occupational health support; rostering; rest breaks and our ability to get front-line crews off on time at the end of their shifts; relieving the pressure on staff in our control rooms (particularly in relation to call handling) by continuing to recruit to vacant positions and; making sure all staff in all parts the business feel valued and respected.

5.6 Volunteers

We are grateful to all our volunteer responders who give up their time to support our teams. We have three different types of volunteer responder:

- **Emergency responders** – 131 clinically-trained volunteers responding on blue lights alongside ambulances to 999 calls.

- **Community first responders** – approximately 150 defibrillator-trained St John Ambulance volunteers responding to 999 calls in their own car alongside ambulances.

- **Volunteers at public-access defibrillator sites** – People who work at the 750+ public locations with defibrillators and are trained to respond to emergencies and use the machines while an ambulance is on the way.

Crucially, all these volunteers carry or have access to defibrillators; a machine that can restart the heart when it stops beating. Early use of a defibrillator doubles the chance of survival for cardiac arrest patients. In 2017/18, volunteer responders attended 13,261 emergencies. They were the first on scene in 7,796 of these cases.

6 Our partners

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

Working with our partners, we will play a critical part in shaping and delivering the changes required to make the urgent and emergency care system more sustainable in London. Find out more about this work in our Strategy for 2018-2020, available on our website.

6.1 Blue light partners

We continue to maintain a close working relationship with London's other blue light services. The introduction of the Policing and Crime Bill (April 2017) now mandates that all three emergency services have a statutory duty to collaborate and where possible ensure that services operate in the most efficient and effective manner.

We regularly attend incidents with the Metropolitan Police Service (MPS) and London Fire Brigade (LFB). We have a dedicated joint response unit working with the police in 12 London boroughs. This service attends police incidents where clinical support is needed and provides triage, assessment and treatment. It has been very successful and in nearly 80% of cases has avoided the need for a full ambulance crew to be dispatched. There is the potential to expand this further to include the fire brigade and to provide a service to more London boroughs.

We have co-responding systems in place with the police across all London boroughs. This means that for a set of specific issues, most commonly cardiac arrest, both police and ambulance staff are dispatched. Police officers are trained in essential first aid and equipped with defibrillators and can start treatment if they are first to reach the scene. Around 32 per cent of people survive a cardiac arrest in a public place, but, with rapid access to a defibrillator and someone trained to use it, the chance of survival can increase to 80 per cent. Through this work we have made 700 more defibrillators available across London. With police officers able to provide CPR support co-responding also frees up our crews to carry out more advanced lifesaving.

We also routinely train together and provide training and information for the police and fire brigade on advanced first aid.

During 2017/18 we supported a bid to the Home Office Police Transformation Fund (PTF) to scope the possibility of a single call handling system and centralised control room for London's emergency services. This bid secured £1.9 million for an initial scoping exercise to review the merits of a single control room for London. The scoping work starts in April 2018 and will run for 12 months.

Preparing for and responding to large scale events and major incidents

We plan for and respond to large scale events in the capital, working closely with other emergency services and partner organisations in London to save lives. Planned events include things like the Notting Hill Carnival and the London Marathon. Major incidents during 2017/18 included the terrorist attacks at London Bridge and Parsons Green, and the Grenfell Tower fire. More than 1,000 of our staff were involved in responding to these incidents.

Our responsibilities during major incidents include:

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

We test our major incident plan on a regular basis both individually and in exercises with our partners.

6.2 Sustainability and Transformation Partnerships

Throughout 2017/18 we have been actively engaged in the work of all five of London's five Sustainability and Transformation Partnerships (STP). Our chief executive and director of strategy have regularly attended core meetings and we worked closely with all areas, particularly on demand management and pressures on emergency departments. We have also worked within individual STPs on a wide range of projects, including:

- Establishing new mental health pathways
- Addressing frequent caller issues in partnership with other agencies
- Attendance at safeguarding boards and child death panels
- Education package to care homes on 'when and why' to call 999 or other options

We are the only NHS trust working across all five STP areas and believe there is an important opportunity to help develop a consistent approach to emergency and urgent care

across the capital. At present there is a mixed approach with a wide range of “out-of-hospital” services in place, being piloted or under development. We recognise the need for locally tailored services but also believe increased consistency would provide a better patient experience and support our staff in providing patients with the most appropriate care. We will continue working as part of all five STPs on this in 2018/19 and beyond.

7 Quality and performance

Our overall performance is measured using a range of key performance indicators (KPIs) across quality of care, response times and finances. Progress is monitored continuously by our Board, sub-committees and the management team. We report progress against these as part of our integrated performance report at monthly public board meetings and the papers are available on our website.

7.1 Quality matters

We are focused on improving the quality of our services and have come a long way in the two years since the Care Quality Commission (CQC) rating of ‘requires improvement’ in 2016. During 2017/18 we have delivered a comprehensive action plan and we welcomed the CQC back in March 2018 to review our progress. Their final assessment will be published on our website later in the year.

We know we have come a long way. But we also know there is more to do. Our new quality strategy, published in 2018, sets the direction for the years ahead. Through it we will focus on quality of clinical care, continuous improvement and putting patients at the centre of everything we do. Our objective is ‘outstanding’ CQC ratings across all our sites and services by 2020.

Quality improvements

Our full quality account for 2017/18 is published as part of our quality strategy. Some highlights from the year are listed below. You can find out more about each of these in our quality account, available on our website.

Patient Safety

- Established a new integrated quality and governance directorate, increasing capacity and capability for our quality agenda.
- Improved processes for identifying safety and quality risks.
- Improved services for mental health and end-of-life patients with specialist nurses and training for our wider clinical staff.
- Implemented a new learning and quality improvement framework with training for staff in quality improvement methodology.
- Independent review of processes for serious incident investigation and learning confirmed “significant assurance”.

Patient experience

- Improved risk assessment tool for mental health patients.
- Investment in new equipment to ensure obese patients get effective dignified care.
- Improved infection control processes monitored through regular assurance visits.
- Multi-agency working to support frequent callers resulting in reduction in calls.

Clinical effectiveness

- Consistent performance against new response time targets (routinely within top 3 ambulance trusts on monthly results)
- Working with emergency departments to reduce patient handover times; significantly reducing waiting times for patients.
- Implemented a new standardised approach to ambulance-led patient cohorting across London.
- Introduced a mortality review group to identify and share learning; with information also shared with other ambulance trusts.

Our quality account also includes information on incidents and how we learn from them; the audits and research we are involved in, and our performance against Duty of Candour requirements.

Our progress during 2017/18 has been significant and has brought about much improved outcomes for our patients. We will strive to maintain this through our quality improvement plans for 2018/19 and beyond.

7.2 999 performance

The main 999 performance indicators are how quickly we reach patients following a call. The way all ambulance trusts are measured for response times changed at the end of October 2017. Below is a summary of our performance in the two periods (April 2017 – October 2017 and November 2017 – March 2018).

999 performance April 2017 – October 2017

Total 999 calls

All 999 calls are given a category. Up to October 2017 category A was the high priority incident and was sub-divided into Red 1 and Red 2. Red 1 were the most time critical including cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 were serious but less immediately time critical including conditions like stroke and fits. Category C incidents were lower priority and sub-divided into four types; C1 incidents had a target response time of 45 minutes and C2, C3 and C4 had a 60 minute target response time.

The table below shows how many calls we received in each category:

Category	**04/17 – 10/17**	**2016/17** (full year)
Red 1	13,146	19,854
Red 2	348,424	590,857
C1	37,486	66,106
C2	400,367	692,775
C3	107,608	185,346
C4	150,898	271,868
Other	48	36
Total calls	**1,057,977**	**1,826,842**
Hear and Treat response	71,068	127,532
Incidents attended	653,120	**1,114,099**

Response times by call category

Category	**National target**	**04/17 – 10/17**	**2016/17**
Red 1 (within 8 minutes)	75%	73.94%	69.19%
Red 2 (within 8 minutes)	75%	70.39%	66.31%
Red 19 (within 19 minutes)	95%	94.64%	93.48%
Category C (C1 - C4)			74.5%

999 performance November 2017 – March 2018

From 1 November 2017 new national indicators for ambulance trusts were introduced. There are now four categories of incidents that we respond to. Category 1 is the highest priority and category 4 the lowest. The new standards are intended to:

- Prioritise the sickest patients quickly to ensure they receive the fastest response.
- Ensure national response targets to apply to every patient for the first time – so ending ‘hidden waits’ for patients in lower categories.
- Ensure more equitable response for patients across the call categories.
- Improve care for stroke and heart attack patients through sending the right resource first time.

Category	Targets	11/17 – 03/18	No. of incidents
1	**7 minutes** mean response time	7.17 mins	41,107
	9 out of 10 people reached in less than **15 minutes**	11.50 mins	
2	**18 minutes** mean response time	21.56 mins	267,780
	9 out of 10 people reached in less than **40 minutes**	45.55 mins	
3	9 out of 10 people reached in less than **2 hours**	2h 39.5 mins	106,795
4	9 out of 10 people reached in less than **3 hours**	2h 34.15 mins	55,467
	Face to face incidents all categories		471,149
	Hear and treat incidents		19,806
	Total incidents		**490,955**

Comparison with other Ambulance trusts

Our performance in 2017/18 has been consistently amongst the best in the country, across both the old and new indicators. Although we have yet to fully alter our operating model to meet the requirements of the new ambulance response standards, since their introduction we have consistently been in the top three for category 1 incidents.

Winter planning and performance

Our preparations for winter pressures in 2017/18 were some of the most detailed we have ever done and helped to ensure that our performance remained strong despite very heavy pressure on our services and the wider NHS. Throughout the winter period we worked closely with NHS England, NHS Improvement, hospitals, Clinical Commissioning Groups and other providers. We ran daily safety reviews to look at and learn from all incidents and for three weeks through the Christmas period our winter planning team was working 16 hours a day. We worked with hospitals to minimise hand over times and had a representative in NHS England's "winter room" to support planning across the whole of London's NHS.

7.3 NHS 111 South East London performance

We run the NHS 111 service in South East London covering a population of 1.8 million people across Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark. NHS 111 is a telephone assessment service for people who need urgent medical help and advice but are not in a life-threatening situation. Calls are answered by highly trained advisors, who are supported by healthcare professionals, 24 hours a day, 365 days a year.

The key performance measures are percentage of calls answered within 60 seconds, calls abandoned after 30 seconds and calls which had to be referred to 999 (with fewer referrals showing better performance). The table below summarises 111 performance in 2017/18 and the previous year for comparison. We have seen a significant increase in calls with nearly 38,000 more calls in 2017/18 than the previous year (over 100 more calls each day on average and nearly 200 more on weekends). This has led to a reduction in our call answering performance but we are continuing to work to improve this.

Measure	National target	2017/18		2016/17	
Total number of calls	-	364,024		319,078	
Average calls per day	-	Weekday	868	Weekday	739
		Weekend	1313	Weekend	1,134
		Bank Holiday	1568	Bank Holiday	1,460
Calls answered within 60 seconds	95%	322,279 (90%)		297057 (94.4%)	
Calls abandoned after 30 seconds	No more than 5%	3564 (1%)		2001 (0.6%)	
Calls referred to 999	<10%	8.2%		9.7%	

Comparison with other NHS 111 providers in London

There are 5 providers of 111 services across 8 areas in London. We are consistently amongst the best performers for percentage of calls answered within 60 seconds and the lowest level of abandoned calls. We also consistently deal with more 111 calls without needing to dispatch and ambulance or recommend A&E.

The services is rated 'good' by the Care Quality Commission. However, we continue to work to make improvements in specific areas. Since April 2017, we have more than halved our vacancy rate (from 13.8% to 5.6%). We have improved team meeting processes and are improving the stability of the telephone systems.

From August 2018, we will be providing the NHS 111 and Integrated Urgent Care service for seven clinical commissioning groups in North East London.

7.4 Financial performance

Our financial performance in 2017/18 is detailed in the financial statements (section 12 of this report). Overall, we finished the year in a positive financial position with a small surplus of 1.5% of our total budget. During the year we invested £23.4m on capital to modernise our Fleet, IM&T systems and Estate.

	2017/18	2016/17
Total budget	£364.6 million	£355.5 million
Year-end surplus/deficit	£5.7 million surplus	£6 million surplus

7.5 Sustainability

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

By introducing our new fleet preparation system (see section 4.4) we have also reduced the environmental impact of cleaning our vehicles. Water consumption has come down from 872 litres a day to 207 litres. Saving nearly a quarter of a million litres a year. The use of cleaning chemicals has also reduced from 40 litres per day down to just 7 litres.

Our fleet management team have been looking at opportunities to introduce electric and hybrid vehicles and we are exploring opportunities for joint development in this area with our other blue light partners. We currently use around 4million litres of diesel per year; so this is an important area we want to develop. We have started trials of an electric response vehicle. We are exploring electric/zero emission options for new vehicles (including motorbikes) and retro fitting electric systems into existing vehicles. We are also looking at options to move our operational managers onto more environmentally friendly vehicles.

Our vehicle replacement programme for 2017/18 has included 140 new vehicles and allowed us to introduce Euro 6 (emission standard) compliant vehicles to better meet the environmental requirements set out by the London Mayor. Our estates team have also been introducing environmental improvements and we have upgraded lighting in a number of our bases to switch to more energy efficient systems.

7.6 Risks and continuing challenges

We manage risk through our corporate risk registers, board assurance framework and risk management policy. The board assurance framework and corporate risk register are presented at Trust Board meetings, and further scrutiny is applied at Quality Governance and Audit Committees. The risk register is reviewed in detail by our Executive Leadership Team each month. Risk Management is an integral part of our approach to continuous quality improvement and supports delivery against key performance indicators. Full details can be found in our annual governance statement in section 9 of this document.

Our new five-year strategy sets out the continuing challenges we face and is summarised below.

8 Developing our five-year strategy

London's NHS continues to face substantial and sustained growth in demand for urgent and emergency care. The pressures include:

- a growing and aging population
- an increasing prevalence of acute and complex conditions
- demand from our most critically ill patients increasing at the highest rate
- a high vacancy rate for frontline staff and increased competition for staff between providers.

The rise in demand puts significant pressure on our staff and affects our ability to deliver a high-quality service. To address these challenges London needs an ambulance service with a clear emphasis on assessment and treatment at scene and able to take clinically appropriate patients to a range of services.

To deliver this we have developed a new five-year strategy, being published in April 2018. Our ambition is to be a world class ambulance service providing access to integrated urgent and emergency care 'on scene', 'on phone' and 'on line'.

A core part of our strategy is developing a wider range of services to respond more effectively to different situations. In 2017/18 we piloted an urgent care advanced paramedic practitioner service with excellent result. The strategy identifies four more *pioneer services* which we will develop for falls, mental health, maternity and end of life care.

We believe developing these services to offer a tailored see and treat response for different patients could mean over a quarter of all patients receive a specialist service that treats and discharges them on scene. Together with improved hear and treat services provided over the phone we believe this could reduce ambulance conveyances to hospital emergency departments by up to 122,000 a year. This work would reduce the burden on emergency departments and reduce the number of patients unnecessarily admitted into hospital overnight. As well as improving patient experience this could save the health system in London between £12.1m and £36.5m per year; allowing this money to be spent elsewhere.

During November and December 2017, we spent six-weeks engaging with staff, partners and patient representatives to make sure the strategy fully addresses their needs. This included over 1,600 interactions with staff, engaging with 23 stakeholder organisations including all five London Sustainability and Transformation Partnerships and face to face meetings with our Patients' Forum.

The new five-year strategy will be published on our website later in 2018
www.londonambulance.nhs.uk

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Accountable Officer: Garrett Emmerson, Chief Executive

Signature: 

Date: 24 May 2018

9 Annual governance statement

9.1 Scope of responsibility

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

9.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of London Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in London Ambulance Service NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

9.3 Capacity to handle risk

Leadership and accountability

A number of changes have been made to the Trust's management structure in 2017/18, including the appointment of a Chief Executive and a number of changes to director portfolios.

I (Garrett Emmerson) was appointed as Chief Executive with effect from 30 May 2017, at which point Andrew Grimshaw (Director of Finance) who had been Acting Chief Executive left the organisation. Andy Bell (Deputy Director of Finance) who had been Acting Director of Finance whilst Andrew was Acting Chief Executive, also left the organisation in June 2017. Lorraine Bewes took on the role of Director of Finance and Performance in July 2017. Other Executive Board members, Dr Trisha Bain (Chief Quality Officer), Dr Fenella Wrigley (Medical Director) and Paul Woodrow (Director of Operations) continued in their roles in 2017/18.

Ross Fullerton (Chief Information Officer) joined the Trust in May 2017, as did Patricia Grealish (Director of People and Organisational Development). Ross replaced Steve Bass, who had taken on the role of interim Chief Information Officer in March 2017. Mark Hirst, interim Director of HR provided support to the Board and Executive Leadership Team (ELT) until Patricia's appointment. Sandra Adams, Director of Corporate Governance/Trust Secretary, left the Trust in April 2017 and an interim arrangement was put in place until Philippa Harding was appointed to the post in November 2017. Charlotte Gawne (Director of Communications) left the Trust in June 2017 and Karen Broughton (Director of

Transformation, Strategy and Workforce) left the Trust in September 2017. Jamie O'Hara joined the Trust as Director of Strategy and Communications in November 2017. During 2017 a new post of Director of Strategic Assets and Property was created, to which Benita Mehra was appointed in January 2018. In addition, as a result of being in Special Measures, the Trust had support from Sally Herne, appointed by NHS Improvement to the role of the Improvement Director and who continued in this role until the end of March 2018.

The Director of Corporate Governance supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Board of Directors, for maintaining the Board Assurance Framework (BAF) that 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 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 its 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 driven forward a significant workplan to strengthen the Trust's risk management processes, at all levels of the organisation, from Board to station-level. This has included an increased focus on strategic risk and the BAF by the Board, ELT and Board Assurance Committees, to the establishment of appropriate Quality Assurance structures and a clearly articulated Quality Assurance Framework. The Trust's focus has been on learning from good practice in this area, both internally and externally.

In 2017 the Chief Executive launched a new approach to performance management, which ensured that Directorates and Operational sectors were held to account for delivery of objectives and improvements, including those relating to governance and quality governance. Work on the extension of the performance management framework continues into 2018/19.

Training

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

The Trust's Risk Management Strategy and Policy sets out the approach that it takes to the provision of training in relation to risk management. An e-learning package 'Introduction to Risk Management' has been developed and will be available to all staff through the Trust intranet. Staff have access to comprehensive risk guidance and advice via the Quality Governance Directorate; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities have this provided internally. Training compliance is reported to the Trust Board and Executive Leadership Team via the People and Culture Committee. The Trust Board receives training every two years, to ensure that the requirements for understanding and discharging duties in relation to risk management at Board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.

The Trust'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 elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. A review of the Training Needs Analysis was undertaken during 2017/18 to ensure that mandatory training remains targeted and appropriate as well as manageable for staff. 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 2018/19. Monitoring and escalation arrangements are in place to ensure that the Trust maintains the good performance seen and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

Leadership development programmes are also being developed for all staff, which will address the importance of managing risk.

9.4 The risk and control framework

Risk Management Strategy and Policy

The Trust Board approved an updated Risk Management Strategy and Policy at its meeting on 27 February 2018. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

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

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

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 exists to review and monitor risks added to the Risk Register and regular reports from the Corporate Risk Register and the BAF are submitted to the relevant Board Assurance Committees and Trust Board. The Audit Committee has the delegated authority on behalf of the Trust Board

for ensuring these arrangements are in place. The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process. The BAF and Risk Register has undergone significant review and amendment during 2017/18 and more closely aligned with the agenda of the Trust Board and Board Assurance Committees.

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 Risk, Compliance and Assurance Group, the Executive Leadership Team or the Trust Board for a decision to be made.

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

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 2017/18 the Trust appointed a full time interim Freedom to Speak Up Guardian (FTSUG) and it is in the process of appointing a substantive FTSUG, supported by a 'hub and spoke' model of Freedom to Speak Up Advocates. The Trust's 2017 staff survey results indicate that there have been improvements with regard to the development of a reporting culture across the organisation.

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 ELT reviewed and agreed the approach to be taken to quality impact assessments (including equality assessments) in December 2017. This is being adopted in the Trust's Business Planning activities for 2018/19.

The Trust's BAF is designed to assist the Trust in the control of risk. The BAF incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Information Governance Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via quarterly BAF / risk register reports and is supported by a robust Internal Audit Programme. The BAF was significantly reviewed during 2017/18 in response to the findings of the Care Quality Commission following its inspection of the Trust at the end of 2016/17.

In respect of the control of risk, ELT members individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to identify, manage and mitigate risks to compliance with the Trust's licence. The Assurance

Committees of the Trust Board in turn have responsibility for providing assurance in respect of the effectiveness of those controls. A system of 'highlight' reports to the Trust Board is in place to highlight any risks to compliance. Board Assurance Committees are well attended by Executive and Non-Executive Directors as well as by other key Trust staff. A review and strengthening of the Board sub-committees was undertaken during 2017/18 to ensure that the Trust's meeting structure is able to meet the challenges to be faced by the organisation during 2018/19 and beyond.

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

- The Trust has in place a Quality Strategy which has been approved by the Trust Board. The Trust Board also agrees annual quality objectives.
- The Trust has in place a Quality Assurance Committee (a committee of the Board) which meets bi-monthly and is chaired by a Non-Executive Director. The Quality Assurance Committee is responsible for monitoring performance against the agreed annual quality objectives. The Committee provides a report of each meeting to the Trust Board.
- The Trust publishes an Annual Quality Account.
- Performance against key quality indicators are reported the Integrated 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.

The effectiveness of the Trust's governance structures also continued to be tested during 2017/18 via internal and external testing including internally via the Deep Dive and Annual Internal Audit Programme and externally via relevant external reviews and visits including during 2017/18 a Well Led Review by the CQC.

As a result of the CQC's inspection, the Trust's rating improved and moved to "good". The CQC was able to report that local governance arrangements had improved and that there was a higher level of awareness and understanding of the value and importance of reporting, reviewing and learning from incidents, for managing risks and performance outcomes. There are still areas that need to be improved, but this finding represents a significant improvement for the Trust.

The Trust's Head of Internal Audit Opinion was one of: 'Significant assurance with minor improvements required'. Our internal audit service's work has confirmed that, whilst some weaknesses were identified in the design of controls in the areas under review during the year, there is generally a sound system of internal control which is designed to meet the Trust's objectives and that controls in place are being consistently applied in the majority of key areas reviewed.

The internal auditors were asked mainly to review areas that members of the management team had identified as areas where internal control was possible weaker. Therefore, whilst the internal auditors issued six partial assurance reports in respect of their 2017/18 internal audit programme they noted the significant improvements that had been made in relation to incident management and the positive assurance ratings provided in relation to the financial controls reviewed in year and in those areas of governance that were subject to audit. They also noted that the management team was making progress in implementing the recommendations raised in relation to the partial assurance reports and that they had seen commitment to making both system and cultural change, most notably in relation to contract management, fleet and procurement.

The partial assurance reports related to:

- Fleet preparation;
- Procurement maturity;
- Contract management;
- Clinical education;
- Non-standard payments; and
- Data quality framework.

<u>CQC registration and compliance with the NHS provider licence</u>

During 2017/18, the Trust received announced and unannounced visits by the CQC relating to its core services as well as a Well-Led Review. No significant issues were raised in respect of these visits.

The Trust Board has assessed itself in compliance with the relevant aspects of the NHS provider licence.

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

NHS Pension Scheme

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

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

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

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

The Board has agreed Standing Orders and Standing Financial Instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.

The Trust implemented a new performance management framework in 2017/18 aligned to both the corporate and sector divisional management structure. The framework included adopting a performance dashboard including metrics based on the Carter Report recommendations and includes a series of performance metrics. 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 integrated quality and performance report provided to each Board meeting.

The Trust's external auditors are required to consider whether the NHS Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee. Their report is on pages 50 to 53.

9.6 Information governance

The Trust continues to strengthen its arrangements for Information Governance and has the following arrangements in place:

- an Information Governance Steering Group;
- an Information Governance Strategy and Policy along with a dedicated Information Security Policy;
- the Trust's was compliant with the requirements of the IG Toolkit at Level 2 by the deadline of 31 March 2018.

A review of the Trust's compliance with the new General Data Protection Requirement (GDPR) has been undertaken. Key actions have been taken in line with guidance from the Information Commissioner's Office. Further work and appropriate programme management arrangements are required to ensure full compliance as soon as possible.

During 207/18, the Trust reported no serious incidents relating to information governance, including data loss or confidentiality breach.

9.7 Annual Quality Account

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

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

Governance & Leadership:

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

Policies & Plans in ensuring quality of care provided:

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

Systems & Processes:

- Systems and processes are in place for the audit and validation of performance data both centrally and at operational level.
- The Trust's Datix reporting system has been reviewed in 2017 and restructured, ensuring regular (weekly) validation, weekly, prior to submission to national datasets.

Data Use & Reporting:

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

The Trust has consulted with its commissioners, patients' forum, healthwatch, CCG and STP leads and Trust staff during 2017/18 in relation to the progress made on the Trust's 2017/18 Quality Strategy and to agree its 2018/19 priorities.

9.8 Review of effectiveness

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

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

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 to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions. The Trust's performance management arrangements were strengthened during 2017/18 including through the introduction and embedding of Executive Performance Reviews and some changes to Director portfolios.

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

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

Conclusion

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

Signed: 

Garrett Emmerson, Chief Executive

Date: 24 May 2018

Statement of the chief executive's responsibilities as the accountable officer of the trust

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

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

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

Signed 

Garrett Emmerson, Chief Executive

Date 24 May 2018

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

Garrett Emmerson, Chief Executive

Date: 24 May 2018

Lorraine Bewes, Finance Director

Date: 24 May 2018

10 Remuneration report

Our Remuneration and Nominations Committee consists of the Chair 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 38 to 41.

10.1 Banded remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2017/18 was in the range of £200,001 to £205,000 on an annualised basis. The pay multiplier in 2017/18, based on annualised salary, was 5.61 times the median remuneration of the workforce, which was £36,504. In 2016/17, the banded remuneration of the highest paid director was £195,001 to £200,000. The pay multiplier in 2016/17, based on annualised salary, was 5.64 times the median remuneration of the workforce, which was £35,218.

In 2017/18, one (2016/17, Nil) employee received remuneration in excess of the highest-paid director. Remuneration ranged from £245,001 to £250,000 (2016/17 £Nil).

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 Chair 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 on the salary and pension entitlement of senior managers has been audited by our external auditors.

10.2 Salary and pension entitlements of senior managers

A) Remuneration 2017/18

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

A) Remuneration 2016/17

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000
Heather Lawrence, Chair	£35,001-£40,000	£0	£0	£0	£0
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Sheila Doyle, Non-Executive Director	£0-£5,000	£0	£0	£0	£0
Jayne Mee, Non-Executive Director	£0-£5,000	£0	£0	£0	£0
Fionna Moore, Chief Executive (up to 31 December 2016)	£145,001-£150,000	£3,600	£0	£0	£0
Andrew Grimshaw, Director of Finance (up to 31 December 2016), Acting Chief Executive (from 1 January 2017)	£130,001-£135,000	£0	£0	£0	£40,001-£42,500
Andy Bell, Acting Director of Finance (from 1 January 2017)	£20,001-£25,000	£0	£0	£0	£40,001-£42,500
Paul Woodrow, Director of Operations	£115,001-£120,000	£7,100	£0	£0	£207,501-£210,000
Fenella Wrigley, Medical Director	£110,001-£115,000	£4,800	£0	£0	£202,501-£205,000
Zoe Packman, Director of Nursing and Quality (up to 25 May 2016)	£15,001-£20,000	£0	£0	£0	£17,501-£20,000
Briony Sloper, Acting Director of Nursing (from 6 June 2016 to 31 December 2016)	£45,001-£50,000	£0	£0	£0	£50,001-£52,250
Patricia Bain, Chief Quality Officer (from 3 January 2017)	£30,001-£35,000	£0	£0	£0	£0

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 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018
Heather Lawrence, Chair	**	**	**	**	**	**	**
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**
Robert McFarland, Non-Executive Director	**	**	**	**	**	**	**
John Jones, Non-Executive Director	**	**	**	**	**	**	**
Fergus Cass, Non-Executive Director	**	**	**	**	**	**	**
Theo de Pencier, Non-Executive Director	**	**	**	**	**	**	**
Sheila Doyle, Non-Executive Director	**	**	**	**	**	**	**
Jayne Mee, Non-Executive Director	**	**	**	**	**	**	**
Amit Khutti, Non-Executive Director (from 1 January 2018)	**	**	**	**	**	**	**
Garrett Emmerson, Chief Executive (from 30 May 2017 to 31 March 2018)	*	*	*	*	*	*	*
Andrew Grimshaw, Acting Chief Executive (from 1 April 2017 to 29 May 2017) and Finance Director (from 30 May 2017 to 16 June 2017)	£0-£2,500	£0-£2,500	£40,001-£45,000	£100,001-£105,000	£630,233	£14,336	£702,771
Lorraine Bewes, Director of Finance (from 17 June 2017 to 31 March 2018)	*	*	*	*	*	*	*
Andy Bell, Acting Director of Finance (from 1 April 2017 to 31 May 2017)	£0-£2,500	£0-£2,500	£15,001-£20,000	£35,001-£40,000	£177,933	£3,352	£199,771
Fenella Wrigley, Medical Director	£0-£2,500	£0-£2,500	£40,001-£45,000	£100,001-£105,000	£637,565	£23,925	£667,855
Paul Woodrow, Director of Operations	£0-£2,500	£0-£2,500	£40,001-£45,000	£110,001-£115,000	£728,704	£31,598	£767,590
Patricia Bain, Chief Quality Officer	*	*	*	*	*	*	*

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

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

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	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£s		£s		£s		£s
Less than £10,000								
£10,000 - £25,000	1	10,534			1	10,534		
Totals	1	10,534	Nil	Nil	1	10,534	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.

10.3 Reporting of other compensation schemes – exit packages

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

The remuneration report includes disclosure of exit payments payable to individuals named in that report.

10.4 Off-Payroll engagements

Table 1: Off-Payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	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 2017 and 31 March 2018, 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 2017 and 31 March 2018	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 2017 and 31 March 2018.

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 includes both off-payroll and on-payroll engagements.	11

11 Staff report

11.1 Average staff numbers

The average number of staff has increased over last year 5,138 (2016/17 5,054) as the trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	2	2	0
Ambulance Service	2,654	2,609	45
Administration and estates	1,377	1,288	89
Healthcare assistants and other support staff	1,075	1,075	0
Nursing, midwifery and heath visiting staff	30	19	11
Total	**5,138**	**4,993**	**145**

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 is used to calculate whole time equivalent numbers, that is, dividing the contracted hours of each employee by the standard working hours.

11.2 Staff composition

At the end of March 2018, we had a workforce of 5,359 staff, made up of 2,925 men and 2,434 women. This was broken down as follows:

	Total	Female	Male
Directors	15	10	5
Senior Managers	171	64	107
Employees	5,173	2,360	2,813
Total	**5,359**	**2,434**	**2,925**

Over the course of the year, a total of 578 people left the service – a turnover rate of 10.8 per cent, compared to 9.8 per cent in 2016/17.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 206 paramedics left during 2017/18.

11.3 Staff sickness

The average working days lost in 2017/18 was 11.7 (2016/17 11.7). The data is based on calendar years January 2017 (2016) to December 2017 (2016).

11.4 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.

11.5 Expenditure on consultancy

In 2017/18 the trust spent £1.6m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer: Garrett Emmerson, Chief Executive

Signature:

Date: 24 May 2018

12 Financial statements

2017/18 Introduction to the Annual Accounts

Financial Performance

For the financial year 2017/18 the Trust reported a surplus of £5.7m. The Trust had planned to report a £2.4m deficit. The improvement was due to in year non recurrent sustainability and transformation fund income. The following table summarises the key elements of the financial performance of the Trust in 2017/18.

	Plan £m	Actual £m	Variance £m
Income	361.1	364.7	3.6
Expenditure	(363.5)	(359.0)	4.5
Surplus / (Deficit)	(2.4)	5.7	8.1
EBITDA Surplus / (Deficit)	18.2	22.4	4.2
Capital Resourcing Limit (CRL)	25.0	23.3	1.7
External Financing Limit (EFL)	8.7	(9.9)	18.6
Cash	11.7	30.3	18.6

In line with all NHS organisations LAS was required to identify efficiencies. In total £17.1m was identified and delivered in 2017/18.

The Trust continued to invest in new equipment, spending in excess of £23.4m 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	23.4
Less:	
NBV of Disposals	(0.1)
Capital Resourcing Limit (CRL)	23.3

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 2018. The results outlined in this section relate to the full 12 month period of 1 April 2017 to 31 March 2018. 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 £8.7m. The Trust had an under spend on its EFL of £18.7m 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 £23.3million on a range of projects, including ambulances and other vehicles including fast response cars, HART, motor bikes and other vehicles (in total 100 vehicles delivered during the year), new technology projects and a range of projects to improve clinical equipment and the Trust's estate. Overall, the Trust under spent by £1.7m against its capital resource limit, which it is permitted to do. The capital programme was primarily funded internally, but was augmented with £1.6m of external support from the Department of Health and Social Care. The under spend on the capital programme will be carried forward into the 2018-19 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 85% of its NHS trade invoices respectively 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 2018/19

The Trust has formally submitted a plan for the coming financial year, 2018/19 that takes into account planned contracted income levels and expenditure requirements. These plans have been set in line with guidance from the DH, NHSI as well as discussions with clinical commissioning groups across London. The plan is set to deliver a deficit of £1.6 million.

Financial risk

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

International Financial Reporting Standards (IFRS)

The Treasury announced that public sector bodies are required to prepare their accounts under International Financial Reporting Statements (IFRS) from 2009/10. 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 2018 for all land and buildings. The net gain and loss on revaluation was £6.3 million and the total impairments were £1.3 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 £4.6 million for the current financial year (£4.6 million in 2016/17).

Subsequent events after the balance sheet date

The Trust has not identified any important event occurring after the financial year end, 31 March 2018, that has a material effect on the 2017/18 financial statements as presented.

Other information

Ernst and Young LLP were the Trust's external auditor for the year ended 31 March 2018. The Trust paid £84,000 (£68,000 in 2016/17) 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 31 March 2018.

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

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

The London Ambulance Service is a NHS Trust established under the National Health Service Act 2006. The Secretary of State for Health has directed that the financial statements of the NHS Trusts will meet the accounting requirements of the NHS Trusts Manual for Accounts, which will be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2017/18 Group Accounting Manual issued by the Department of Health and Social Care.

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

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 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 34. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 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 2018 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

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

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

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.

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, 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 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

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

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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 36, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

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

Auditor's responsibility for the audit of the financial statements

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

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at 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 August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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.

Janet Dawson (Key Audit Partner)

Ernst & Young LLP (Local Auditor)

London

Date 25 May 2018

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

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

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	355,557	343,299
Other operating income	4	9,041	12,208
Operating expenses	5, 7	(355,193)	(345,525)
Operating surplus/(deficit) from continuing operations		**9,405**	**9,982**
Finance income	10	114	84
Finance expenses	11	(27)	(142)
PDC dividends payable		(3,780)	(4,079)
Net finance costs		**(3,693)**	**(4,137)**
Other gains / (losses)	12	17	118
Surplus / (deficit) for the year		**5,729**	**5,963**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	1,309	(2,474)
Revaluations	15	6,333	667
Other recognised gains and losses		-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available-for-sale financial investments	12	-	-
Recycling gains / (losses) on available-for-sale financial investments	12	-	-
Foreign exchange gains / (losses) recognised directly in OCI	12	-	-
Total comprehensive income / (expense) for the period		**13,371**	**4,156**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	4,770	6,577
Property, plant and equipment	14	162,111	142,368
Total non-current assets		**166,881**	**148,945**
Current assets			
Inventories	16	2,746	3,115
Trade and other receivables	17	24,098	35,518
Non-current assets held for sale / assets in disposal groups	18	-	44
Cash and cash equivalents	19	30,300	18,637
Total current assets		**57,144**	**57,314**
Current liabilities			
Trade and other payables	20	(44,918)	(41,457)
Provisions	23	(8,259)	(8,064)
Other liabilities	21	(90)	(57)
Total current liabilities		**(53,267)**	**(49,578)**
Total assets less current liabilities		**170,758**	**156,681**
Non-current liabilities			
Borrowings	22	(107)	(107)
Provisions	23	(9,576)	(10,548)
Total non-current liabilities		**(9,683)**	**(10,655)**
Total assets employed		**161,075**	**146,026**
Financed by			
Public dividend capital		59,694	58,016
Revaluation reserve		58,081	52,217
Other reserves		(419)	(419)
Income and expenditure reserve		43,719	36,212
Total taxpayers' equity		**161,075**	**146,026**

The notes on pages 60 to 92 form part of these accounts.

Name Garrett Emmerson
Position Chief Executive
Date 24 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

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

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**58,016**	**56,153**	**(419)**	**28,120**	**141,870**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**58,016**	**56,153**	**(419)**	**28,120**	**141,870**
Surplus/(deficit) for the year	-	-	-	5,963	**5,963**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	**-**
Other transfers between reserves	-	(2,129)	-	2,129	**-**
Impairments	-	(2,474)	-	-	**(2,474)**
Revaluations	-	667	-	-	**667**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	**-**
Other reserve movements	-	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**58,016**	**52,217**	**(419)**	**36,212**	**146,026**

Information on reserves

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

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

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

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		9,405	9,982
Non-cash income and expense:			
Depreciation and amortisation	5.1	13,054	13,784
Net impairments	6	(9)	308
Income recognised in respect of capital donations	4	-	(159)
(Increase) / decrease in receivables and other assets		11,798	(21,062)
(Increase) / decrease in inventories		369	(116)
Increase / (decrease) in payables and other liabilties		865	1,548
Increase / (decrease) in provisions		(804)	4,207
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**34,678**	**8,492**
Cash flows from investing activities			
Interest received		103	93
Purchase of intangible assets		(960)	(308)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(19,817)	(5,949)
Sales of property, plant, equipment and investment property		130	329
Receipt of cash donations to purchase capital assets		-	-
Net cash generated from / (used in) investing activities		**(20,544)**	**(5,835)**
Cash flows from financing activities			
Public dividend capital received		1,678	-
Public dividend capital repaid		-	-
Other interest paid		-	-
PDC dividend (paid) / refunded		(4,149)	(4,229)
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**(2,471)**	**(4,229)**
Increase / (decrease) in cash and cash equivalents		**11,663**	**(1,572)**
Cash and cash equivalents at 1 April - brought forward		**18,637**	**20,209**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**18,637**	**20,209**
Cash and cash equivalents at 31 March	19	**30,300**	**18,637**

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 2017/18 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 accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis. This is based on the expectation the the Trust will be able to maintain a positive cash flow across 2018/19, not require any external financial support to achieve a positive cash flow and be able to pay its creditors across 2018/19 as they fall due. Trust management expect these conditions to be met in and continue beyond 2018/19.

Note 1.2 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 1.2.1 Sources of estimation uncertainty

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

Asset Valuations

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

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

Provisions

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

Annual Leave Accrual

The accrual is based on management's estimation of untaken leave as at 31 March 2018. The carrying value of the accrual is £4.58m within note 20 under accruals and deferred income.

Injury Cost Recovery Scheme Accrual
The Trust receives income from the NHS injury cost recovery scheme for the recovery of ambulance journey costs relating to road traffic accidents. Accruals are made for receivables that are uncertain in amount. The receivables are based on "management estimates supported by the number of cases" supplied by hospitals. The carrying value of the receivables is £3.25m within note 17 under prepayments and accrued income.

Note 1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

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

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

Note 1.4 Expenditure on employee benefits

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

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

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

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

Note 1.5 Expenditure on other goods and services

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

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably; and either
• 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 economic lives.

Note 1.6.2 Measurement

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

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic 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’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

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

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

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

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

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

Note 1.6.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Note 1.6.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.6.5 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic 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 economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

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

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

Expenditure on research is not capitalised.

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

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

Software

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

Note 1.7.2 Measurement

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

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

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

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

Note 1.7.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

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

Note 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.9 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.10 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and measurement
Financial assets are categorised as loans and receivables.

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

Note 1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The Trust as lessee

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

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

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

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

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

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

Note 1.12 Provisions

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

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 23 but is not recognised in the Trust's accounts.

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

Note 1.13 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Note 1.14 Public dividend capital

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

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

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

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.15 Value added tax

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

Note 1.16 Losses and special payments

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

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

Note 1.17 Gifts

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

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18, and the application of the Standards as revised would not have a material impact on the financial statements for 2017-18, were they applied in the year.

- IAS 7 Statement of cash flows
- IFRS 12 Disclosure of interest in other entities

Accounting Standards issued but not applicable in this financial year include:
- IFRS 9 Financial instruments
- IFRS 15 Revenue from contracts with customers
- IFRS 16 Leases
- IFRS 17 Insurance contracts

The Trust does not expect material changes to arise when IFRS9, IFRS 15 and IFRS 17 are implemented. However for IFRS 16 we are expecting material changes due to operating leases coming on to the balance sheet. The Trust is currently assessing the impact these changes will have on the financial statements.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	**2017/18**	**2016/17**
	£000	**£000**
A & E income	352,358	339,077
Patient transport services income	2,001	2,987
Other income	1,198	1,235
Total income from activities	**355,557**	**343,299**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2017/18**	**2016/17**
	£000	**£000**
NHS England	7,166	6,227
Clinical commissioning groups	342,183	328,709
Department of Health and Social Care	-	508
Other NHS providers	1,472	2,133
NHS other	653	2,074
Local authorities	27	(5)
NHS injury scheme	1,198	1,235
Non NHS: other	2,858	2,418
Total income from activities	**355,557**	**343,299**
Of which:		
Related to continuing operations	355,557	343,299

Note 4 Other operating income

	2017/18	**2016/17**
	£000	**£000**
Research and development	237	294
Education and training	1,080	1,785
Receipt of capital grants and donations	-	159
Non-patient care services to other bodies	66	-
Sustainability and transformation fund income	7,514	9,636
Income in respect of staff costs where accounted on gross basis	144	243
Other income	-	91
Total other operating income	**9,041**	**12,208**
Of which:		
Related to continuing operations	9,041	12,208

Note 5 Expenses

Note 5.1 Operating expenses

	2017/18	2016/17
	£000	£000
Staff and executive directors costs	253,754	239,674
Remuneration of non-executive directors	89	83
Supplies and services - clinical (excluding drugs costs)	7,719	6,531
Supplies and services - general	11,215	10,610
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	802	951
Inventories written down	-	75
Consultancy costs	1,605	1,546
Establishment	9,285	8,417
Premises	9,199	9,481
Transport (including patient travel)	30,065	30,331
Depreciation on property, plant and equipment	10,465	11,095
Amortisation on intangible assets	2,589	2,689
Net impairments	(9)	308
Increase/(decrease) in provision for impairment of receivables	2	72
Increase/(decrease) in other provisions	149	-
Change in provisions discount rate(s)	131	1,243
Audit fees payable to the external auditor:		
audit services- statutory audit	84	68
other auditor remuneration (external auditor only)	-	19
Internal audit costs	156	123
Clinical negligence	2,785	1,989
Legal fees	1,012	385
Insurance	1,303	1,250
Research and development	823	802
Education and training	6,651	5,991
Rentals under operating leases	5,211	5,082
Redundancy	535	-
Car parking & security	223	206
Hospitality	-	10
Other	(650)	6,494
Total	**355,193**	**345,525**
Of which:		
Related to continuing operations	355,193	345,525

Note 5.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	19
Total	**-**	**19**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £0m).

Note 6 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(9)	308
Total net impairments charged to operating surplus / deficit	**(9)**	**308**
Impairments charged to the revaluation reserve	(1,309)	2,474
Total net impairments	**(1,318)**	**2,782**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	205,507	193,346
Social security costs	23,130	21,994
Apprenticeship levy	1,025	-
Employer's contributions to NHS pensions	22,947	22,479
Termination benefits	535	-
Temporary staff (including agency)	6,698	7,182
Total gross staff costs	**259,842**	**245,001**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**259,842**	**245,001**
Of which		
Costs capitalised as part of assets	427	208

Note 7.1 Retirements due to ill-health

During 2017/18 there were 5 early retirements from the trust agreed on the grounds of ill-health (10 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £262k (£750k in 2016/17).

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

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2018 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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. The lease term varies between 1 and 15 years.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	5,211	5,082
Total	**5,211**	**5,082**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	3,744	4,755
- later than one year and not later than five years;	9,521	10,319
- later than five years.	5,281	6,680
Total	**18,546**	**21,754**

Note 10 Finance income

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

	2017/18 £000	2016/17 £000
Interest on bank accounts	96	65
Interest on other investments / financial assets	18	19
Total	**114**	**84**

Note 11 Finance expenditure

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

	2017/18 £000	2016/17 £000
Unwinding of discount on provisions	27	142
Total finance costs	**27**	**142**

Note 12 Other gains / (losses)

	2017/18 £000	2016/17 £000
Gains on disposal of assets	29	181
Losses on disposal of assets	(12)	(63)
Total gains / (losses) on disposal of assets	17	118

Note 13 Intangible Assets

Note 13.1 Intangible assets - 2017/18

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

Note 13.2 Intangible assets - 2016/17

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,511**	**-**	**-**	**16,510**	**-**	**705**	**-**	**19,726**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**2,511**	**-**	**-**	**16,510**	**-**	**705**	**-**	**19,726**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	-	-	11	-	556	-	**567**
Reclassifications	138	-	-	131	-	(271)	-	**(2)**
Disposals / derecognition	(6)	-	-	(59)	-	-	-	**(65)**
Valuation / gross cost at 31 March 2017	**2,643**	**-**	**-**	**16,593**	**-**	**990**	**-**	**20,226**
Amortisation at 1 April 2016 - as previously stated	**2,125**	**-**	**-**	**8,897**	**-**	**-**	**-**	**11,022**
Provided during the year	**257**	**-**	**-**	**2,432**	**-**	**-**	**-**	**2,689**
Disposals / derecognition	(3)	-	-	(59)	-	-	-	**(62)**
Amortisation at 31 March 2017	**2,379**	**-**	**-**	**11,270**	**-**	**-**	**-**	**13,649**
Net book value at 31 March 2017	**264**	**-**	**-**	**5,323**	**-**	**990**	**-**	**6,577**
Net book value at 1 April 2016	**386**	**-**	**-**	**7,613**	**-**	**705**	**-**	**8,704**

Note 14 Property, Plant and Equipment

Note 14.1 Property, plant and equipment - 2017/18

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

Note 14.2 Property, plant and equipment - 2016/17

	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 2016 - as previously stated	**51,758**	**62,039**	**-**	**2,096**	**16,026**	**45,189**	**12,773**	**74**	**189,955**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**51,758**	**62,039**	**-**	**2,096**	**16,026**	**45,189**	**12,773**	**74**	**189,955**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	1,545	-	8,909	101	1,048	717	-	**12,320**
Impairments	(886)	(4,418)	-	-	-	-	-	-	**(5,304)**
Revaluations	348	114	-	-	-	-	-	-	**462**
Reclassifications	-	2	-	(1,691)	756	292	643	-	**2**
Disposals / derecognition	-	(107)	-	-	(67)	(3,990)	(594)	-	**(4,758)**
Valuation/gross cost at 31 March 2017	**51,220**	**59,175**	**-**	**9,314**	**16,816**	**42,539**	**13,539**	**74**	**192,677**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**4**	**-**	**-**	**10,080**	**26,051**	**10,358**	**59**	**46,552**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**4**	**-**	**-**	**10,080**	**26,051**	**10,358**	**59**	**46,552**
Provided during the year	**-**	**2,723**	**-**	**-**	**1,987**	**4,954**	**1,429**	**2**	**11,095**
Impairments	-	(2,522)	-	-	-	-	-	-	**(2,522)**
Revaluations	-	(205)	-	-	-	-	-	-	**(205)**
Disposals/ derecognition	-	-	-	-	(42)	(3,975)	(594)	-	**(4,611)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**12,025**	**27,030**	**11,193**	**61**	**50,309**
Net book value at 31 March 2017	**51,220**	**59,175**	**-**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**
Net book value at 1 April 2016	**51,758**	**62,035**	**-**	**2,096**	**5,946**	**19,138**	**2,415**	**15**	**143,403**

Note 14.3 Property, plant and equipment financing - 2017/18

	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 2018									
Owned - purchased	52,077	64,200	-	18,708	4,158	19,089	3,749	17	**161,998**
Owned - donated	-	-	-	-	-	113	-	-	**113**
NBV total at 31 March 2018	**52,077**	**64,200**	**-**	**18,708**	**4,158**	**19,202**	**3,749**	**17**	**162,111**

Note 14.4 Property, plant and equipment financing - 2016/17

	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 2017									
Owned - purchased	51,220	59,175	-	9,314	4,791	15,358	2,346	13	**142,217**
Owned - donated	-	-	-	-	-	151	-	-	**151**
NBV total at 31 March 2017	**51,220**	**59,175**	**-**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**

Note 15 Revaluations of property, plant and equipment

A professional revaluation was undertaken on all land and buildings at 31 March 2018.

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

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

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

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

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

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

GROSS CARRYING VALUE OF ASSETS IN USE	**2017/18**
	£000
Furniture & fittings	56
Transport equipment	8,395
Plant & machinery	7,694
Information technology	15,630
Total	**31,775**

Note 16 Inventories

	31 March 2018	**31 March 2017**
	£000	**£000**
Drugs	60	41
Consumables	2,686	3,074
Total inventories	**2,746**	**3,115**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £10,757k (2016/17: £10,147k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £75k).

Note 17 Receivables

Note 17.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	3,747	6,916
Capital receivables (including accrued capital related income)	-	2
Accrued income	14,765	23,898
Provision for impaired receivables	(853)	(851)
Prepayments (non-PFI)	5,547	4,420
Interest receivable	12	1
PDC dividend receivable	420	51
VAT receivable	84	692
Other receivables	376	389
Total current trade and other receivables	**24,098**	**35,518**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Prepayments (non-PFI)	-	-
Interest receivable	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	14,785	27,238
Non-current	-	-

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**851**	**782**
Prior period adjustments	-	-
At 1 April - restated	**851**	**782**
Increase in provision	77	47
Amounts utilised	-	(3)
Unused amounts reversed	(75)	25
At 31 March	**853**	**851**

The Trust makes provisions for all non-NHS debts over 180 days past their due date and any organisation that has been put into receivership or liquidation.

Note 17.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	7	-	-	-
Over 180 days	103	-	65	-
Total	**110**	**-**	**65**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,878	-	2,000	-
30-60 Days	326	-	13	-
60-90 days	54	-	41	-
90- 180 days	101	-	117	-
Over 180 days	409	-	146	-
Total	**2,768**	**-**	**2,317**	**-**

The majority of the Trust's debt is owed by Clinical Commissioning Groups, Foundation Trusts and NHS Trusts whose parent entity is also the Department of Health and Social Care, and therefore risk of default is low.

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

	2017/18 £000	2016/17 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**44**	**101**
Prior period adjustment		**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**44**	**101**
Assets sold in year	(44)	**(57)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**44**

Note 19 Cash and cash equivalents movements

Note 19.1 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.

	2017/18 £000	2016/17 £000
At 1 April	**18,637**	**20,209**
Prior period adjustments	-	-
At 1 April (restated)	**18,637**	**20,209**
Net change in year	11,663	(1,572)
At 31 March	**30,300**	**18,637**
Broken down into:		
Cash at commercial banks and in hand	7	12
Cash with the Government Banking Service	30,293	2,625
Deposits with the National Loan Fund	-	16,000
Total cash and cash equivalents as in SoFP	**30,300**	**18,637**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**30,300**	**18,637**

Note 20 Payables

Note 20.1 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	7,445	6,014
Capital payables	10,715	8,086
Accruals	17,719	18,035
Social security costs	3,268	3,342
Other taxes payable	2,428	2,622
Other payables	3,343	3,358
Total current trade and other payables	**44,918**	**41,457**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
VAT payables	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,839	1,286
Non-current	-	-

Note 20.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018	31 March 2017
	£000	£000
- outstanding pension contributions	**3,234**	3,229

Note 21 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	90	57
Total other current liabilities	**90**	**57**
Non-current		
Deferred income	-	-
Total other non-current liabilities	**-**	**-**

Note 22 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Other loans	-	-
Total current borrowings	**-**	**-**
Non-current		
Other loans	107	107
Total non-current borrowings	**107**	**107**

Note 23 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Continuing care	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**9,713**	**444**	**-**	**-**	**-**	**-**	**8,455**	**18,612**
Change in the discount rate	121	-	-	-	-	-	10	**131**
Arising during the year	179	490	-	-	-	525	5,076	**6,270**
Utilised during the year	(405)	(291)	-	-	-	-	(1,453)	**(2,149)**
Reversed unused	(815)	(385)	-	-	-	-	(3,856)	**(5,056)**
Unwinding of discount	23	-	-	-	-	-	4	**27**
At 31 March 2018	**8,816**	**258**	**-**	**-**	**-**	**525**	**8,236**	**17,835**
Expected timing of cash flows:								
- not later than one year;	463	258	-	-	-	525	7,013	**8,259**
- later than one year and not later than five years;	1,840	-	-	-	-	-	612	**2,452**
- later than five years.	6,513	-	-	-	-	-	611	**7,124**
Total	**8,816**	**258**	**-**	**-**	**-**	**525**	**8,236**	**17,835**

The Early Departure Costs provision of £8,816k (2016/17 £9,713k) comprises pensions relating to claims for Personal Injury Benefits. The amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of 0.10% is applied.

The Legal Claims provision of £258k (2016/17 £444k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

The Redundancy provision of £525k (2016/17 nil) relates to ongoing management restructures within the Trust.

The other provision of £8,236k (2016/17 £8,455k) includes £2,619k relocation costs for recruitment of overseas paramedics, £2,291k in relation to pending legal cases affecting calculation of holiday pay, £876k for pending employment tribunals, £809k for service penalties, £264k for changes in VAT rules, and £1,370k in respect of pension payments due to employees made redundant prior to 1995 as a result of the restructuring of the Trust. The provisions are calculated using actuarial tables and are payable quarterly over the life of the employees.

Note 23.1 Clinical negligence liabilities

At 31 March 2018, £59,070k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of London Ambulance Service NHS Trust (31 March 2017: £55,349k).

Note 24 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(106)	(182)
Gross value of contingent liabilities	**(106)**	**(182)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(106)**	**(182)**
Net value of contingent assets	-	-

Note 25 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	3,265	4,459
Intangible assets	14	141
Total	**3,279**	**4,600**

Note 26 Financial instruments

Note 26.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 26.2 Carrying values of financial assets

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

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	28,706	-	-	-	**28,706**
Cash and cash equivalents at bank and in hand	18,637	-	-	-	**18,637**
Total at 31 March 2017	**47,343**	**-**	**-**	**-**	**47,343**

Note 26.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	107	-	**107**
Trade and other payables excluding non financial liabilities	39,318	-	**39,318**
Total at 31 March 2018	**39,425**	**-**	**39,425**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	107	-	**107**
Trade and other payables excluding non financial liabilities	39,789	-	**39,789**
Total at 31 March 2017	**39,896**	**-**	**39,896**

Note 26.4 Fair values of financial assets and liabilities

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

Note 26.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	39,318	39,789
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	**39,425**	**39,896**

Note 27 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	1,506	1,532	1,432	1,637
Total losses	**1,506**	**1,532**	**1,432**	**1,637**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	41	1,002	58	306
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**41**	**1,002**	**58**	**306**
Total losses and special payments	**1,547**	**2,534**	**1,490**	**1,944**

Note 28 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 Barnet CCG	-	13,146	-	229
NHS Brent CCG	-	16,024	-	298
NHS Bromley CCG	-	12,821	61	302
NHS Camden CCG	-	10,759	-	74
NHS Central London (Westminster) CCG	-	11,733	-	1,115
NHS City and Hackney CCG	-	11,273	-	155
NHS Croydon CCG	-	15,102	-	405
NHS Ealing CCG	-	13,181	-	409
NHS Enfield CCG	-	11,976	-	191
NHS England	-	13,818	-	5,802
NHS Greenwich CCG	-	11,450	-	128
NHS Havering CCG	-	10,365	-	203
NHS Hillingdon CCG	-	13,667	-	209
NHS Hounslow CCG	-	10,041	-	-
NHS Lambeth CCG	-	13,856	296	161
NHS Lewisham CCG	-	11,862	-	253
NHS Newham CCG	-	12,304	-	15
NHS Redbridge CCG	-	10,428	-	172
NHS Southwark CCG	-	13,702	-	29
NHS Tower Hamlets CCG	-	10,252	-	28
NHS Wandsworth CCG	-	10,483	-	170

The Trust has a number of staff who also work for St John Ambulance Service. The transactions with St John Ambulance Service during the year comprised expenditure of £1,234k (2016/17 £1,445k) and the amount payable by the Trust as at 31 March 2018 was £193k (31 March 2017 £29k).

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 2017/18.

Note 29 Events after the reporting date

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

Note 30 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	55,980	96,013	55,286	86,195
Total non-NHS trade invoices paid within target	47,695	69,177	46,377	69,717
Percentage of non-NHS trade invoices paid within target	85.20%	72.05%	83.89%	80.88%
NHS Payables				
Total NHS trade invoices paid in the year	304	2,488	351	1,859
Total NHS trade invoices paid within target	242	1,073	294	1,218
Percentage of NHS trade invoices paid within target	79.61%	43.13%	83.76%	65.52%

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 31 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	(9,985)	1,572
External financing requirement	(9,985)	1,572
External financing limit (EFL)	8,696	1,572
Under / (over) spend against EFL	18,681	-

Note 32 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	23,406	12,887
Less: Disposals	(111)	(207)
Less: Donated and granted capital additions	-	(159)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	23,295	12,521
Capital Resource Limit	24,964	19,168
Under / (over) spend against CRL	1,669	6,647

Note 33 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	5,339
Add back income for impact of 2016/17 post-accounts STF reallocation	419
Breakeven duty financial performance surplus / (deficit)	5,758
Reconciliation to I&E Surplus	
Add back all I&E impairments / (reversal)	9
Add back depreciation on capital donations	(38)
Surplus / (deficit) for the year	5,729

Note 34 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,425	1,002	2,751	262	262	6,048	(4,405)	6,143	5,758
Breakeven duty cumulative position	2,569	3,994	4,996	7,747	8,009	8,271	14,319	9,914	16,057	21,815
Operating income		279,864	283,617	281,731	303,109	303,827	324,052	319,992	355,507	364,598
Cumulative breakeven position as a percentage of operating income		1.43%	1.76%	2.75%	2.64%	2.72%	4.42%	3.10%	4.52%	5.98%

13 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.