
# Annual Report & Accounts 2020/21

# Our vision

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

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

on scene • on phone • online

# Our purpose

We exist to:

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

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

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

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

# Our values & behaviours

### Respectful

Caring for our patients and each other with compassion and empathy

Championing equality and diversity

Acting fairly

### Professional

Acting with honesty and integrity

Aspiring to clinical, technical and managerial excellence

Leading by example

Being accountable and outcomes orientated

### Innovative

Thinking creatively

Driving value and sustainable change

Harnessing technology and new ways of working

Taking courageous decisions

### Collaborative

Listening and learning from each other

Working with partners

Being open and transparent

Building trust

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## SECTION ONE: PERFORMANCE REPORT

# 1 CHAIR'S FOREWORD

As we come through the pandemic, it is more important than ever for us to be a full system player in the provision of urgent and emergency care. This will improve outcomes, health and wellbeing for our patients as we move into Integrated Care Systems (ICSs).

This year, through COVID-19, we have demonstrated the benefits of effective system working by collaborating closely with NHS England/Improvement and the five ICSs to innovate and respond to the changing needs of our patients.

When reflecting on the last 12 months, my thoughts are with those we have lost, those who are grieving and those who have made heart-breaking sacrifices and continue to make those sacrifices.

In this year like no other, everyone across London Ambulance Service has played a crucial role in responding to COVID-19 and saving lives.

Throughout the pandemic our staff have continued to provide compassionate care to all patients and their families, which given the circumstances they were enduring is truly remarkable. My heartfelt thanks goes to staff and volunteers who have gone that extra mile, often at personal cost.

Not only have we prioritised our quality of care, but even in the darkest days of the pandemic, we strove to ensure our people felt cared for and supported at work. This has not always been easy but the pressures of responding to COVID-19 have brought the health and wellbeing of our staff into sharp focus.

One of the positives to come out of the pandemic has been the commitment and energy given to creating a safe environment for all our teams by developing our wellbeing services and trying to reduce workplace stress. This has included ensuring our people were among the first to be offered the COVID-19 vaccine.

And while we were being tested by the demands of the health crisis, we came together to talk about the very important issues highlighted by the murder of George Floyd in America and the Black Lives Matter movement. I have personally listened to our staff who shared their stories of being a Black person living in London and the discrimination they and their families suffer often day in day out.

We are resolute in our determination to stamp out racism. We began an engagement programme to improve inclusivity, equality and diversity. Our aim is for every single person working at London Ambulance Service to feel respected and valued.

We are building an organisation everyone should feel proud to be a part of.

This year we have launched both a Public and Patient Advisory group co-chaired by Dame Christine Beasley and Michael E Bryan and a Chair's Staff Advisory Group. Listening to our staff and patients is essential in improving both our culture and the way care is delivered.

These forums for engagement will


be invaluable in our recovery from COVID-19; as will our close collaboration with our NHS partners.

These partnerships have allowed us to further integrate 999 and 111 services, develop new patient pathways, including, most notably, our role in the 'hospital at home' initiative for patients suffering with COVID.

We will build on our work with ICSs to work out the best use of resources, including technology, data and people.

Furthermore, as the only NHS provider trust to operate across the whole of London, we are uniquely placed to influence the design and delivery of the city's health and social care system.

Our ambition is to be a world-class ambulance service for Londoners, a vision supported by both NHSE London and the Mayor of London. The latter visited our headquarters and our new call handling training centre this year.

We have also been honoured to host visits by the Prime Minister Boris Johnson and their Royal Highnesses, the Duke and Duchess of Cambridge. All our visitors have expressed their gratitude and admiration for the work of our people throughout this crisis.

On behalf of the Board, I would like to echo that thanks to our Chief Executive, executive team, managers, staff, volunteers and partners.

Sadly this year we said goodbye to Dr Trisha Bain and Fergus Cass. I would like to thank them for their expertise and wisdom which will continue to shape London Ambulance Service for many years to come. In April we welcomed our new Director of Corporate Affairs, Syma Dawson and I am also delighted that we have appointed Dr John Martin to the Board as Chief Paramedic and Quality Officer.

# 2 CHIEF EXECUTIVE'S FOREWORD

The worst of times can bring out the best in people. The peaks of the pandemic were certainly some of the very worst times we have endured; but the way our people have risen to this extraordinary challenge has shown them at their very best.

The virus was spreading so rapidly in London in the winter of 2020-21, the Mayor of London declared a Major Incident.

In the face of undeniable pressure, what we have achieved has been truly remarkable. Our staff and volunteers have proved to be resilient and resourceful throughout a time which has been frightening for us all.

Not only have we remained steadfastly focused on excellent patient care, but we have completely transformed our ways of working: we have increased our workforce and number of ambulances on the road, allowing us to help thousands of people every day.

Our performance across the whole year has remained strong. Except for some extremely busy days during the two peaks in COVID cases, including the two busiest in our history, we have been reaching patients within target times. By treating more people over the telephone and on scene, we have been able to reduce the pressure on emergency departments.

That is not to say there haven't been immense difficulties: 999 calls doubling; 111 calls tripling; younger patients in cardiac arrest; handover delays at hospitals; and huge numbers of staff and volunteers off sick or isolating. For all our staff it has often been frustrating, distressing and exhausting. However, we have continued to rise to the challenge of supporting Londoners when they need us most.

Our priority throughout has also been to keep our people healthy and safe. This meant ramping up our services to support mental and physical health; which included ensuring our staff and volunteers had the right protection as well as early access to testing and the COVID-19 vaccine.

The disproportionate impact of the virus on people from Black, Asian and minority ethnic (BAME) communities has been clear since the early days of the pandemic. This has been concerning for us, and we have worked very hard to assess the risks posed by COVID-19 to ensure we are doing everything we can to keep our people safe.

Equally concerning, from the learning we have done across the organisation in response to Black Lives Matter, is the fact that our BAME colleagues haven't always felt the respect and recognition everyone deserves. We are committed to rooting out racism while improving race equality and diversity across all parts of the organisation.

We are asking senior leaders within the organisation to lead the way in delivering cultural transformation. We must empower our people, facilitate innovation and collaboration, and increase our professionalism and respect.

Nowhere has the professionalism and respect of our people been better demonstrated than in the latest series of the "Ambulance" documentary, which was broadcast on BBC One in the autumn. Recorded in 2019 prior to the COVID-19 pandemic, this


fantastic production showcased the incredible dedication of our ambulance crews and call handlers while also shining a spotlight on those who work so hard behind the scenes.

Viewers saw the diversity of jobs we are called to, as well as some of the challenges – and the programme led to record numbers visiting our jobs pages, wanting to join us.

Some of those inspired by the series, may be among our newest Assistant Ambulance Practitioner (AAPs) recruits. This is a brand new role – only created this year – and in just a matter of months, we have recruited and trained more than 100 people who are already working on ambulances and caring for patients.

It is just this type of innovation which has led to us winning and being nominated for a host of accolades including both the Mental Health Initiative of the Year Award and End of Life Care Award at the Health Service Journal Patient Safety Awards as well as the Strategy & Design Award at the Supply Chain Excellence Awards.

None of these achievements would be possible without the support we have had from our NHS partners, our emergency services colleagues and other organisations who have enabled us to deliver the best service possible to our patients during this unprecedented year.

We are now starting to think about what recovery from this crisis will look like: we know it will be challenging. But given the dedication and commitment shown by everyone at London Ambulance Service, we know we have the very best people for the job.

# CORONAVIRUS

# 3 CORONAVIRUS

This year, London Ambulance Service has been at the heart of the nation's response to the COVID-19 emergency – the greatest peacetime healthcare challenge since the creation of the NHS in 1948. In this section, and in advance of our review of the year generally, we set out how we responded to this challenge.

The first time we were called to a patient suspected of having COVID-19 was 25 January 2020. At that point we were dealing with a new virus about which little was known worldwide. There were no pre-existing guidelines on how to care for patients.

We supported the development of many of the protocols in triage and assessment of this new disease, amending them as more was learned. We continued to be at the forefront in responding to the pandemic as cases peaked for a second time last winter.

The busiest day in the history of London Ambulance Service was 4 January 2021 when we took 8,464 999 calls. On New Year's Day in 2021, ambulance crews treated 3,764 patients – the highest number of patients we have ever seen face-to-face.

The work to rapidly mobilise a pandemic response involved significant changes across our operational teams and required fundamental variations to our ways of working.

## First wave

As the crisis first unfolded in early 2020, three immediate operational challenges were identified. These were: ensuring we had the maximum number of ambulances available; having the resilience needed if 999 or 111 call volumes suddenly increased; and being able to mobilise additional blue light drivers for our ambulances to free up clinicians to provide care. We took a number of immediate and substantial actions in order to manage the extreme levels of demand placed on our 999 and 111 services.

They included:

- Building a dedicated COVID-19 999 call-handling centre
- Expanding the NHS 111 facility to accommodate more clinicians to respond to COVID-19 calls
- Enhancing infrastructure to transfer calls to other ambulance services and between 999 and 111
- Redeploying all clinicians to patient facing duties
- Strengthening our leadership team to operate a full seven-day-a-week capability
- Bringing in 900 volunteers, student paramedics and former members of staff
- Training hundreds of London firefighters – and later Metropolitan police officers – to drive ambulances and support our crews
- Rapidly acquiring over 100 extra ambulances and moving crews from other response vehicles onto ambulances
- Developing partnerships with the military and other organisations, like the AA to keep more of our vehicles on the road 24-hours a day, seven days a week
- Working with NHS partners to develop new or improved patient pathways
- Providing additional senior clinical support for 999 and 111 centres and for clinicians on ambulances
- Implementing regular safety and quality reviews for continual oversight of patient safety
- Consolidating operations into larger hub ambulance stations
- Redesigning and increasing the size of our logistics warehouses for storing PPE and other essentials
- Helping design the NHS Nightingale London hospital and creating and delivering a bespoke critical care transfer service
- Coordinating patient transport services across London
- Increasing our engagement with staff and volunteers, including launching LAS TV Live

- Working with the media and other partners to share important information, including how the public could protect themselves

As a result of these actions, by mid-April 2020 we were meeting national performance targets every day.

As we emerged from the first wave of COVID-19, work was done to learn from our response and build resilience for the future, in expectation of a second wave.

## Second wave

In December 2020, COVID-19 started spreading far quicker than national forecasting and modelling had predicted due to a new, more transmissible variant of the virus. Community infection rates quadrupled in a matter of weeks.

Not only did call volumes and face-to-face incidents rise dramatically, but so did infection rates among our own people. At the peak, despite stringent PPE and social distancing measures, the Trust had around 800 staff members absent and nearly 600 isolating – around a fifth of our entire workforce.

Our colleagues at London Fire Brigade, who had been trained to drive ambulances, were also suffering high rates of sickness which meant we could not bring on board these extra blue light drivers as quickly as we had planned and hoped for.

With hospitals dealing with unprecedented numbers of patients, pressure mounted in emergency departments (EDs). When EDs were at their busiest, the delays for patients to be handed over to hospital, added up to 700 hours a day in lost operational time for London Ambulance Service. This meant that, at times, about 25% of ambulances were waiting in queues outside emergency departments and unable to respond to patients who had made a 999 emergency call.


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## Our response

As a 111 provider for 40% of London, we increased call taking capacity through partnership arrangements with out-of-London providers, where there were fewer COVID infections.

Our 999 call handling workforce and infrastructure had already been increased after the first wave. Crucially we had also put in place arrangements with ambulance services across the country to agree a mutual aid framework. These arrangements allowed us to answer more 999 calls than ever before – and in turn triage a greater number of patients than ever before.

We trained police officers who, as well as firefighters, boosted our numbers to enable us to mobilise up to 500 ambulances per day. We have consistently maintained a fleet of 530 ambulances which can be deployed – with over 90% availability – at all times. This is down to the AA and our own mechanics working 7 days a week to keep vehicles well-maintained.

We increased the number of clinicians in our 999 clinical hub, agreeing a minimum of 35 clinicians rostered on at peak times during any 24-hour period. They were able to undertake enhanced clinical assessments, ensuring the safety of patients waiting for an ambulance. These clinicians were also able to direct patients who did not need an ambulance to alternative care pathways such as direct booking in to primary care and therefore reduce the need for ambulances.

These actions meant that for most of the year we were reaching patients within our target response time. Our average response time for reaching the very sickest patients was 6 minutes and 16 seconds.

## Learning

Despite meeting our target times, the pandemic has exposed weaknesses and inefficiencies in the way we previously operated.

We are determined to use this opportunity and build on some of the improvements we have made so that we can continue to maintain and sustain the benefits achieved.

Some of those improvements, like greater integration, were always part of our strategy for delivering against the NHS Long Term Plan.

However new priorities (detailed in a later chapter) have emerged and we will continue to embrace transformation in the months and years to come.

# THANK YOU


Everything we achieved this year was only made possible by the immense effort by many people right across London Ambulance Service, as well as the fantastic help we received from so many other organisations including:

NHS London and NHS England, our partner ambulance services, St John Ambulance, the AA, London Fire Brigade, Metropolitan Police Service, Transport for London, NHS Charities Together, London Air Ambulance, Stagecoach, Wilker ambulance converters, Telent, Bowmans, Wembley Stadium, Virgin Atlantic, British Airways, our partner universities (Anglia Ruskin, University of Herefordshire, St George's University, University of West London, University of Greenwich and University of Cumbria), the armed forces, the Hampton by Hilton Hotel, Waterloo and several other hotels across London, and a multitude of other organisations that have provided welfare support including food and isolation packs and other essential equipment necessary to develop and sustain our response.

# ABOUT LONDON AMBULANCE SERVICE

# 4 ABOUT LONDON AMBULANCE SERVICE

**We are respectful. We are professional. We are innovators. We are collaborators. We are the NHS. We are London. We are life savers.**

We answer more 999 and 111 calls than any other ambulance service in the country. We attend more than 3,000 emergencies a day.

Our staff, volunteers, patients and local communities are at the heart of what we do and we involve them in helping to shape our work and the care we provide.

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

We have a substantive headcount of nearly 7,000 but with contractors and volunteers, there are 9,600 people working for us and together we are striving to be a world-class ambulance service for a world-class city.

We are governed by a Trust Board made up of 14 members: a non-executive chair, seven non-executive directors, five executive directors, including the chief executive, and an associate non-executive director.

Our Executive Committee leads and manages the performance of the Trust within the framework established by the Board. It consists of eight directors, including the five executive directors on the Board.

We are committed to promoting equal opportunities across everything we do, in terms of employment and training, the care we provide and our engagement and decision making.

We have changed our ways of working to respond to COVID-19 and we will build on these improvements.

And as the nation moves towards recovery, we will continue to evolve to meet the changing needs of the nine million people who live and work in London.

## 1904

**The first petrol-powered ambulance introduced**


## 1930

**London County Council took over responsibility for all the hospitals and ambulances**


## 1945

**National Health Service was established**

## 1965

**London Ambulance Service created**

## History

The first ambulances appeared in London towards the end of the 19th century. These were horse-drawn ambulances operated by six hospitals in the city. The first petrol-powered ambulance was introduced in 1904.

Major change came in 1930 when London County Council took over responsibility for all the hospitals and ambulances.

During WWII, the London Auxiliary Ambulance Service was set up – and most ambulances were driven by women.

In 1948 the National Health Service was established and with that the requirement for ambulances to be available for all those who needed them.

In the 1950s the London County

Council's ambulance service moved to headquarters at Waterloo Road – close to the current HQ.

London Ambulance Service was created in 1965 when one single ambulance service replaced the nine existing services working in the city. Back then we had nearly 1,000 vehicles and 2,500 members of staff.

In April 1996 London Ambulance Service became an NHS trust.


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AMBULANCE SERVICE
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## A 21st century service

The London Ambulance Service of today bears little resemblance to the one created more than 50 years ago.

Back then we only focused on patients with life-threatening conditions and getting them to hospital as quickly as possible. Today, we still respond to life or death emergencies but the scope of our work has expanded to treat many more patients.

We have highly trained clinicians who can treat patients in their own homes or treat and advise over the phone.

**Our core work:**

- Answer, prioritise and allocate 999 calls across London
- Respond to emergency and urgent 999 calls by sending clinicians to the scene or by treating over the phone
- Provide 111 integrated urgent care services for millions of people in south east, north east and north west London
- Take patients referred by a Community Healthcare Professional to hospital for emergency assessment.



**Other work includes:**

- Plan for, and respond to, major and significant incidents with London's other emergency services, NHSE London, the Mayor, local authorities
- Provide paramedics to work for London's Air Ambulance and decide when to dispatch the helicopter
- Educate the public in life-saving skills and use of public access defibrillators as well as raising awareness of issues including knife crime, alcohol abuse and road safety
- Engage with NHS partners, local authorities and the Mayor to encourage a healthier population and a safer London
- Find hospital beds for seriously ill patients and provide transport for the transfer of poorly new-born babies between hospitals in London, Kent, Surrey and Sussex.

# OUR PRIORITIES

# 5 OUR PRIORITIES

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

Our 5-year strategy was launched in 2018 – before COVID-19 emerged and before the global pandemic disrupted life as we knew it.

The virus has changed the NHS; it has changed London Ambulance Service.

Yet the core elements of our strategy helped enable our response to COVID-19 and remain relevant and appropriate today. And throughout the pandemic we have continued to drive forward progress across each of our three strategic themes.

## Strategic Themes

### Theme 1

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

- In addition to our south east and north east London 111 services, we have become the lead provider of Integrated Urgent Care (IUC) services in north west London and are working with other providers to support the delivery of IUC services in south west London.
- We established dedicated COVID call hubs and have retained increased call-handling functions to improve accessibility of our services.
- We have expanded our video consultation ability in our clinical hub and Clinical Assessment Service to support the remote delivery of assessment and care where appropriate.

### Theme 2

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

- We have successfully expanded our multiple award-winning Mental Health Pioneer Service across London in collaboration with London's mental health trusts. The service, which sees a registered mental health nurse dispatched alongside a paramedic, continues to deliver improved patient care; reduce hospital conveyance rates; and increase the resilience for providing crisis services across the capital.
- Thanks to our partnership with Macmillan Cancer Support, another award-winning initiative, all 18 ambulance group stations across London now have a clinician with additional training to help support crews attending patients nearing their end of life, and rapid access to Coordinate My Care, an electronic system holding patient care records.
- Through pilots in north east London, we have developed

contacts and relationships with system partners to reduce avoidable journeys to hospital and deliver care in the most appropriate setting.

- We have expanded our Advanced Paramedic Practitioner programme from 51 in December 2018 to 82 in March 2021. These experienced paramedics are trained to have extra clinical skills and are authorised to administer a range of additional medicines so they can give patients the very best care for their needs.

## Theme 3

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

- Full details of our partnership working with NHS and emergency services can be found in the Our Partners chapter page 51. This includes paramedics working with GPs in south London; better access to secondary care settings for our patients; and firefighters and police officers responding to 999 calls with our medics.

As we emerge from the pandemic, we need to build on this momentum of positive transformation, and remain resilient to future crises and the long-term impact of COVID-19.

Over the coming months, we will refresh our strategy to ensure we adapt to the changing opportunities and challenges we face.

We are already know that areas of focus on will include:

## Wellbeing

Ensuring our people are both mentally and physically healthy is a top priority for London Ambulance Service. This has been a traumatic year for staff and volunteers: caring for so many patients, while sadly having to deal with the loss of friends, relatives and colleagues.

We remain focused on providing emotional and practical support to our people so they can continue to care for London.

This year we have brought all health and wellbeing initiatives into a central Wellbeing Hub so resources are easily accessible and to focus on the areas which benefit staff the most.

We are working to ensure those services reflect the diverse needs of our people while developing new initiatives to promote physical, emotional and mental wellbeing.

We are creating an environment where people have sufficient breaks from work and are encouraged to take their leave in a managed way.

We want to provide staff and volunteers with a safe rest space to process the physical and psychological demands of work and offer access to a broad range of psychological support, if needed.

Some of the most popular initiatives include:

- Packs of food and drink for staff and volunteers who were having to isolate
- Provision of hot and cold meals and drinks which were distributed across the trust
- Tea trucks which take drinks

and snacks to ambulance crews waiting at busy hospitals
- Wellbeing webinars designed in collaboration with the North West London Mental Health lead to help with problems like stress, anxiety and sleep
- Support for staff working from home to encourage a healthy and balanced approach
- 'Welcome back from shielding' packs to ease the return to work for those away for a long period.

## Health and safety

Our ambulance crews treat more than 1.1 million patients every year while our 999 and 111 call handlers help more than 3 million. However they are facing an increase in violence and abuse from a minority of the public they work so hard to care for.

Staff and volunteers have reported being punched, kicked, bitten, spat at, assaulted with weapons, threatened and subjected to racist and sexual abuse.

In response we have recruited two Violence Reduction Officers as part of our ongoing work to protect staff. The officers are making sure people have the support they need while also giving practical help for victims who want to take their cases to court.

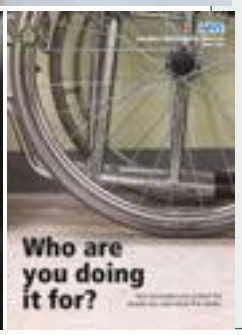
The team has been working closely with the police to increase the number of successful prosecutions.

In a trial which started in February 2021, crews working in high risk areas have been given body-worn cameras so they can record evidence if a patient or member of the public becomes aggressive or abusive.

We continue to publicise these initiatives and prosecutions through our #notpartofthejob campaign which aims to deter potential offenders by highlighting the serious consequences of abusing staff and volunteers.








## Flu and COVID-19 vaccination programmes

We had 200 peer vaccinators involved in our 2020 flu campaign which made the vaccine available to everyone working at London Ambulance Service.

All staff and volunteers were offered the vaccine by 30th November 2020 to make way for the COVID-19 vaccination programme. By this date, we had achieved a 78% vaccination rate for frontline workers and 72% across the organisation.

We secured early access to the COVID vaccine for our staff and volunteers in December 2020. Since then we have worked hard to provide up-to-date information about the vaccine and how staff and volunteers can receive it as well as practical help, like a shuttle bus between 999 and 111 control rooms to the Excel Centre vaccine clinic. By March 2021, 75% of our staff and volunteers had received their first vaccine and that number rose to 82% for patient-facing staff. More than 20% of our people had received both doses by then.

Meanwhile our trust pharmacists and members of our clinical directorate have been available to answer questions and concerns throughout the year.

## Black Lives Matter

The murder of George Floyd in the United States on 25 May 2020 had a considerable impact on Black people throughout the world. The Black Lives Matter movement shone a spotlight on all the work we have done in respect of the Workforce Race Equality Standard (WRES), including increasing the diversity of our overall workforce, increasing the number of Black, Asian and minority ethnic (BAME) people on our Board and in senior positions, as well as improving perceptions of career opportunities and reducing discrimination.

However it became clear we had further to go in becoming an anti-racist organisation. This prompted the Chair and the Chief Executive to encourage open and honest 'big conversations' with our staff and volunteers about race and racism. The Trust has since developed an action plan to address equality and diversity as well as the immediate issues faced by Black people in the organisation. Further details of this action plan can be found in the Our People chapter starting page 43.

## Staff and volunteer engagement and communication

In the early days of the pandemic, with so little known about the disease, it was essential to share information quickly, while also making sure our people had the practical and emotional support to do their job.

Our flagship internal communication tool has been LAS TV Live: a question and answer session with senior executives, which is broadcast live three times a week. This enabled us to keep staff and volunteers up to date with the latest information while being able to address any questions or concerns with transparency and openness.

In January, the sessions attracted up to 700 live viewers and over a thousand downloads after the broadcast.

In addition, we launched an Executive Daily Briefing, which provided a daily update of our operational challenges and achievements through the height of the second wave. We also published 442 bulletins which cover the latest clinical or operational guidance and 335 articles on our intranet.

We had the highest ever engagement for our staff survey and the responses have been analysed to ensure staff experience drives the improvements we are making at London Ambulance Service. You can find our full staff survey analysis on page 99.


## Assistant Ambulance Practitioners

In a year of incredible change and development, the creation of a completely new patient-facing role at London Ambulance Service has been one of our most ambitious achievements.

The first ever cohort of Assistant Ambulance Practitioners (AAPs) celebrated their graduation event in February 2021 and are now working alongside medics on ambulances.

Recruits to the new role undertake a 12-week programme which includes studying for a level 3 diploma in Ambulance Emergency and Urgent Care Support.

Entrants also complete a blue light driving course before they work under the supervision of a mentor in clinical practice for six months.

AAPs develop skills as an entry-level ambulance practitioner which they can ultimately progress to a paramedic role.

## Digital 999

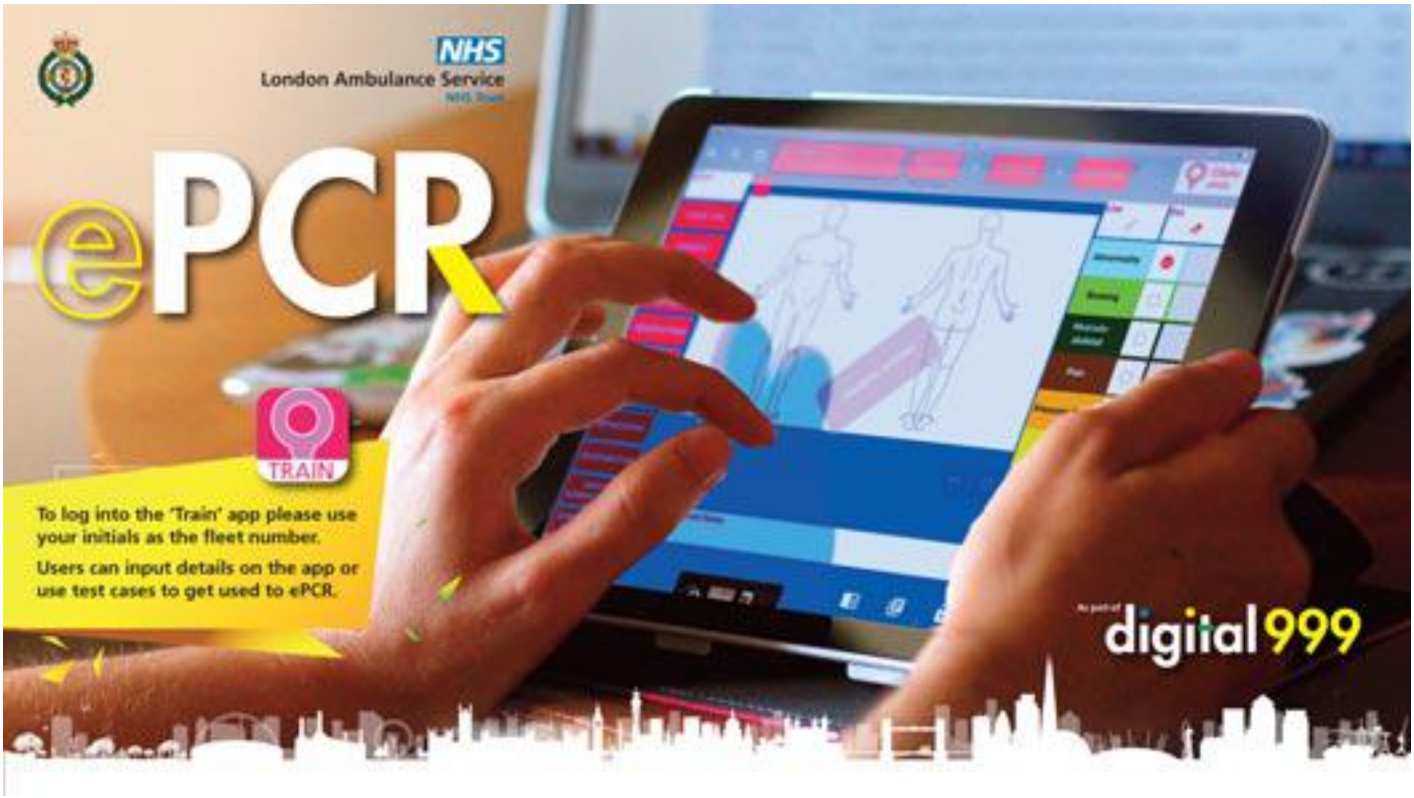
We want to embrace the opportunities of data and digital tech to improve the patient experience – and COVID-19 has accelerated much of this.

The Trust implemented electronic patient care records (ePCR) in November 2020, which provides an electronic platform to enter patient data, moving away from paper-based forms. The new system enables the seamless transfer of information to the hospital and produces one contemporaneous set of notes per patient. This innovation will save us from processing and scanning more than 2 million paper records each year.

By the end of March 2021, 4,000 staff and volunteers had been trained on ePCR with more than 125,000 records captured.

Work is continuing to implement a new Computer Aided Dispatch (CAD) to be delivered next year. The new system for our 999 control room will provide the technology needed to improve operational processes when handling emergency calls, and allow us to better collaborate with other ambulance trusts and emergency service partners.

Meanwhile we have replaced our existing CAD hardware and




migrated it to two external data centres so there would be no loss of data and the patient experience will be uninterrupted, in the event of CAD failure.

We have migrated our email service of 11,072 accounts to NHS.net to ensure compliance with NHS security standards for the transfer of patient information.

## Capital programme

We have spent more than £43 million as part of an ambitious and exciting programme which aims to improve the quality of care we provide to our patients across London by transforming both our ambulance operations and estate.

With some of our ambulance stations dating back to Victorian times and unfit for a 21st century emergency service, we plan to replace them with a network of state-of-the-art ambulance deployment centres.

After careful review of our estate, we have selected a site in Romford for the development of our first pioneer centre – also known as Hub 1.

This site will include areas and facilities to 'make ready' and maintain our ambulances; as well as administrative and training facilities and dedicated wellbeing spaces for our crews at the start and end of their shifts.

Already in 2020/21 – to help us better respond to COVID-19 – we have invested £3.3 million in consolidating our estate, and planned estates work, which resulted in ambulances moving between fewer sites, allowing our vehicle preparation team to save 165 hours a day to restock and clean vehicles. We have also made improvements to a large number of ambulance stations, providing better parking, bathrooms and mess rooms.

Progress is continuing on the design, purchase and construction of a new Medicines Packing Unit which is compliant against regulatory requirements for medicine storage, packing and distribution. We are also working to secure a lease for a suitable warehouse for the Logistics Support Unit which will be fit-for-purpose and allow us to move away from the five separate poor quality units we have been using in Deptford.

Meanwhile we have been making radical changes in our education sites to ensure we can train staff with the necessary skills and expertise to deliver more integrated urgent and emergency care. Instead of classrooms in multiple sites across London, we have built two dedicated fit-for-purpose and digitally enabled training facilities.

# OUR PATIENTS

# 6 OUR PATIENTS

Every year in London close to 3.5 million people call 999 or 111 in need of our help. We aim to provide the best possible care or advice for each and every one of them.

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

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

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

## Caring for our patients with COVID-19

The challenge of referring patients to the right healthcare facility and managing the flow of the sickest patients into emergency departments (EDs) demanded greater collaboration within the NHS, external stakeholders and regional providers than ever before.

We worked with Integrated Care Systems (ICSs) to establish pathways which were dynamic

and responsive to the local area, taking into account capacity, oxygen supply and specialist care options, while reducing the risk of crowding in EDs. We worked together to increase opportunities to care for patients closer to home either by telephone, video or in person. This collaborative work will continue as it means better outcomes for all patients.

By studying the outcomes of our COVID-19 patients, our Clinical Audit and Research Unit (CARU) has been able to participate in projects which should benefit future treatment and care. Two of these research projects have been designated "Urgent Public Health" status by the Government due to their importance to the pandemic. The team also used its research to publish the UK's first scientific paper to describe the association between out-of-hospital cardiac arrest (OHCA) and COVID-19 and found an increased rate in OHCA accompanied by a reduction in survival rates. You can find the paper at the PubMed.gov website.

## Emergency care: right care, right place

Just under half of all our 999 calls are for patients with potentially life-threatening illnesses or injuries. This includes patients in cardiac arrest, having a heart attack or a stroke or suffering a major traumatic injury or sepsis. Our Clinical Annual Reports can be found in our January 2021 Board papers on our website. They demonstrate the very high standard of care we provided to these patients.

The north central London video conferencing pathway for patients with stroke symptoms launched in May 2020. Of the 1,000 patients seen then, the service has safely triaged 48% of cases as non-stroke and diverted them mainly to local EDs (43%). The other 5% of patients were assessed as non-acute and/or not having had a stroke. We have also expedited the referrals and specialist assessment for patients who have had a high risk transient ischaemic attack (TIA) patients, also known as a 'mini stroke'. Stroke mimics have been identified in 8.5% of cases. The use of the video conferencing pathway has not delayed the definitive care.

In north east London we have co-designed and implemented two innovative pathways. The King George's Hospital Beech Frailty Unit is able to assess and manage older adults from the boroughs of Havering, Redbridge, and Barking and Dagenham using comprehensive geriatric assessment (CGA). This diagnostic process is used to determine the medical, psychological, and functional capabilities of an older person in order to develop a coordinated and integrated plan for treatment and long-term follow up. A doctor-led multidisciplinary team delivers this service and enables more elderly patients to be cared for in the community. London Ambulance Service directly conveys around 50 patients a week to this unit.

Changes in medicines legislation mean that paramedics who have undergone appropriate training and mentorship are now able to prescribe medicines, which benefits both our patients and the wider NHS. The first phase of a national pilot has concluded and work is under way into how to progress training for our advanced paramedics to become prescribers. For patients this will mean more timely access to medicines, care closer to home promoting fewer unnecessary trips to hospital, and fewer additional appointments with their GP or other health professionals.

## Urgent calls

Urgent care patients make up a significant proportion of our workload and we continue to make progress towards ensuring equity of access for all patients whether they call 999 in an emergency – with chest pain for example – or 111 with an urgent care condition, like a cough. We manage these patients through our integrated urgent care (IUC)/111 services, 999 clinical hub (CHUB) and our specialist paramedics, all of whom

provide a detailed clinical assessment and can then get the patient the right care in the right place in the right time-frame.

Our CHUB clinicians assess patients who have called 999 but who do not require an emergency ambulance immediately. Around 11% of 999 calls are handled by the clinical hub team, which is the highest "hear and treat" rate in the country.

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

Our clinicians, in both 111 and CHUB, can access patient records and care plans to better inform their decisions; they can book appointments directly into local services; and they can prescribe medication over the telephone when required.

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

## Special patient groups

1. **Bariatric patients**
   In January, we published a clinical audit on our web site examining the response and clinical assessment provided to bariatric patients, more commonly known as obese patients. While we found a very high standard of assessment, we do need to improve how we identify and dispatch bariatric vehicles. Recommendations have been made and we have committed to a deep dive into the problem to improve the service for these patients.

2. **Maternity patients**
   Over the past year, the maternity team has worked with teams in our 999 emergency operations centres and NHS 111 sites. We have made it easier to access referrals and improved the experience of women accessing care. We are evaluating the early pregnancy pathway and looking at the potential for a Maternity Triage Line.

Throughout the year, a range of education and training options have been delivered for maternal and newborn care and safety. Our staff and volunteers now receive ongoing support from a maternity team member, to feed into education and training developments.

Our award-winning team also contribute nationally, as part of the Joint Royal Colleges Ambulance Services Liaison and the UK Ambulance Services Maternity Leads group, ensuring that best practice is adopted nationwide.

3. **End of Life Care**
   Our End of Life Care (EoLC) pilot service ended this year but the work is being continued by an established team which means we continue to provide innovative and collaborative care to patients at their end of their life.

   We aim to support dying patients and their families and we respect their wishes if they choose to receive care at home or in the community rather than being taken to hospital. EoLC "Champions" are promoting this work at a local level with colleagues, increasing skills and knowledge across the Trust, and improving staff confidence to access appropriate care pathways.

4. **Mental Health**
   Mental Health was identified as a pioneering service in the 2018-23 trust strategy. We currently have six Mental Health Joint Response Cars (MHJRC) running across London. Evaluation of the service found that when a specialist mental health team is sent to a patient, in around 80% of cases, people could be treated at the scene rather an ambulance trip to hospital, which can add to the patient's distress.

## Infection prevention and control

This year we welcomed a new substantive Head of Infection Prevention and Control (IPC) to London Ambulance Service. We recognise the work undertaken by the interim Head of Infection and Control during the early stages of the pandemic.

The IPC team works closely with all directorates and plays an integral role in ensuring the safety of our patients, as well as our staff, contractors and volunteers.

In response to COVID-19, a practical visual resource was developed and published showing patient-facing colleagues how to correctly don and doff PPE. Protective clothing and equipment is not just for COVID-19 patients but for all infectious diseases. We are working hard to ensure we maintain the supply chain for FFP3 disposable respirators and disposable gowns.

As new strains of coronavirus emerge, the team has provided up-to-date guidance and helped staff and volunteers across the organisation to make informed risk assessments. The team will continue to liaise with colleagues to promote early recognition and reporting of potential infection incidents to reduce the risk of transmission.

London Ambulance Service has exceeded national compliance targets for hand hygiene and continues to maintain high level IPC compliance with cleanliness.

We provide IPC training to all staff and volunteers including mandatory modules, local teaching and scenario-based teaching.

## Medicines modernisation

The COVID-19 pandemic was a powerful reminder of the need for the professionalisation of the medicines packing and distribution function. This plays a vital and important role in ensuring that each frontline clinician has the appropriate drugs to treat their patients.

Projects that sit under the Medicines Modernisation programme are phased across three financial years and ensure that staff are equipped with the correct skills and qualifications in accordance with the Pharmacy Order 2010; the core medicines estate meets the highest quality assurance standards; and that medicines continue to be tracked and temperature is monitored for all storage areas.

The medicines management team will expand next year and we continue to recruit and mentor pharmacy professionals, ensuring a diverse clinical skill set within the service.

The past year seen a lot of change for medicines management – medicines are no longer regulated by the European Medicines


Agency (EMA) and now solely regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy team has provided clinical and pharmaceutical support to immunisation projects in collaboration with our wellbeing team, which has resulted in the successful partnership work across London for the COVID-19 vaccination programme.

## Developing improved models of care for our patients

The Clinical Directorate has been looking towards the future, with how we respond to urgent and emergency calls across London. With the patients we serve in mind, the clinical team is working with the Operational Directorate in partnering with Primary Care Networks (PCN) to pilot paramedics rotating between the ambulance service and primary care.

A scheme in Merton has seen paramedics on e-bikes visit patients in the community, giving flu jabs, treating those suffering with long-term conditions, and checking patients following their discharge from hospital. The success of this pilot has led to a similar partnership being set up in the borough of Redbridge, with plans to roll out this service across London.

These opportunities offer career development for paramedics as well as reducing avoidable trips to hospital for patients. With support from Health Education England, advanced paramedics in urgent care are using their skills in clinical and education supervision to develop the PCN paramedic programme.

Additionally, a new model of care is being developed for our patients who experience a fall, and sometimes face long waits for assistance, causing intense distress to both the patient and their family.

If our telephone assessment of these patients identifies them as having no injuries or symptoms that require immediate intervention, we will dispatch volunteer community first responders (CFRs) to the scene, decreasing the time the patient waits for a response, and increasing the positive patient experience. The pilot was due to launch in May 2021.

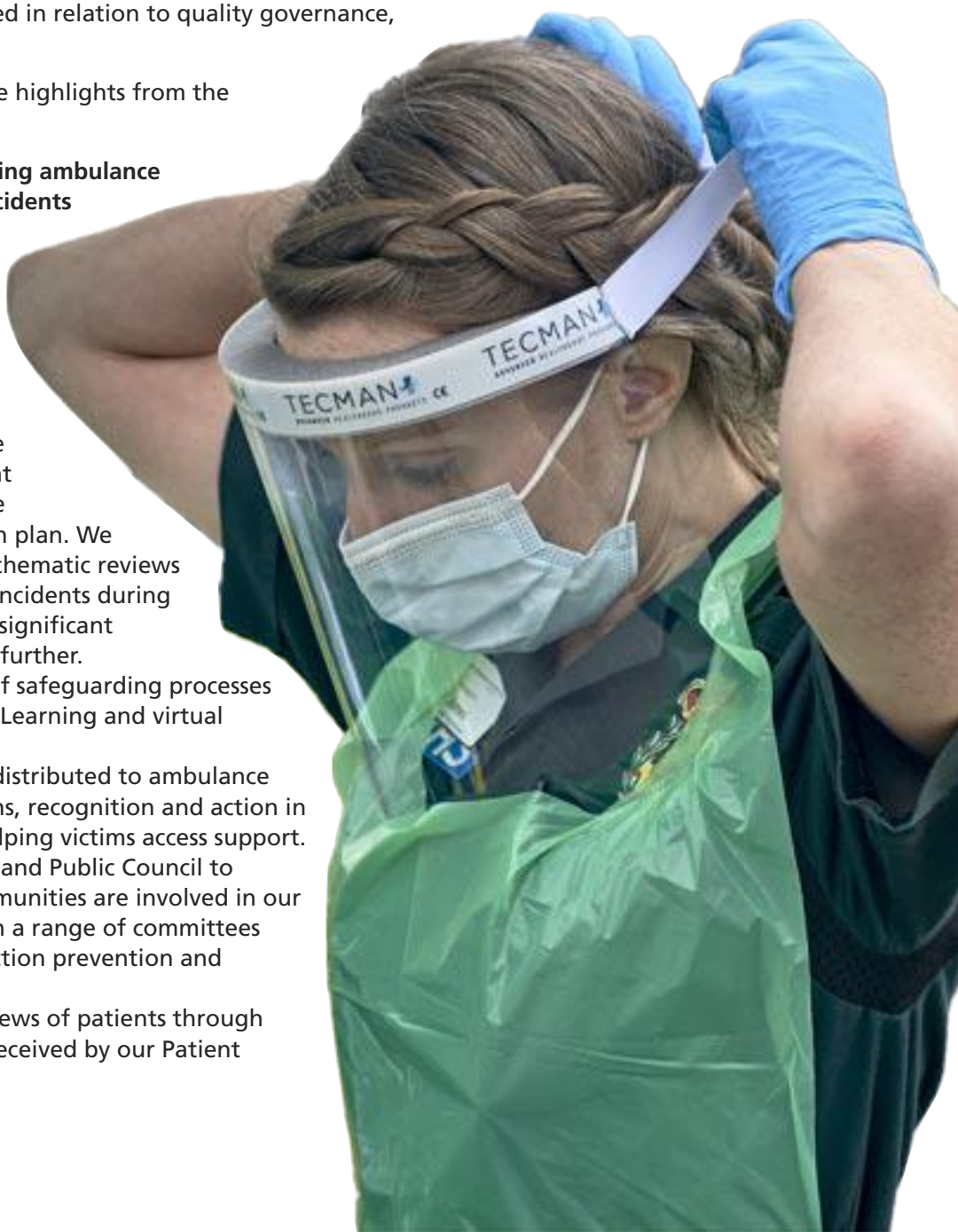
## Patient safety

We are committed to providing high quality and safe care, delivered with compassion, respect and dignity.

Despite the challenges of this year, we doubled our efforts to ensure patient safety while supporting the wellbeing of our staff and volunteers. Significant work has been achieved in relation to quality governance, assurance and improvement.

Below is an outline of some of the highlights from the 2020/2021 financial year:

- **The Trust is the highest reporting ambulance service for reporting safety incidents reflecting a strong safety culture aiming to provide the highest standards of patient care. We report around 5,000 incidents per year compared to the next highest at around 2,000.**
- We are an early adopter of the national Patient Safety Incident Response Framework and have developed our implementation plan. We have tested the plan through thematic reviews of some of our patient safety incidents during the pandemic which provided significant learning that refined the plan further.
- We have reviewed a number of safeguarding processes and developed safeguarding eLearning and virtual packages.
- Domestic abuse stickers were distributed to ambulance crews to promote conversations, recognition and action in relation to domestic abuse, helping victims access support.
- We have established a Patient and Public Council to ensure patients and local communities are involved in our strategic plans. Members sit on a range of committees including in research and infection prevention and control.
- We continue to monitor the views of patients through complaints and compliments received by our Patient Experiences Department.




PARAMEDIC

# 7 OUR PERFORMANCE

This year London Ambulance Service has experienced the busiest days in our history. During some very difficult weeks of the pandemic, our biggest challenge was maintaining service delivery and safety for our patients.

As explained in the **Coronavirus chapter**, we quickly implemented new ways of working to deal with the huge spike in 999 calls we were answering and the face-to-face incidents we were attending.

While patients waited longer for an ambulance during the first and second peaks of COVID-19, the full year picture shows the Trust achieved the National Performance Standard for Category 1 patients, which has a target average response time.

**Performance standards for UK ambulance trusts**

| Category | Response | Target average response time |
|---|---|---|
| 1 | An immediate response to a life threatening condition, such as cardiac or respiratory arrest | 7 minutes |
| 2 | A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport | 18 minutes |
| 3 | An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting | 2 hours |
| 4 | A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic | 3 hours |

## Ambulance Response Programme

The Ambulance Response Programme (ARP) sets the performance standards for all ambulance trusts in the UK

The impact of lockdown on the public, alongside increased awareness and activity for 111 services, meant we had fewer 999 calls and patient-facing incidents in 2020/21 than the previous year.

**In 2020/21 we met our Category 1 target, reaching our sickest patients in 6 minutes and 16 seconds, on average.**

## Category 2 performance

For a significant majority of the year, we reached our Category 2 patients well within the national target times.

However during the first and second waves of COVID-19, when 999 calls, staff sickness and handover times at hospitals were at their highest, some patients had long waits for an ambulance to reach them.

We responded to this dip in performance with several measures including working with hospitals; putting as many crews out on the road as possible; and training firefighters and police to drive ambulances.

With all our efforts focused on recovering performance, we were meeting targets across all categories of incident by the last week of January 2021.

Had it not been for those particularly challenging weeks in April 2020, December 2020 and the first week of January 2021, we would have met the 18 minute target for Category 2 across the year.

## Progress

One of the most significant new ways of working was reducing the number of solo responders in cars and increasing the number of ambulances available, to ensure patients who need to go to hospital can be conveyed without delay. We continuously review performance but the ambulance-led delivery model has proven to be resilient and flexible and means the sickest patients get the fastest response and that all patients get the right response first time.


Progress has been made in increasing the number of patients we have been able to treat on scene – known as 'See and Treat'. In 2020/21 our crews were able to treat and discharge or refer 32% of patients. The figure was 27% the previous year.

Access to electronic Patient Care Reports (ePCR) and Summary Care Records has made it easier for clinicians to find appropriate, community-based care for our patients, giving them and their families a better experience and outcome.

The increase in both 'See and Treat' and easier access to alternative pathways has meant

## Ambulance response times

| | 2018/19 | 2018/19 | 2019/20 | 2019/20 | 2020/21 | 2020/21 |
|---|---|---|---|---|---|---|
| **Category** | **Response Time** | **Incidents (n)** | **Response Time** | **Incidents (n)** | **Response Time** | **Incidents (n)** |
| **Category 1** | 00:06:28 | 128,505 | 06:51:00 | 79,738 | 00:06:16 | **86,586** |
| | 00:10:45 | | 11:30:00 | | 00:10:38 | |
| **Category 2** | 00:19:16 | 685,298 | 00:23:49 | 620,913 | 19:38:00 | **677,861** |
| | 00:39:29 | | 00:49:23 | | 00:38:21 | |
| **Category 3** | 00:53:51 | 243,942 | 01:08:57 | 237,596 | 00:42:43 | **260,659** |
| | 02:09:47 | | 02:45:15 | | 01:33:37 | |
| **Category 4** | 01:19:27 | 15,972 | 03:48:30 | 13,986 | 02:51:48 | **15,218** |
| **Category 5** | No National Target | 28,305 | No National Target | 16,604 | No National Target | **17,827** |

## Performance summary

| Measure | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| **Total 999 calls** | 1,937,210 | 2,084,306 | 1,813,112 |
| **90th Centile Call Answering (secs)** | 24 | 88 | 4 |
| **Call Answering within 5 Secs (%)** | 86.4% | 77.6% | 90.7% |
| **Incidents attended (Face to Face)** | 1,141,704 | 1,181,149 | 1,100,902 |
| **Average Response time Category 1 (Mean)** | **00:06:28** | **00:06:51** | **00:06:16** |

fewer hospital journeys – down to 51% of all the 999 patients we attend. We are now among the top performing trusts in the country for emergency department (ED) avoidance.

### Vehicle availability

We purchased 37 new ambulances to replace the oldest vehicles in our fleet. Newer vehicles are more reliable, reduce emissions and cut running and maintenance costs. Meanwhile our AA partners have been carrying out overnight repairs and fixing some minor repairs.

These improvements had a huge impact on our overall out of service rate which averaged at 1,284 hours in 2020/21 down from 5,730 the previous year.

By March 2021 we had 542 ambulances in service, which is 10% more than the previous year and at the peak of the pandemic, operations were able to deploy over 800 crews a day.

### Logistics

The work of our logistics team has transformed beyond recognition as they have ensured ambulance crews have the PPE, medicines and support needed to safely respond to the pandemic. They won a national Supply Chain Excellence award in recognition of their outstanding efforts.

The team, in collaboration with the Trust's pharmacists, did the necessary planning to ensure we did not run out of oxygen, despite nationwide shortages at hospitals. They also organised vehicle preparation teams to clean ambulances and equipment at key hospitals which meant crews were able to reach their next patient faster.

### 999 calls

We received 1,813,112 calls to our 999 operations centre in 2020/21 which is fewer than the year before. Over the same period calls to 111 increased. London Ambulance Service's media and social media activity focused on signposting the public to the appropriate services – especially at times of peak demand and during waves of the COVID-19 pandemic. At the same time a government campaign was launched to increase public awareness of NHS 111 phone and online services.

Once assessed, 46% of 999 calls were given a Category 1 or 2 response, which means nearly half our calls were from patients who were experiencing life-threatening or emergency medical events.

Call handling performance has improved compared to last year, and remains strong compared to the national average. However there were several weeks during the two main peaks of COVID when call numbers and sickness rates were so high, we were unable to meet our call handling targets.

As is standard practice during periods of high demand and high levels of staff sickness, ambulance services provide support for each other, which includes answering 999 calls. At the end of 2020, a decision to request aid under the mutual aid framework was made and support was in place within 24 hours.

Our Business Intelligence team were able to produce an entirely new set of forecasts, which displayed predicted call volumes by hour and staff and volunteer numbers, which meant we could request assistance at specific levels and for specific hours. These forecasts became accurate enough to be able to automate the function.

## Expansion of the clinical hub

The clinical hub (CHUB) is staffed by clinicians who provide a telephone assessment of patients to determine whether they require an emergency ambulance or can be treated over the phone or referred to another provider.

Increased staffing in 2020/21 allowed us to respond to 133,293 calls this way and treat our patients successfully and safely without the need to dispatch an ambulance. This was essential at times of extraordinary demand and equates to almost 11% of 999 calls, an increase of nearly 3% on the previous year. We have the highest 'Hear and Treat' rates among ambulance trusts in England, including those with a blended 999 and 111 workforce.

In November 2020, CHUB clinicians began reviewing calls from North West London Integrated Care System where the NHS Pathways assessment outcome was a Category 3 or 4 ambulance. Since then, the CHUB has assessed 15,000 calls, of which over 70% did not require an emergency ambulance.

We have been working closely with our NHS partners to provide our clinicians with a greater range of referral options for patients who do not require emergency intervention.

## Development and training

Due to the number of large projects ongoing within the division, a number of development roles have been created to support this work and assist the 999 Operations Senior Leadership team.

A bespoke training package in management essentials, coaching and supportive conversations has been designed and is being initiated among watch management teams.

We have built a new training facility that is larger and more flexible enabling three times as many staff to be trained simultaneously. This translates to better patient care as more of our staff and volunteers are trained in the most up-to-date clinical protocols.

A dedicated Incident Response Officer (IRO) Core Skills Refresher (CSR) course has been developed jointly with Resilience and Specialist Assets to incorporate specific learning from incidents and focus on command and control aspects of the role.

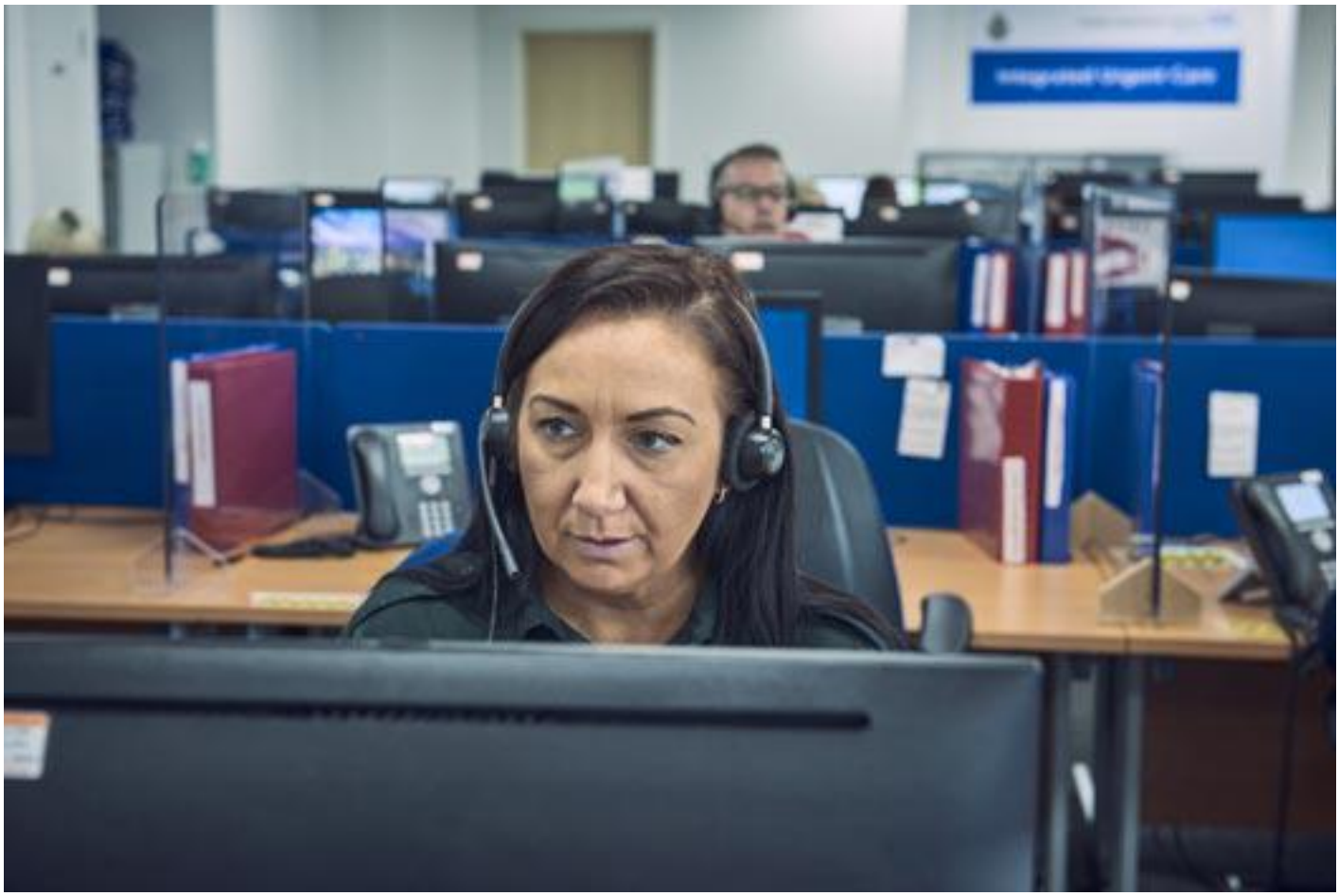
We created a new role of Chief Paramedic and Quality Officer to bring together for the first time responsibility for clinical quality and ensuring paramedics and ambulance clinicians have access to world-class training and professional development.


LONDON AMBULANCE
EMERGENCY RESOURCE DISPATCHER

## NHS 111 calls

The pandemic has increased awareness of 111 services and led to an 11.5% increase across our North East and South East London Integrated Urgent Care (IUC) services compared to last year. We have only been providing a 111 service in North West London since November 2020 so cannot provide comparison data.

Despite this we have improved performance for call answering and call abandonment.

## NHS 111 services

| Measure | National target | 2019/20 SEL | 2019/20 NEL | 2020/21 SEL | 2020/21 NEL | 2020/21 NWL |
|---|---|---|---|---|---|---|
| Total number of calls | - | 544,616 | 677,319 | 625,585 | 756,488 | 257,014 |
| Average calls per day | - | 1,492 | 1,856 | 1,807 | 2,198 | 1,904 |
| Calls answered within 60 seconds | 95% | 60% | 60% | 88% | 87% | 84% |
| Calls abandoned after 30 seconds | <5% | 12% | 13% | 3% | 3% | 3% |
| Calls referred to 999 | <10% | 7% | 7% | 8% | 8% | 8% |

### Integration of 999 and 111

Our strategic vision to become primary integrator of urgent and emergency care has accelerated in 2020/21. We now hold contracts for NHS 111 delivery across three of the five London Integrated Care Systems (ICSs) serving around 6 million patients.

A priority for NHS 111 is to expand workforce capacity to ensure we have a sufficient and sustainable number of trained call handlers and clinical advisors to meet demand, and there is infrastructure in place to allow some clinicians to work remotely.

We have a dedicated Integrated Patient Care Directorate with a senior management structure to support our new focus on call answering response and development of the Clinical Assessment Service (CAS) across 111 and 999.

NHS England and Improvement launched the NHS 111 First programme to reduce the number of walk-in ED attendances in 2020. It was designed to protect NHS staff and patients by reducing the risk of infection caused by overcrowded waiting rooms. The scheme encouraged patients to call NHS 111 before attending ED to allow NHS 111 teams to assess their need and, where possible, carry out a clinical assessment using telephone or video consultation to provide appropriate care closer to home.

We have been a key partner in a range of new initiatives and pilots to design, develop and embed improved patient pathways across the urgent and emergency care systems, including community teams. Through collaboration with Barts Health NHS Trust, we have successfully developed a process for call handlers and ambulance crews to refer patients to secondary care clinicians in EDs for telephone consultations.


**when it's less urgent than 999**

# OUR PEOPLE

# 8 OUR PEOPLE

London Ambulance Service is a growing team of multi-skilled people, in a variety of roles, focused on a single, simple purpose: to save lives. We call ourselves a family: the family in green.

We have more people working for us than ever before. Our substantive employment headcount is 6,497 people but when you add all our contractors, agency and bank staff, students and volunteers, we have 9,600 people caring for Londoners.

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

## Behind the scenes

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

Most of our workforce has contact with patients – our ambulance crews and call handlers. But it takes a whole team working behind the scenes to ensure all our patients get the right help at the right time.

These include:

- Our People and Culture team looking after welfare, recruitment and making sure we have the right HR policies
- Information Management and Technology (IM&T) specialists delivering innovative technological change to improve the quality of care we provide to patients
- Fleet and logistics teams keeping vehicles maintained and stocked with essential medicine and equipment
- An estates team responsible for creating safe, secure offices or ambulance stations for staff and volunteers to work
- Communications staff engaging with our key NHS and public sector partners, our people and the media to improve understanding of our work
- Teams reviewing our governance, performance and the experience of patients so we are always improving
- A Clinical Directorate which is responsible for clinical delivery and strategy and clinical innovation

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

## Recruitment

The recruitment team continues to work with Ambulance Services and Clinical Education colleagues to deliver a strong pipeline of registered and non-registered staff.

We have recruited 3,370 new people this year. One of the most remarkable achievements has been to create the new role of Assistant Ambulance Practitioners, advertise, interview and make offers for this new job and give our 102 new recruits training – all in a single year. You can read more about this role on the Our Priorities page 19.

A joint recruitment scheme was developed for call handlers for both the 9s and 1s, allowing the process to be streamlined and beneficial for both departments. For 2020/21 we have recruited and trained 173 Emergency Call Handlers and 81 call handlers have been promoted to Emergency Care Coordinators.

We further increased our clinical advisor staffing by 43%, with 128 staff being recruited and trained to work in the CHUB over the last year.

## Apprenticeships

London Ambulance Service has been recognised as **the top NHS trust in the country** for its apprenticeship opportunities, in a national and government-backed league table developed by the National Apprenticeships Service. As well as creating the new Assistant Ambulance Practitioner apprenticeship, this year we have also teamed up with the University of Cumbria to offer paramedic degree apprenticeships. These positions are open to existing staff who will complete classroom and online learning alongside their usual shifts.

We routinely offer apprenticeships to staff to help them develop and gain new knowledge and experiences. This includes leadership and management programmes.

## Retention

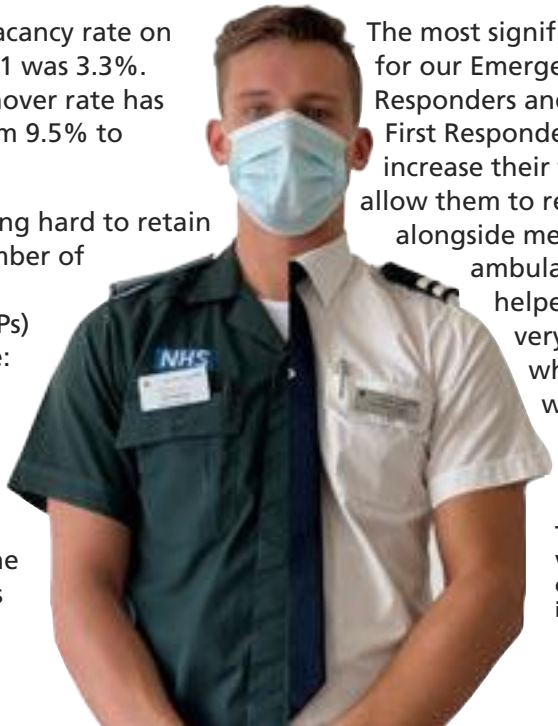
Our overall vacancy rate on 31 March 2021 was 3.3%. Our staff turnover rate has improved from 9.5% to 8.1%.

We are working hard to retain our large number of international paramedics (IPs) which include: funding indefinite leave to remain; supporting staff to use the Government's automatic one-year visa extension; and enhancing our programme of retention interviews. We had 88 IP leavers in 2020/2021 which is slightly less than our forecast of 90.

## Volunteers

Volunteers play a vital role at London Ambulance Service and we have always valued their commitment and time. This year, the work of our volunteers throughout the pandemic has been exceptional. They have moved into different roles, changed ambulance stations and learned new skills to help us keep as many ambulances on the road as possible.

The most significant change for our Emergency Responders and Community First Responders was to increase their training to allow them to respond alongside medics on ambulances. This helped us cope with very high demand while many staff were off sick or isolating.



**This airline pilot works as a volunteer emergency responder in his spare time.**

We plan to continue to keep our ERs trained to work on ambulances so they are able to step in at times of high demand in the future.

This will involve increasing the number of ERs with a blue light driving qualification and C1 category training, which means they can treat our sickest patients.

Other roles our volunteers have committed to this year include:

- Providing comfort calls to patients waiting for ambulances
- Call handling on the staff 'swabbing helpline'
- Delivering and collecting self-swab kits to staff who couldn't get themselves to a COVID test centre
- Taking blood samples for antibody testing
- Organising logistics for mass testing requests from NHSE, including asymptomatic PCR testing and lateral flow testing
- Setting up the database of volunteers and helping to run our COVID Personnel Hub
- Providing support to Emergency Preparedness, Resilience and Response (EPRR) particularly in relation to the Nightingale Hospital

Our Emergency Responders and Community First Responders have volunteered 33,723 hours this year. They have worked a further 11,740 hours alongside a paramedic on an ambulance.


## Diversity

The murder of George Floyd and the Black Lives Matter movement prompted some honest and sometimes harrowing conversations at London Ambulance Service. It became apparent we needed an immediate action plan to address discrimination and equality.

Key actions include:

- Embedding fair recruitment principles across the Trust
- Training of Black, Asian and minority ethnic (BAME) staff to sit on interview panels to increase diversity in senior roles
- Launch of B-Mentored programme, a mentoring scheme to support BAME staff to progress their careers
- Increase the diversity of the Clinical Team Manager leadership pool
- New Equality Diversity and Inclusion corporate induction including sessions on unconscious bias and cultural awareness
- Weekly BAME drop-in sessions for staff and volunteers to raise concerns or any issues they may have

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

## Workforce Race Equality Standard (WRES)

London Ambulance Service is one of the highest performing trusts for BAME representation at Board level. We have successfully recruited to a new role of Associate Director of Culture, Diversity and Inclusion.

Our percentage of BAME staff has improved to 18%, against our end of year target of 17.5%. We are actively working alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.

However we have work to do to improve opportunities for development while also working to reduce the number of racist attacks on our staff and volunteers by the public and patients.

## Our people in numbers


## Staff survey

The annual NHS staff survey took place in autumn 2020 and with 72% of our staff responding, it provides a valuable picture of how people feel about work.

The results show there have been improvements in:

- Relationships with managers
- Staff wellbeing
- Safety culture
- Reducing bullying and abuse from managers and colleagues

However, the survey shows there are three key areas which we need to focus on:

- Building a safer environment and protecting people from abuse and violence
- Stepping up our approach to equality, diversity and inclusion
- Continuing to strengthen our wellbeing services

There is a fuller analysis of the staff survey results in the Staff Report on page 99.

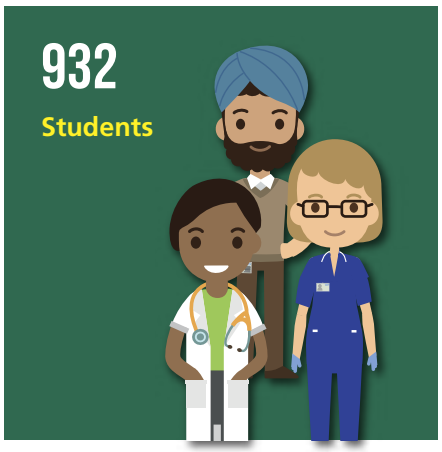

## Health and Wellbeing

We are still working to understand the full impact of COVID-19 on the physical and mental health of our staff and volunteers. We want our people to be happy and feel they can thrive at work. We need staff and volunteers who feel cared for so they, in turn, can care effectively for their patients. London Ambulance Service should be a place that enables our staff to be healthy and prioritise their wellbeing.

Our newly created Wellbeing Hub is our flagship initiative in improving the quality of life for our people. This service has been used extensively by staff and acts as a first point of call for any health and wellbeing related information and issues. Since its inception in July 2020, the Wellbeing Hub has dealt with 2,413 enquiries, relating mainly to COVID-19, vaccination advice, mental health and physical health support.

You can read more about our Health and Wellbeing work – including our vaccinations programmes – in the Our Priorities chapter from page 19.






## Recognising our people

We want our teams to thrive and feel valued and we do that by creating a culture of engagement and loyalty. This year, to recognise the extraordinary work of our teams in responding to COVID-19, every member of staff has been given an extra day of annual leave.

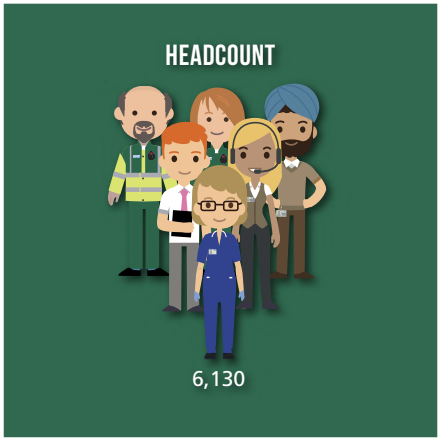
We have established schemes to encourage positive feedback and continue to recognise the day-to-day contributions of staff and volunteers through internally publishing the names of all those who receive a letter or message of thanks; or reach long-service milestones. We use our LAS TV Live broadcasts to encourage staff and volunteers to praise or thank colleagues for exceptional work.

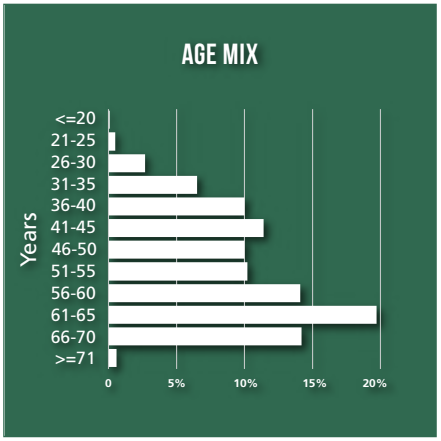
Our annual VIP Awards are one of the highlights of the yearly calendar and the entire workforce is able to vote for the employee of the year. Sadly, this year we had to swap our usual glamorous ceremony for a virtual event. However this did not take away from the honour given to paramedic Keiren Rodwell, who was nominated for the award by his manager for being, "caring and compassionate, as well as clinically brilliant."

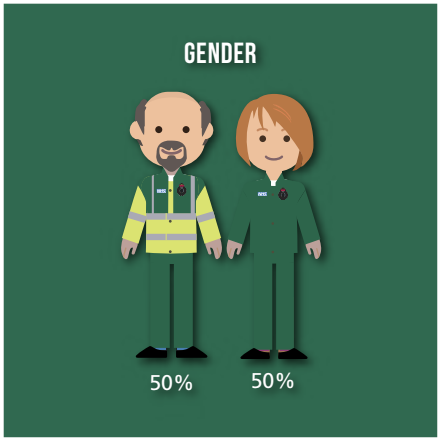
Much of the planning and organising of the VIP Awards and our other recognition events, including long service awards, are down to Communications Officer Claire Clarkson. The dedication and hard work she brings to this role were recognised nationally when Claire was named Exceptional Administrator of the Year in the 2020 Ambulance Leadership Forum awards, organised by the Association of Ambulance Chief Executives.

## Freedom to Speak Up

The Trust has a full time Freedom To Speak Up (FTSU) guardian and



coordinator. We also have 25 advocates, all of whom have received training in how to promote the work of FTSU and support staff and volunteers to raise concerns.

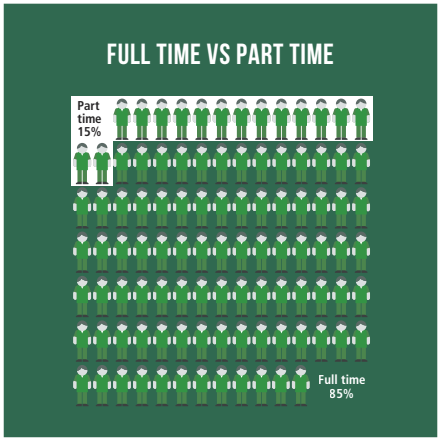
All concerns are investigated and many have led to improvements in processes in a number of different parts of the service. The LAS FTSU team were finalists for the FTSU category at the HSJ Awards. You can read more about our FTSU work in our Annual Governance Statement on page 81.

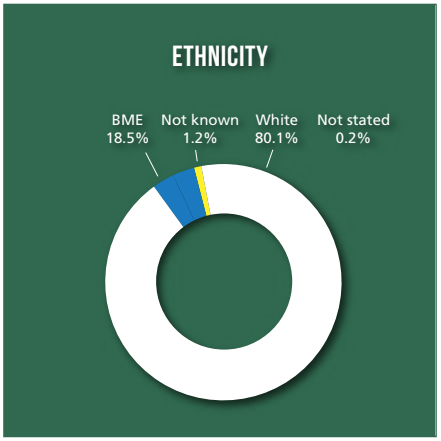
## Developing and managing talent

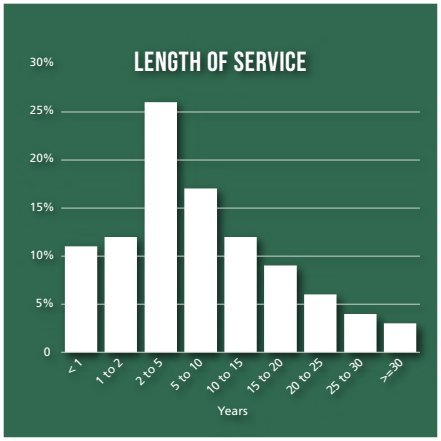
It is essential people feel they can enjoy a meaningful career within London Ambulance Service. We are constantly looking at ways to attract and retain high-quality employees and develop their skills. We want to ensure we have a motivated workforce who are given every opportunity to shine.

Some of the work we have done to achieve this includes:

- All staff discussions on the benefits and considerations of home working which will inform our new Agile Working Policy
- Redesign of the Engaging Leader course
- Increasing the provision of blended learning opportunities
- Creating a business administration apprenticeship
- Establishing a Clinical Team Manager recruitment and training plan



# OUR PARTNERS

# 9 OUR PARTNERS

Collaboration is key to our success and allows us to provide the best possible care for the people who need us. The pandemic has not only shown what we can do with strong partnerships, but how quickly we can bring about change and improvements for our patients.

We will continue to engage with patient groups, stakeholders, wider system partners and emergency service colleagues to build on our successes and ensure communities are empowered to help shape the future of their health services. A list of the partners who have supported our response to COVID-19 can be found on page 7.

## Working with our community

The involvement of our patients and communities is crucial in improving all aspects of care including patient safety, patient experience and health outcomes.

In June 2020, we launched the London Ambulance Service Public and Patients Council, which brings together a wide range of patients and public representatives from across London.

The council, which is chaired jointly by Dame Christine Beasley and Michael E Bryan, meets at regular intervals to give feedback on the care we provide and to help shape the way care is delivered. Members provide a voice for patients, the public and carers in the design, development and delivery of Trust services.

We also continue to work closely with local Healthwatch, including keeping them updated about our response to COVID-19.

In September 2020, the Board agreed a new 'patients and communities engagement and involvement strategy' which was developed in partnership with the council and sets out a range of priorities to enhance the way we involve and listen to patients and communities.

This includes co-designing a visits programme – giving patient and public representatives access to our 999,111 and ambulance services so they can provide constructive feedback. The strategy will also see the establishment of a Youth Empowerment Squad, supporting young people to learn more about our work, share their feedback and influence our decision-making.

Ordinarily London Ambulance Service invests in a wide-ranging public education programme, working with community groups and partner agencies to engage with the public. However this year, COVID-19 has meant our public engagements have been cancelled and staff have been re-deployed to support the response to the pandemic.

## Working with our NHS partners

As the only NHS trust to cover the whole of London, we work closely with NHS England/Improvement, our 32 commissioners, hospitals and specialist trusts.

We have built on the strong relationships with London's five Sustainability and Transformation Partnerships (STPs). This has included exploring opportunities for further integration of the 999 and 111 systems, as well as longer term policy and strategic plans, most notably the advent of Integrated Care Systems (ICSs). While progress on the development of ICSs was hampered by the pandemic, they are becoming increasingly established in the planning and coordination of care.

In May, London Ambulance Service worked with University College London Hospital to launch video conferencing for the assessment of patients suffering stroke symptoms. Details of this initiative are in Our Patients section on page 27.

This year also saw the launch of a new pilot in Merton which led to paramedics working in GP surgeries to improve care. Full details of this scheme are also in Our Patients section on page 27.

## Working with our emergency services colleagues

Firefighters and police officers have been driving ambulances and assisting our crews in a ground-breaking blue light collaboration during the pandemic.

The partnership led to us training hundreds of officers from London Fire Brigade and the Metropolitan Police Service to help us respond to the biggest public health challenge in our history.

Both firefighters and police officers are used to driving on blue lights, have basic first aid skills and know the streets of London well, making them ideal partners when demand peaked and the crisis threatened to overwhelm hospitals.

The three emergency services have always worked in partnership responding to routine 999 calls and we have regularly trained and exercised together to ensure we work in a co-ordinated and effective manner at major and critical incidents.

With the roll out of body worn cameras and our commitment to cutting the number of assaults on our staff and volunteers, we have also been working with the police to develop our violence reduction processes. We are sharing learning and best practice to ensure our people get the justice and support they need.

## Working with the Mayor of London

The Mayor of London is chair of the London Resilience Forum and re-established a Strategic Coordinating Group in September to bring together emergency services, NHS providers, local authorities and Public Health England in response to the increasing spread of COVID-19.

We have a close relationship with the Mayor and over the year he made several visits to London Ambulance Service, including to our 111 call centre in Barking and opening our new state-of-the-art


999 call handling training centre.

We continue to work with the London Situational Awareness

Team, which provides the Mayor's Office and London Assembly Members with accurate and timely information on our performance.

## Working with local authorities

Our partnerships with local councils aim to give Londoners the best health, social care and community services – particularly when working in a tough financial environment.

This year we have been engaging with local authorities on their Low Traffic Neighbourhood (LTN) schemes. We support the aim to cut heavy and non-local traffic on residential streets and create healthier neighbourhoods, while making sure ambulance emergency response times are not undermined.

Our Chair and Chief Operating Officer have met London council leaders to ensure our suggestions have been listened to and our concerns taken on board. We will continue to work together to ensure any changes to road layouts or road closures do not delay us reaching critically ill people or getting them to the nearest emergency department.

## Working with charities

Our partnership with London's Air Ambulance Charity is a key part of our mission. We provide paramedics to respond – by helicopter or by car – to life-or-death emergencies in London. Every day one of our paramedics works alongside a doctor as part of the London's Air Ambulance service to treat patients, while a second paramedic is in our 999 control room deciding which calls might need this advanced trauma team.

We further support the charity by providing our clinicians to work alongside an emergency medicine doctor on the Physician Response Unit. The team carries advanced medication, equipment and treatments usually only found in hospital, which means patients can be treated in their homes rather than being taken to an emergency department.

Our partnership work with Macmillan has led to all our ambulance crews being trained in end-of-life care. This specialist training means terminally ill people get the care that meets their needs and respects their wishes. This can help avoid unnecessary trips to the hospital which can be distressing to the patient and their family.

We work closely with St John Ambulance, often to plan and prepare for large public events. This partnership was only strengthened during the pandemic when we gave more than one hundred volunteers from St John enhanced training so they could respond with our paramedics on ambulances.

We are extremely grateful to NHS Charities Together for the support they have given us, including over £1.1 million of funding which we will receive in 2021/22. This money will allow us to support the welfare of our staff and volunteers, including helping to run our popular 'tea trucks'. Much of this money was raised by the late Sir Captain Tom Moore.

As well as our long-established relationships with charities, we are developing new ones, in order to share best practice as we aim to boost our own charity and volunteering programmes. You can read about our LAS Charitable Fund on our Public Value page.

## Working with universities

In partnership with the University of Cumbria, we launched a paramedic apprenticeship programme in March. The nationally accredited programme is designed to make it easier for staff to gain a degree in paramedicine. The course means our Emergency Ambulance Crews (EACs) and Emergency Medical Technicians (EMTs) can continue to work on ambulances while they develop their emergency care skills and progress to becoming a paramedic.

We have continued to work with our partner universities closer to the capital to offer placements to students enrolled in their Paramedic Science degree courses. Second and third year students were a key part of our response to the pandemic and universities are a valuable source for recruitment.

Meanwhile our Clinical Audit and Research Unit (CARU) leads on developing research studies – often in partnership with universities – which contribute to and improve emergency medical care and patient outcomes. These studies are not only used within London Ambulance Service but by practitioners of emergency medicine around the world.

## London Ambulance Service Public and Patients Council

### Dame Christine Beasley, co-Chair

Dame Christine is a nurse who has worked in a variety of nursing and general management roles in the NHS for over 50 years. She has also been Chair or Trustee for a number of charities.

### Michael E Bryan, co-Chair

Michael is a volunteer for, a former patient of and emergency partner to London Ambulance Service. He combines his medical studies with his experience of biotechnology to help patients. He was also involved in coordinating the Metropolitan Police's response to the pandemic.

### Dame Christine and Michael write:

In the year since the council was established we have sought to make it a critical friend to London Ambulance Service.

All our work and our discussions are centred round a focus on improving the service to patients and ensuring patient experience is at the heart of the organisation. We have been looking at both short and medium term issues.

The council has contributed to and influenced the roll out of the Electronic Patient Care Records (ePCR) which is helping to free up more time for staff to spend with patients. Some members of the council have also participated in the Station Accreditation Programme which helps to make sure that patients are cared for safely and effectively.

We have set up a series of sub-groups and some of our most important work is looking at how to improve the patient pathway. In particular, members are working with colleagues from London Ambulance Service to improve the pathways for patients with mental health problems and those nearing the end of their life.

We think the council has got off to a very good start and we are currently developing our programme of work for the next two years.

# OUR PUBLIC VALUE

# 10 OUR PUBLIC VALUE

The COVID-19 pandemic led to the suspension of contracting and operational planning and the introduction of an interim financial framework for the first half of 2020/21 and revised financial arrangements for the second half of the financial year.

London Ambulance Service spent an additional £85.8 million in response to COVID-19. This included:

- £39.3m on staff costs
- £18.7m on increased 111 capacity
- £7.7m on additional fleet capacity
- £6m on Personal Protective Equipment
- £3.8m on IT and telephony expansion
- £2m in additional decontamination costs.

In addition to this, the trust received an additional £2.6m for centrally provided COVID expenditure bringing the total COVID spend to £88.4m. This extra COVID funding allowed us to increase frontline ambulance and call handling hours by over 500,000 hours (21%) despite staff sickness reaching 25%. This allowed the Trust to consistently deliver national performance standards across 47 weeks of 2020/21.

| Finances | 2020/21 | 2019/20 | 2018/19 |
|---|---|---|---|
| Total Income | £570.3 million | £438.7 million | £389.3 million |
| Year End Surplus | 3.5 million | £0.2 million | £6.6 million |

| Investment | 2020/21 | 2019/20 | 2018/19 |
|---|---|---|---|
| Capital Expenditure | £44 million | £22.5 million | £21.5 million |

In order to ensure the maintenance of an appropriate control environment, existing controls were adapted to ensure that they maintained appropriate oversight and assurance, whilst recognising the significant operational pressures facing the Trust. These amendments included changes to the Standing Financial Instructions with regard to COVID 19 related expenditure to support the emergency COVID response and attendant accelerated decision making. The Trust was selected for the first wave of a national audit conducted by Deloitte on the validity and appropriateness of COVID-19 expenditure claims. This provided external assurance on the appropriateness of the claims during the first COVID wave in quarter 4 19/20. The COVID-19 expenditure arrangements were also reviewed by internal audit in February 20/21 providing a finding of significant assurance with some improvement required, which has now been addressed.

Throughout the year we have continued to focus on maximising available resources to provide the best possible value for the public, who ultimately fund the London Ambulance Service. The Trust delivered the control total agreed with North West London Integrated Care System whilst saving £8.3 million through a number of schemes, including working with partners to secure free fuel during both waves of the pandemic.

A number of significant backlog and resilience challenges were exposed by the COVID-19 pandemic in early 2020/21. In order to strengthen service resilience, system partners supported us to deliver urgent infrastructure work to maintain safe patient care. As a result capital investment was nearly doubled in 2020/21 as set out in the table above.

This investment has bolstered our resilience, to the benefit of the London-wide healthcare system. Many of the projects embarked on will be completed in 2021/22.

London Ambulance Service spent £16 million on digital programmes including upgrading control room systems and implementing electronic patient records; £9 million increasing and modernising its fleet and improving crew safety systems; and £14.5 million on estates modernisation including consolidating its training estate, expanding control room capacity and improving medicines management.

The current financial framework will remain in place for at least the first half of 2021/22 as the NHS moves from response to recovery and lockdown restrictions ease. The framework for the second half of the year remains uncertain as the impact of vaccinations, increased test and trace and easing lockdown restrictions on the NHS becomes clear. However we will continue to implement our modernisation programme and maintain resilience and have a capital plan of £45.7 million, subject to confirmed funding.

We have also identified a savings programme of £9 million for 2021/22 to ensure we continue to deliver value and provide the maximum level of patient care for the resources we receive. This includes ensuring cost reductions through improved supply chain management, increasing productivity and driving down corporate overhead costs.

## London Ambulance Service Charitable Fund

The LAS Charitable Fund has grown in strength over the last year, increasing its income from around £40,000 a year to a total of £366,000 in donations and grants in 2020/21.

We are developing a fundraising strategy for our charity so we can invest more meaningfully in the welfare of our people as they deliver the best emergency care for Londoners.

Following significant engagement, we have been awarded various grants to build capacity and capability for our volunteering strand of the charity, as well as to support our frontline workforce.

We are extremely grateful to NHS Charities Together for their support and the £200,000 we have received in 2020/21 with a further £900,000 to follow in 2021/22. This money will support the welfare of our people, and resource our Volunteering Strategy and its aim to recruit 100,000 volunteers.

# Sean's story

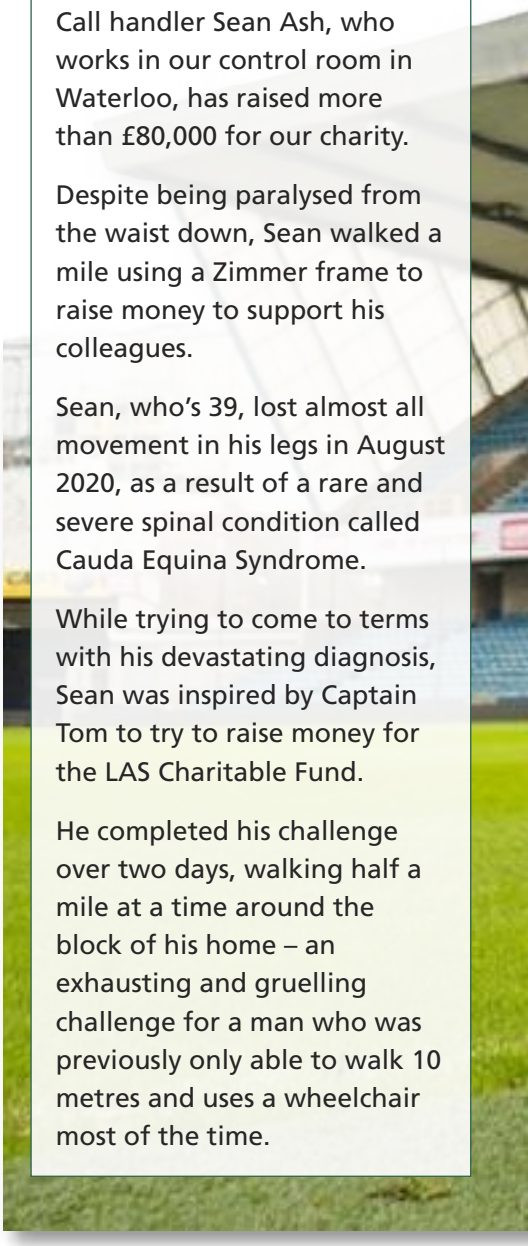
Call handler Sean Ash, who works in our control room in Waterloo, has raised more than £80,000 for our charity.

Despite being paralysed from the waist down, Sean walked a mile using a Zimmer frame to raise money to support his colleagues.

Sean, who's 39, lost almost all movement in his legs in August 2020, as a result of a rare and severe spinal condition called Cauda Equina Syndrome.

While trying to come to terms with his devastating diagnosis, Sean was inspired by Captain Tom to try to raise money for the LAS Charitable Fund.

He completed his challenge over two days, walking half a mile at a time around the block of his home – an exhausting and gruelling challenge for a man who was previously only able to walk 10 metres and uses a wheelchair most of the time.




drive
simplexity

# RISKS

# 11 RISKS

The need to respond to COVID-19 has provided both the Trust, and the wider NHS, with one of our biggest ever challenges over the past 12 months. As a Trust we have adapted to a rapidly changing environment with new ways of working to protect the health and safety of patients and our people during the pandemic.

We also adapted our governance practices to react to the fluid nature of managing risks in this unique environment. As we plan for the future in a post-pandemic world, we will continue to review the key risks which may prevent us from achieving our strategic objectives and delivering for the people of London.

As of 31 March 2021, we identified the following strategic risks:

- Continuing to deliver high quality care to patients during COVID-19 whilst maintaining the safety of staff and the public.
  *We have developed a strategic response to the impact of COVID-19 on the service and the wider community, stepping up resilience to manage surges in demand during the peaks of the pandemic, and integrating them into 'business as usual' going forward.*

- The potential for software, hardware or communications failure in IT systems.
  *We have initiated a number of projects to mitigate the impact of these risks, including unified communications and telephone improvement projects which are overseen by a Programme Management Board.*

- System wide threat of cyber-attacks which could disrupt the Trust's ability to operate
  *We continue to mitigate this threat through technical solutions and utilising support from NHS Digital.*

- Challenge of maintaining a sustainable clinical workforce
  *The Trust is mitigating this risk through a UK graduate recruitment programme, further development of our international recruitment pipeline and working with providers to ensure that the ambulance service remains the employer of choice for paramedics.*

- Uncertainty around future funding arrangements
  *The Trust has continued to work with partners in the North West London Integrated Care System group to ensure that sufficient funding is identified to sustainably deliver against agreed national quality and performance standards in 2021/22 and beyond.*

- A lack of contemporaneous immunisation records
  *We have carried out a review and redesign approach to immunisations to provide assurance around immunity and potentially reduce the need for individuals to isolate following exposure to an infectious disease.*


SECTION TWO: ACCOUNTABILITY REPORT

# DIRECTORS' REPORT

## SECTION TWO: ACCOUNTABILITY REPORT

# 1 DIRECTORS' REPORT

## 1.1 Board and Executives appointment status – 2020/2021

| | Name | From | Until |
|---|---|---|---|
| **Board members) Non-Executive Directors** | | | |
| Chair | Heather Lawrence | 01/04/2016 | 31/03/2022 |
| Non-Executive Director | Karim Brohi | 01/03/2019 | 28/02/2023 |
| Non-Executive Director | Fergus Cass | 01/03/2014 | 28/02/2021 |
| Non-Executive Director | Sheila Doyle | 06/02/2017 | 05/02/2023 |
| Non-Executive Director | Amit Khutti | 01/01/2018 | 29/02/2024 |
| Non-Executive Director | Jayne Mee | 09/01/2017 | 30/06/2021 |
| Non-Executive Director | Rommel Pereira | 01/02/2020 | 31/01/2024 |
| **Non-Executive Director** | Mark Spencer | 01/03/2019 | 28/02/2023 |
| Associate Non-Executive Director | Jill Anderson | 01/06/2020 | 31/05/2022 |
| **(Board members) Executive Directors** | | | |
| Chief Executive | Garrett Emmerson | 30/05/2017 | Present |
| Chief Operating Officer | Khadir Meer | 02/09/2019 | Present |
| Chief Quality Officer | Dr Trisha Bain | 01/01/2017 | 28/02/2021 |
| Chief Paramedic and Quality Officer | Dr John Martin | 01/03/2021 | Present |
| Chief Medical Officer | Dr Fenella Wrigley | 01/03/2016 | Present |
| Chief Finance Officer | Lorraine Bewes | 17/06/2017 | Present |
| **Executive Committee members** | | | |
| Director of Strategy, Technology and Development | Ross Fullerton | 15/05/2017 | 30/03/21 |
| Director of Corporate Affairs | Syma Dawson | 01/04/2020 | Present |
| Director of Communication and Engagement | Antony Tiernan | 20/08/2019 | Present |
| Director of People and Culture | Ali Layne-Smith | 01/09/2019 | 12/01/2021 |
| Interim Director of People and Culture | Kim Nurse | 16/11/2020 | Present |

## 1.2 Composition of the Board of Directors

Our Trust Board is made up of 14 members — our Chair, seven non-executive directors, five executive directors (including our Chief Executive) and an associate non-executive director.

Our Executive Committee consists of nine executive directors and directors, including the five executive directors on the Trust Board.

The chief executive and the other executive directors are appointed through a process of open advertising and formal selection interview. Non-executive directors are appointed by the same method but through NHS Improvement. All executive appointments are permanent and subject to normal terms and conditions of employment.

## Our Trust Board

Our Board of Directors comprises a Chair, non-executive directors and our Chief Executive Officer, Chief Operating Officer, Chief Finance Officer, Chief Medical Officer and Chief Quality Officer.

The Board is responsible for setting the strategic direction, culture and organisational performance of our Service and is accountable for ensuring that the Service delivers safe, high-quality care and gives patients the best care.

# Non-Executive Directors

## Heather Lawrence OBE,
Chair

Heather joined us as Chair in April 2016.

Heather has extensive experience both as an executive, and Non-Executive Director in the healthcare sector, and has chaired and contributed to a number of national health boards.

Heather's experience as a Non-Executive Director began in 2012 when she was appointed by the Secretary of State for Health as Non-Executive Director of Monitor, the NHS Regulator. At the same time she was appointed to a FTSE 250 international health board. In 2017, Heather was appointed as Non-Executive Director on the Royal Marsden Hospital NHS Foundation Trust board, where she now also chairs the quality committee.

Heather also has more than 20 years' experience as a Chief Executive Officer in the hospital and healthcare sector, most recently as Chief Executive Officer of Chelsea and Westminster Hospital NHS Foundation Trust from 2000 to July 2012, taking it to foundation trust status in 2006.

Heather believes that excellence in healthcare is something that everyone should be entitled to and continually strives to deliver this by ensuring that all staff feel valued and enabled to innovate, and transform care for patients.

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

## Rommel Pereira,
Deputy Chair

Rommel has a track record in finance, business transformation, technology, customer service, procurement and business development.

Rommel is a chartered accountant and retired as Finance Director of the Bank of England at the end of 2018. Prior to this he was an Executive Director of the Financial Services Compensation Scheme and Group Chief Operating Officer for the Metropolitan Housing Partnership. His earlier career included senior management roles at JP Morgan Chase.

He currently holds Non-Executive directorships at One Housing Group, Homerton University Hospital NHS Foundation Trust and The National Archives.

## Fergus Cass
(until end of February 2021)

Fergus joined us in March 2014. He was a Non-Executive Director of NHS North West London until the replacement of primary care trusts in 2013 and previously served on the board of NHS Kensington and Chelsea.

He worked for the multinational consumer goods company, Unilever, for 36 years, initially in finance and later as a general manager, heading businesses in Africa and South Eastern Europe. He holds degrees in economics and is a qualified accountant.

Fergus was Chair of the Finance and Investment Committee and Charitable Funds Committee and our Freedom to Speak Up lead until end February 2021.

# Non-Executive Directors

## Sheila Doyle

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

She specialises in delivering transformational change through the application of innovative technology solutions. She has managed international teams of 400 employees, delivered numerous complex change programmes and integrated diverse technology platforms in support of mergers and acquisitions.

Sheila spent a number of years in Hong Kong, Singapore and Australia providing consulting services to the financial services and manufacturing sectors. She served as a Non-Executive Director on the board of Companies House and was also a member of the Audit Committee.

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

## Professor Karim Brohi

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

## Jayne Mee

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

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

Through her work as an executive coach, Jayne supports executives and organisations in culture change, engagement and transformation.

She is also a Non-Executive Director at University Hospitals Bristol and Weston NHS Foundation Trust and a trustee of St John Ambulance, where she chairs the People Committee and the Remuneration Committee. She is also HR counsel at Prezzo Restaurants.

Jayne is Chair of the People and Culture Committee.

## Dr Mark Spencer

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

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

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

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

## Amit Khutti

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

Before becoming an entrepreneur, Amit led on strategy and planning for Chelsea and Westminster NHS Foundation Trust. Prior to joining the NHS, he was a Senior Civil Servant working on delivering key health targets for then Prime Minister Tony Blair.

Amit started his working life as a management consultant for McKinsey & Co, after studying English Literature at Oxford University.

Amit was appointed as Chair of the Finance and Investment Committee and our Freedom to Speak Up lead in March 2021.

## Jill Anderson

Jill joined us in June 2020. She brings more than 30 years' experience in the healthcare sector, including executive responsibility in finance, commercial, research and supply chain functions across large multinational organisations.

Jill is currently chief financial officer for ViiV Healthcare, a global subsidiary of the pharmaceutical company GlaxoSmithKline (GSK), which is dedicated to improving the lives of people living with HIV. She is actively engaged in diversity initiatives such as back-to-work programmes for people who are HIV positive.

A graduate in chemistry from the University of Exeter, Jill qualified as an accountant before joining GSK in 1990. She left to launch her own consultancy in 2001 before returning to GSK in 2011.

# Executive Directors and Directors

## Garrett Emmerson,
Chief Executive Officer

Over the last four years, Garrett has led the service through several major incidents including the 2017 and 2019 terror attacks, the Grenfell Tower tragedy and, most recently, the Trust's response to the COVID-19 pandemic.

Since his appointment, London Ambulance Service moved from being in 'Special Measures', to achieving a Care Quality Commission (CQC) rating of "Good" overall in May 2018; a rating that was sustained in 2019. Garrett is leading delivery of the Trust's vision to become London's primary integrator of access to urgent and emergency care.

Garrett was previously Chief Operating Officer for surface transport at Transport for London (TfL), where he led transport operations across London for 8 years, and was responsible for implementing TfL's £4bn road investment programme. Prior to that Garrett was Director of Strategy at TfL and, before that, was a Director at transport consultancy, Steer Davies Gleave.

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

## Khadir Meer,
Chief Operating Officer

Khadir joined us in September 2019 in the newly created role of Chief Operating Officer. He has more than 20 years of experience in public service including 10 years working for the NHS in London. There his roles included Director of Performance and Improvement and Chief Operating Officer for NHS England (London).

Khadir oversees operations and performance at London Ambulance Service, including both 111 and 999 call answering and clinical triage; ambulance services; projects and programme delivery; technical services; and asset and property management.

In his role as Chief Operating Officer, Khadir leads teams at the forefront of LAS pioneering work in delivering outstanding patient care on scene, on the phone and online – and providing patients with the best care for their needs.

## Dr Trisha Bain,

Chief Paramedic & Quality Officer

Trisha joined us in January 2017 as Chief Quality Officer and played a key role in the Trust moving out of "Special Measures" in 2018 and achieving a "Good" rating from the Care Quality Commission.

She came to us with more than 20 years' experience in quality improvement, patient safety and implementing system wide improvement programmes within NHS healthcare services. Before joining us, she was the Chief Quality Officer at Medway NHS Foundation Trust, and her career has also included roles with the former Commission for Healthcare Improvement and the National Patient Safety Agency.

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

Trisha left the Trust in February 2021.

## Dr John Martin,

Chief Paramedic & Quality Officer

John joined us in March 2021 in this newly-created role. He has responsibility for both clinical quality at the Trust and for ensuring paramedics and ambulance clinicians have access to world-class training, education and professional development.

John is a registered and practising paramedic and President of the College of Paramedics.

This is a return to London for John who worked for London Ambulance Service while completing his paramedic science degree at the University of Hertfordshire almost 20 years ago.

Following a career as a paramedic with East of England Ambulance Service between 2002 and 2014, John was selected for an NHS executive leadership programme.

In the six years since, he has performed a number of director roles at Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust.

## Dr Fenella Wrigley,

Chief Medical Officer

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

She joined us as Assistant Medical Director for control services in 2008 and became Deputy Medical Director in 2010. Fenella has led on our development of urgent care, clinically overseeing the introduction of a clinical hub to provide clinical support and 'hear and treat', and our step-in provision for NHS 111.

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

# Executive Directors and Directors

## Lorraine Bewes OBE,
Chief Finance Officer

Lorraine has served as Chief Finance Officer since December 2017. Her executive portfolio covers finance, performance, forecasting and business intelligence, procurement and commissioning contracts teams. She has 28 years of NHS senior operational executive experience as well as senior director roles at University College London Hospitals and Hammersmith and Charing Cross Hospitals.

Her last executive role was Chief Financial Officer of Chelsea and Westminster Hospital where she oversaw a portfolio of finance, strategy, business planning, commercial and procurement services, informatics, clinical coding and information governance. She was also part of the management teams who took the trust to foundation trust status and negotiated the acquisition of West Middlesex hospital.

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

## Ross Fullerton
(until March 2021)

Ross joined us in May 2017 as Chief Information Officer, before becoming our Director of Strategy, Technology and Development in September 2019.

He has had nearly 20 years' experience leading information technology teams and advising IT leaders. Ross held senior IT leadership roles in the defence sector for five years.

Prior to this, Ross spent 10 years as a consultant where he led IT departments through major change at organisations including Centrica, BP, Marks and Spencer and the Student Loans Company.

Ross left the Trust on 31 March 2021.

## Syma Dawson,
Director of Corporate Affairs

Syma joined us in April 2020 from the Royal Marsden NHS Foundation Trust where she was Associate Director of Corporate Affairs and led the corporate governance team for eight years.

She is responsible for ensuring the right rules, processes and systems are in place so that our organisation performs effectively and lawfully.

Syma has worked in a range of NHS organisations including North East Ambulance Service. She is an Associate of the Chartered Governance Institute and a Chartered Secretary by qualification.

## Antony Tiernan,

Director of Communications and Engagement.

Antony joined us in August 2019 as Director of Communications and Engagement, managing our external communications, internal communications and partnerships teams as well as leading on volunteering.

He has more than 20 years' experience in health related communications, and most recently worked at NHS England and Improvement where he worked in senior strategic communications roles, including leading the campaign to celebrate 70 years of the NHS.

Antony spent 5 years at Guy's and St Thomas' NHS Foundation Trust and led on the opening of the £60 million Evelina Children's Hospital. He has also worked as Director of Communications at both Epsom and St Helier Hospitals NHS Trust and West Hertfordshire Hospitals NHS Trust.

In 2018, he was named by the CIPR (Chartered Institute of Public Relations) as one of the UK's top PR people.

## Kim Nurse,

Interim Director of People and Culture

Kim joined us on secondment from West Midlands Ambulance Service where she is the Executive Director of Workforce and Organisational Development.

Kim brings a wealth of experience, with more than 17 years working at director level in a number of ambulance services.

## Register of Interests of Decision-Making Staff 2020/2021

| Name | Role | Description of Interest | Relevant Dates | | Comments |
|---|---|---|---|---|---|
| | | | From | To | |
| **Heather Lawrence** | Chair | Non-Executive Director – Royal Marsden Trust Board | July 2016 | Present | |
| | | Trustee NHS Providers – Ambulance Chair Rep | Autumn 2019 | Present | |
| | | Trustee British Renal Society | Autumn 2019 | Present | |
| | | NHS Improvement Chairman's advisory group member | 2017 | Present | |
| **Rommel Pereira** | Non-Executive Director | Non Executive Director, Homerton University Hospital Foundation Trust | 01/06/2019 | 31/05/2023 | |
| | | Non Executive Director / Chair of Audit & Risk Committee, One Housing Group | 21/09/2018 | 20/09/2021 | |
| **Sheila Doyle** | Non-Executive Director | Deloitte – Employee | 01/01/2016 | Present | I am a partner and full time employee at Deloitte |
| **Jayne Mee** | Non-Executive Director | Calabash Limited – Director | 01/08/2015 | Present | |
| | | St John Ambulance – Trustee | Apr-15 | Present | |
| | | University Hospitals Bristol NHS Foundation Trust – Non Executive Director | Jun-19 | Present | |
| **Jill Anderson** | Associate Non-Executive Director | ViiV Healthcare Ltd, subsidiary of Glaxo SmithKlineChief Financial Officer | 01/06/20 | Present | |
| | | Ordinary shares in GlaxoSmithKline awarded as part of reward package and long term incentives | 01/06/20 | Present | |
| **Fergus Cass** | Non-Executive Director | NIL | | | |
| **Amit Khutti** | Non-Executive Director | NIL | | | |
| **Karim Brohi** | Non-Executive Director | Queen Mary University of London Professor of Trauma Sciences, / Honorary Consultant Trauma Surgeon, Barts Health NHS Trust | 01/03/2008 | Present | |
| | | Clinical Director, London Major Trauma System NHS England (London) | 01/10/2015 | Present | |
| | | No clinical private practice. Act as medicolegal expert witness for both personal injury and clinical negligence. | 08/06/2020 | Present | |
| **Dr Mark Spencer** | Non-Executive Director | NIL | | | I continue as Med Dir NWL and as a GP sub-contracted to CareUK |

| Name | Role | Description of Interest | Relevant Dates | | Comments |
|---|---|---|---|---|---|
| | | | From | To | |
| **Garrett Emmerson** | CEO | Non-Executive Director University Buses | 01/02/2019 | Present | |
| **Khadir Meer** | Chief Operating Officer | Chair of Minik Kardes (Children's Charity) | 2011 | Present | |
| **Lorraine Bewes** | Chief Finance Officer | NIL | | | |
| **Fenella Wrigley** | Chief Medical Director | Royal London Hospital, Barts<br><br>Health Emergency Medicine Consultant Financial – Substantive NHS consultant | 01/07/2008 | Present | |
| | | St John Ambulance London Region Regional Professional lead for Specialist Events Non-Financial – Voluntary role | 01/08/2012 | Present | |
| | | All England Lawn Tennis Club Chief Medical Officer – Financial | 01/09/2018 | Present | |
| | | Home Office Immigration Services Clinical Advisor – Financial | 01/04/2013 | Present | |
| **Patricia Bain** | Chief Quality Officer | NIL | | | |
| **Antony Tiernan** | Director of Communications and Engagement | Member, NHS England communications development board (non pecuniary) | 01/04/2017 | Ongoing | Unpaid – non-financial professional interest |
| | | Member of the HSJ (Health Service Journal) Awards Advisory Board | 01/01/2019 | Ongoing | Unpaid – non-financial professional interest |
| **Syma Dawson** | Director of Corporate Affairs | NIL | | | |


35

# 1.4 Meeting attendance 2020/2021

## Trust Board

| Members | 28/04/20 | 26/05/20 | 30/06/20 | 07/07/20 | 28/07/20 | 25/08/20 | 29/09/20 | 27/10/20 | 24/11/20 | 15/12/20 | 26/01/21 | 23/02/21 | 30/03/21 | Attendance % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heather Lawrence | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Trisha Bain ** | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | | 91% |
| Lorraine Bewes | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Karim Brohi | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | 92% |
| Fergus Cass ***** | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 100% |
| Sheila Doyle | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Garrett Emmerson | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Amit Khutti | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| John Martin* | | | | | | | | | | | | | ✓ | 100% |
| Jayne Mee | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Khadir Meer | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Rommel Pereira | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Mark Spencer | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Fenella Wrigley | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Jill Anderson | | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 92% |
| **Attendees** | | | | | | | | | | | | | | |
| Syma Dawson | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - | - | 100% |
| Ross Fullerton | | x | - | - | ✓ | ✓ | ✓ | - | ✓ | ✓ | ✓ | - | ✓ | 88% |
| Ali Layne-Smith *** | | x | - | ✓ | ✓ | - | x | - | x | - | | | | 40% |
| Kim Nurse **** | | | | | | | | | ✓ | - | ✓ | - | ✓ | 100% |
| Antony Tiernan | | - | - | - | ✓ | - | ✓ | - | ✓ | - | ✓ | - | ✓ | 100% |

* John Martin joined the Trust 1 March 2021
** Trisha Bain left the Trust 28 February 2021
*** Ali Layne Smith left the Trust December 2020
**** Kim Nurse Joined the Trust November 2020
***** Fergus Cass left the Trust 28 February 2021
Informal Development sessions

## Audit Committee

| Members | 17/04/20 | 26/05/20 | 18/06/20 | 03/09/20 | 05/11/20 | 26/02/21 | Attendance % |
|---|---|---|---|---|---|---|---|
| Rommel Pereira | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Fergus Cass * | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Sheila Doyle | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| **Attendees** | | | | | | | |
| Lorraine Bewes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Syma Dawson | ✓ | ✓ | ✓ | ✓ | x | x | 66% |
| Garrett Emmerson | x | ✓ | ✓ | ✓ | x | x | 50% |
| Khadir Meer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Mark Spencer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |

* Fergus Cass left the Trust 28 February 2021

## Finance and Investment Committee

| Members | 21/05/20 | 21/07/20 | 22/09/20 | 17/11/20 | 15/01/21 - Extra | 19/01/21 | 09/02/21 - Extra | 11/.02/21 - Extra | 23/03/21 | Attendance % |
|---|---|---|---|---|---|---|---|---|---|---|
| Fergus Cass* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - | 100% |
| Lorraine Bewes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Sheila Doyle | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | x | ✓ | 77% |
| Garrett Emmerson | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | x | ✓ | 77% |
| Amit Khutti | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | 88% |
| Rommel Pereira | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ | 88% |
| **Attendees** | | | | | | | | | | |
| Syma Dawson | ✓ | ✓ | x | x | x | x | x | x | x | 22% |
| Heather Lawrence | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | 88% |
| Khadir Meer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |

* Fergus Cass left the Trust 28 February 2021

**Extraordinary meeting**

## Logistics and Infrastructure Committee

| Members | 12/05/20 | 14/07/20 | 15/09/20 | 10/11/20 | 12/01/21 | 16/03/21 | Attendance % |
|---|---|---|---|---|---|---|---|
| Sheila Doyle | ✓ | ✓ | ✓ | ✓ | Cancelled | ✓ | 100% |
| Lorraine Bewes | x | ✓ | ✓ | ✓ | | ✓ | 80% |
| Fergus Cass | ✓ | ✓ | ✓ | ✓ | | - | 100% |
| Amit Khutti | ✓ | ✓ | ✓ | ✓ | | ✓ | 100% |
| Khadir Meer | ✓ | ✓ | ✓ | ✓ | | ✓ | 100% |
| Rommel Pereira | ✓ | ✓ | x | ✓ | | ✓ | 80% |
| **Attendees** | | | | | | | |
| Syma Dawson | ✓ | ✓ | ✓ | x | | x | 60% |
| Ross Fullerton | - | - | ✓ | ✓ | | ✓ | 100% |

* Fergus Cass left the Trust 28 February 2021

## People and Culture Committee

| Members | 14/04/20 | 16/07/20 | 17/09/20 | 12/11/20 | 14/01/21 | 18/03/21 | Attendance % |
|---|---|---|---|---|---|---|---|
| Jayne Mee | Cancelled | ✓ | Cancelled | ✓ | ✓ | ✓ | 100% |
| Trisha Bain *** | | ✓ | | x | x | - | 33% |
| Karim Brohi | | ✓ | | ✓ | ✓ | x | 75% |
| Ali Layne-Smith * | | ✓ | | x | - | - | 50% |
| John Martin **** | | - | | - | - | ✓ | 100% |
| Khadir Meer | | ✓ | | ✓ | x | ✓ | 75% |
| Kim Nurse ** | | - | | x | ✓ | ✓ | 66% |
| Mark Spencer | | ✓ | | ✓ | ✓ | ✓ | 100% |
| **Attendees** | | | | | | | |
| Garrett Emmerson | | x | | ✓ | x | ✓ | 50% |
| Syma Dawson | | ✓ | | ✓ | ✓ | x | 75% |
| Fenella Wrigley | | ✓ | | ✓ | ✓ | ✓ | 100% |

* Ali Layne Smith left the Trust December 2020
** Kim Nurse Joined the Trust November 2020
*** Trisha Bain left the Trust 28 February 2021
**** John Martin joined the Trust 1 March 2021

## Quality Assurance Committee

| Members | 05/05/19 | 07/07/20 | 08/09/20 | 03/11/20 | 14/01/21 | 09/03/21 | Attendance % |
|---|---|---|---|---|---|---|---|
| Mark Spencer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| Trisha Bain * | ✓ | ✓ | ✓ | ✓ | ✓ | | 100% |
| Karim Brohi | ✓ | x | ✓ | ✓ | ✓ | ✓ | 83% |
| Heather Lawrence | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| John Martin ** | | | | | | ✓ | 100% |
| Jayne Mee | ✓ | ✓ | x | ✓ | ✓ | ✓ | 83% |
| Khadir Meer | ✓ | ✓ | ✓ | ✓ | x | ✓ | 83% |
| Fenella Wrigley | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 100% |
| **Attendees** | | | | | | | |
| Syma Dawson | ✓ | ✓ | ✓ | ✓ | ✓ | x | 83% |
| Rommel Pereira | ✓ | ✓ | ✓ | ✓ | x | ✓ | 83% |

* Trisha Bain left the Trust 28 February 2021
** John Martin joined the Trust 1 March 2021

## Charitable Funds Committee

| Members | 03/11/20 | 19/01/21 | 22/02/21 | Attendance % |
|---|---|---|---|---|
| Fergus Cass* | ✓ | ✓ | ✓ | 100% |
| Lorraine Bewes | ✓ | ✓ | ✓ | 100% |
| Rommel Pereira | x | ✓ | ✓ | 66% |
| Antony Tiernan | x | ✓ | ✓ | 66% |
| **Attendees** | | | | |
| Syma Dawson | x | x | x | 0% |

* Fergus Cass left the Trust 28 February 2021

## Statement of Disclosure to Auditors

The Directors confirm that so far as they are aware:

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

## 1.2. Statement of Accountable Officer's Responsibility

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

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

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

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

Garrett Emmerson, 25 June 2021

**Chief Executive**

# ANNUAL GOVERNANCE STATEMENT

# 2 ANNUAL GOVERNANCE STATEMENT

## Scope of responsibility

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

## The purpose of the system of internal control

2 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of London Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in London Ambulance Service NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

### Leadership

3 Risk management is a key component of enhancing patient and staff care and is an integral part of the Trust's strategic management. It is the process whereby the Trust methodically addresses the risks related to its activities with the goal of achieving sustained benefits to patient care and outcomes through delivery of our strategy. The focus of risk management at London Ambulance Service is about being aware of emerging problems, working through what impact they could have and implementing changes and plans to mitigate against the worst case scenario. This is achieved through ensuring clear leadership and accountabilities throughout the Trust and encouraging cross directorate working.

4 The Chief Executive Officer is accountable to the Board for the quality of risk management arrangements within the Trust. Operationally, during 2020 /21 responsibility for the implementation of risk management has been

delegated to the Chief Quality Officer and the Director of Corporate Affairs. Since March 2021 the role of the Chief Quality Officer has been replaced by the role of Chief Paramedic and Chief Quality Officer who has now assumed the responsibility for clinical risk management.

5 The Director of Corporate Affairs supports Executive Committee (ExCo) members and Non-Executive Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Trust Board, for maintaining the Board Assurance Framework (BAF). The BAF defines the principal risks to achieving the Trust's strategic objectives, together with associated controls, sources of assurance and action plans. The Chief Paramedic and Quality Officer, and previously the Chief Quality Officer, is the quality governance lead for the Trust. The Chief Paramedic and Quality Officer, and previously the Chief Quality Officer is responsible for the Trust's Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. They are also responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet requirements in relation to clinical governance and risk, up to and including the Trust's Corporate Risk Register. The holders of these posts have continued to drive forward a significant workplan in 2020/21 to strengthen the Trust's risk management processes, at all levels of the organisation, from Board to station-level.

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

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

8 The Quality and Corporate Affairs Directorates also has expanded over the past 12 months to provide further assurance that there are experienced and appropriately qualified staff to lead, support and advise staff at all levels across the organisation with the identification and management of risk.

9 The Risk Management Strategy and Policy sets out clearly defined roles and responsibilities for the senior leadership team and the risk register contains a clear definition of the Corporate (Trust Wide) Risk Register and the process for inclusion. This ensures that the right risks have been identified and prioritised for action. The Trust's Risk Compliance and Assurance Group (RCAG), chaired by the Chief Paramedic and Quality Officer (previously Chief Quality officer) meets regularly to review risk management and the . This ensures appropriate seniority and reflects this Executive Officer's overall responsibility for risk management requirements up to and including the Corporate (Trust Wide) Risk Register The Trust Risk Manager has continued to improve, strengthen and embed Risk Management systems and processes across the Trust by increased engagement (both operational and corporate) to raise, review and mitigate risk.

**Staff – Training**

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

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

understanding of the risk management process. Risk management training is provided to Executive Committee and Board members every two years, in respect to high level awareness of risk management and to ensure that risks aligned to their remit are reviewed. The Trust Board last received such training in September 2020.

12 The Trust's mandatory and statutory training programme is regularly refreshed to ensure that it remains responsive to the needs of Trust staff and volunteers. There is regular review of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which includes elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. Despite significant operational pressures due to the impact of COVID-19, the Trust has been able to achieve average target levels of 84% compliance with mandatory and statutory training requirements during 2020/21. Monitoring and escalation arrangements are in place to ensure that the Trust maintains its current good performance and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

## The risk and control framework

### Risk Management Strategy and Policy

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

14 The Risk Management Strategy and Policy, which was reviewed and amended in March 2020, provides the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the Trust is able to deliver its objectives by identifying and managing risks, enhancing opportunities and creating an environment that adds value to ongoing operational activities. The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical risks. This includes but is not limited to; strategic, financial, operational, regulatory, environmental and reputational risks.

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

### Identifying and reporting risk

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

17 The Trust Board reviewed its approach to strategic risk management in September 2020. A new BAF format was adopted in line with the template recommended by NHS Providers (deemed to be best practice by industry standards). The new BAF format was reviewed by the Trust's internal auditors in February 2021. The Trust Board was provided with a significant level of assurance through this independent assessment of the BAF's operational effectiveness

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

that level, such issues are escalated to the appropriate corporate committee, the RCAG, the ExCo or the Trust Board for a decision to be made.

### Managing risk

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

20 Of fundamental importance to the early identification, escalation and control of risk is the Trust's commitment to the ongoing development of a culture where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong', and a progressively 'risk aware' workforce. In addition to standard incident reporting processes, the Trust has had a full time Freedom To Speak Up (FTSU) guardian since 2018/19. Concerns raised through FTSU are all investigated and many have led to improvements in processes in a number of different parts of the service. At Board level, Fergus Cass was the Trust's Non-Executive Director lead for FTSU prior to stepping down from the Board in February 2021, at which point Amit Khutti took on this role.

Key events for FTSU:

- At present there are 25 Freedom to Speak Up advocates, all of whom have received training in how to promote the work of FTSU and support staff to raise concerns.
- Erica Green served as the Trust's FTSU guardian between May 2020 and Feb 2021. The role is currently filled by Katy Crichton on an interim basis.
- In August 2020, station administrator Carmen Peters was appointed as a full-time coordinator role to assist with supporting the Guardian, liaising with the advocates and providing an alternative pathway for staff to raise concerns if a conflict of interest occurs with the Guardian.
- The team were finalists for the FTSU category at the Health Service Journal Awards.
- The guardian and coordinator are both engaged with the B-ME Black and Minority Ethnic Network, Enabled Disability Network and the LGBT society. The FTSU coordinator is also the engagement and welfare officer for the B-ME and Enabled Network.
- FTSU and B-ME Network collaborated on events and communications for Black History Month
- The guardian gave a presentation at an International Women's Day virtual event where she spoke about the work of Freedom to Speak Up.
- During FTSU month in October 2020, the guardian and coordinator held a virtual event for the advocates. The Chair and the CEO gave virtual personal speeches virtually and the LEAP team conducted a workshop around stress and boundaries
- The guardian and coordinator also visited multiple sites across the Service during October, offering tea and coffee to staff on a tea truck.
- The guardian and coordinator ran virtual shielding mess rooms, for staff shielding due to the pandemic.
- The guardian or coordinator were invited to the Resolution Framework meetings to help shape the implementation of this within the Trust.
- The FTSU coordinator attended the White Ribbon campaign meetings
- The FTSU page on our intranet has been reviewed and refreshed. They are frequently updated with information about the advocates, how to speak up, and a news section and also contains information on the learning that has occurred as a result of FTSU.
- In collaboration with the LEAP team, The Freedom to Speak Up team produced a staff support and wellbeing document for all staff to access in light of the COVID-19 pandemic.
- An infographic has been developed in order to help colleagues understand the speaking up process.
- The Trust responded to a range of safety concerns from staff in relation to COVID-19 during the early stages of the pandemic. These were raised openly through a variety of channels, including FTSU, and were managed with the provision of optional alternatives for Personal Protective Equipment (PPE) which met the Public Health England (PHE) guidance, development of a wellbeing hub and more management support being available to frontline clinicians.
- Fair treatment issues were raised and responded to in relation to certain areas of the organisation including fleet, estates and HART.
- Capacity and continuity of FTSU support has been maintained at both an executive and non-executive level of the Trust.
- In 2020/21 155 concerns were raised compared to 278 in the previous financial year. 32% of these came from BAME colleagues, a significant rise on last year, potentially because of focus on the Black

Lives Matter movement
- The focus for the next financial year will be working with managers across the Trust to reduce the number of colleagues who feel they need to raised concerns via FTSU and improve other existing pathways

21 Business Planning and Service Development proposals do not proceed without an appropriate assessment of, and therefore recognition / acceptance of, the risks involved and the involvement of the relevant expertise. The Trust's ExCo reviewed and agreed the approach to be taken to quality impact assessments (including equality and data protection assessments) in December 2017. This has continued to be used in the Trust's Business Planning activities for 2020/21.

22 The design of the Trust's BAF was reviewed in September 2020 when a revised format was approved by the Board, incorporating more detailed mapping to strategic risks, tolerance levels and residual to target gap analysis. The BAF incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Data Protection and Security Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via regular BAF / risk register reports and is supported by a robust Internal Audit Programme.

23 The Trust last considered its approach to risk management and approved its risk appetite statement in September 2020. The Board is currently considering longer term strategic risks faced by the Trust, including the incorporation of the longer term impact of COVID-19 within the core risks on its BAF. An assurance mapping exercise is being undertaken to create a more formalised, structured assurance reporting mechanism to the Board, which will highlight any anomalies, gaps and duplications of assurance to streamline the information provided to the Board.

24 The Board has had to focus on a number of emerging risks in 2020/21 including the increased pressure on the service due to the impact of; the COVID-19 Pandemic, the transition arrangements for the UK's departure from the European Union; securing adequate funding arrangements to enable the Trust to deliver commissioned services and to support the Trust's modernisation programme. The Board has been closely monitoring the mitigation of risks relating to COVID-19 via the appropriate assurance committees, Executive Committee and the Audit Committee. The Finance and Investment Committee receive regular reports on progress with commissioning arrangements and the business case to support the modernisation programme.

25 Throughout 2020/21, the Trust faced unprecedented levels of demand associated with the commencement of first peak of the COVID-19 pandemic in March 2020 and the second in December 2020. Arrangements were put in place at the beginning of the first peak to enable changes to governance and assurance frameworks to ensure a prompt response to the pandemic and reduce burden at a time of significant operational pressure. Use of existing business continuity and Strategic Command structures for decision-making as well as amended executive decision-making and Board Assurance structures enabled the Trust to provide assurance over its decision-making during this period. Actions taken included weekly strategic briefings of Trust Board members, with the ability to quickly escalate and implement issues as they arose whilst maintaining independent assurance and oversight. Peer review of plans was sought from the NHS England Ambulance Strategic Commander to provide further assurance. In order to ensure that all decisions were recorded appropriately, the Trust implemented a formal decision log. These arrangements were flexed to meet the decrease and increases in pressure throughout this period, some of which have been incorporated into BAU. The Trust requested a review to be carried out of the decision making process during the COVID-19 pandemic.

26 In order to ensure the maintenance of an appropriate control environment, existing controls were adapted to ensure that they maintained appropriate oversight and assurance, whilst recognising the significant operational pressures facing the organisation. These amendments included changes to the Standing Financial Instructions with regard to COVID-19-related expenditure. The amendments in the Trust's governance and assurance arrangements enabled the organisation to focus on the operational response and importantly, patient safety and quality. The appropriateness of the oversight and

assurance arrangements were reviewed as part of a wider review of the Trust's Response to COVID-19 in September 2020, following the first COVID wave, to ensure that any lessons were learned.

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

- The Trust's Quality Strategy is based on the Care Quality Commission (CQC) fundamental standards. The Trust Board also agrees annual quality priorities.
- The Trust has a Quality Assurance Committee (a committee of the Board) which meets bi-monthly and is chaired by a Non-Executive Director who is a practising clinician. The Quality Assurance Committee is responsible for monitoring performance against the agreed annual quality objectives and is supported by the bi-monthly Quality Oversight Group as well as local Sector/Service Quality Governance meetings. The Quality Assurance 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 to the Trust Board in both the Trust's Quality Report and the Integrated Quality and Performance Report.
- Quality improvements – including the response to CQC findings and recommendations are progressed through the Trust's Quality Improvement Plan which is monitored at the Organisational Performance Meeting and at local Service/Sector Quality Governance meetings
- A Station/Service Accreditation programme has been developed which aims to drive quality standards by empowering front line staff to make improvements in line with the Care Quality Commission's (CQC) fundamental standards. During 2020/2021, the Trust ran a pilot which was successful. The programme is planned for roll out this financial year and it is supported by the Patient & Public Council.
- 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 Council (PPC) representatives (e.g. Health Watch).
- Patient and Staff Stories are presented respectively to meetings of the Trust Board and actions and lessons learned are widely shared.
- The Trust has implemented the Patient Safety Incident Response Framework (PSIRF) as an early adopter. This approach allows the Trust to focus on continuously improving by addressing causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- The Trust has implemented the Learning from Death process with an internally developed digital platform to enable reviews and oversight to be undertaken and reported on.
- Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience – a patient safety specialist will be appointed during Q1/2 of 2021/22 to lead on Learning from Deaths and external collaboration.
- The Trust has a safeguarding team and a patient experience team to oversee safeguarding matters and patient experience respectively.
- To maintain safety throughout the COVID-19 pandemic additional senior clinical support was provided to the control rooms (999 and 111) and frontline crews. Additionally close collaboration with the wider London NHS system enabled additional expert support to be accessible for patients who either did not need to be conveyed to an emergency department or did not wish to go to hospital.
- Throughout COVID-19 patients who experienced delays in either accessing 999 or 111 or delays to receive a definitive clinical assessment either on the phone or face-to-face as a result of the unprecedented demand were reviewed by an external team and learning was shared.
- As part of the frontline delivery for the NHS in London the Trust were invited to, and engaged in, many COVID-19 surveillance research pilots to help with the understanding of this new disease. This included being early adopters of antibody testing, lateral flow testing, testing to releases.
- The COVID-19 vaccination programme was delivered to staff and volunteers through collaboration with larger Trusts and Regional centres. We supported this with providing vaccinators.
- The Trust's COVID-19 expenditure claims in the first COVID surge were audited by Deloitte as part of a national rolling audit programme and the Trust commissioned a further internal audit review of the COVID-19 expenditure during 2020/21. Both reviews provided significant external assurance on

the appropriateness and reasonableness of the expenditure incurred in response to the COVID-19 pandemic.

28 In 2020/21 the key performance indicators reported to the Trust Board were rated for data quality as part of the Data Quality Reviews (further The following key work was undertaken throughout the year to ensure data quality with the Trust:

- Data Quality Reviews of 11 key systems or reporting arrangements were carried out to assess the quality of data.
- Actions were developed based on the findings and recommendations of these reviews which is regularly monitored by IGG (Information Governance Group) and QAC (Quality Assurance Committee).
- An internal audit by Grant Thornton on Data Quality was carried out in November 2020. The audit reviewed the design and operation of the Data Quality control environment and concluded that the process has provided a SIGNIFICANT level of assurance (highest possible rating).

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

- Has formed a Strategic Workforce Planning Group, which is chaired by our Chief Operating Officer / Deputy Chief Executive, and has clear oversight of risk management.
- Employs sufficient numbers of suitably qualified, skilled and experienced staff to meet the care and treatment needs of our patients safely and effectively.
- Has a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and to keep them safe at all times.
- Deploys an approach that reflects current legislation and guidance where it is available.

30 In 2020/21 the Trust retained its focus on the strategic risks associated with workforce, through the BAF and through the People and Culture Committee. The People and Culture Committee has had a specific focus upon the development of a workforce planning model, providing assurance to the Board on this. ExCo has also met as a Strategic Workforce Planning Group in 2020/21 and regularly received reports on strategic workforce planning activities, to provide additional oversight in this area.

31 During the course of the year, a control issue was identified in respect of the Trust's medicines management and compliance with Medicines & Healthcare products Regulatory Agency (MHRA) regulations. Since 2016, a pharmacist led review of the medicines packing and distribution function (at the Logistics Support Unit) is undertaken every 18 months. In addition, Grant Thornton carry out internal audits on a periodic basis. During a Chief Pharmacist-led review of medicines management at the Logistics Support Unit, it was identified that the Trust should acquire a MHRA Wholesale Dealers License (WDL). This control issue was identified due to a change in the way the MHRA inspects suppliers. In order to achieve a WDL, the Trust must work to Good Distribution Practice (GDP) systems and processes. At the time of the review the estate, staff, systems and processes were sub optimal mostly due to the position of the specialist function in the Trust structure. A comprehensive action plan is now under way and a new medicines management distribution unit is being constructed and management of the function strengthened and led by the Chief Pharmacist.

32 In addition, an internal review of Occupational Health (OH) records highlighted that the transfer of vaccination record information between previous providers did not provide adequate assurance of immunity. The Trust does not have an internal OH provider and has had the OH service provided by a range of procured providers over the past decade. Each time a new provider has been procured the staff records have needed to be transferred over from the old provider to the new provider. The internal review identified weaknesses in assurance around the transfer and management of these transfer arrangements resulting in the Trust, via the OH provider, lacking assurance around contemporaneous immunisation records for some staff. This lack of assurance around immunity could potentially result in individuals being required to isolate following exposure to an infectious disease. The Trust's Board, advised by its Audit Committee, has recognised that this presented a significant control issue.

33 To address this issue, the Trust commenced an

immunisation review programme in 2020/21 including:

- Analysis of immunisation records to identify any gaps.
- Contact tracing processes were followed to identify and protect staff at risk of a lack of immunisation/immunity.
- A task and finish group commenced work to review the systems and processes pre and in early employment to improve the opportunities for immunisations prior to commencement in roles where the risks are the highest.
- Amendment to the recruitment offer letters from Q1/2 to include the immunisation requirements.
- Work to create a reporting framework in ESR so that individual immunisation records are now captured within the system.
- Engagement of an internal OH specialist nurse lead to provide expert advice to the Chief Medical Officer and Head of Wellbeing.

34 In terms of contracting requirements and due diligence an extensive action plan was developed in relation to contractual monitoring, procurement, recording and management of immunisation records to mitigate any further risks. The Trust will complete delivery of Phase 2 of its immunisation catch up programme and look to embed new processes as part of the retendering of its Occupational Health contract. A validation audit will be carried out with the appointed Occupational Health contract holder to validate records transferred to them with those in ESR. The Trust will also review the clinical evidence for periodic immunity reviews and update its Workforce Immunisation Policy accordingly. This work will take place with a view to establishing significant assurance in the first half of the 2021/22 year.

## Quality Strategy

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

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

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

## CQC registration and compliance with the NHS provider licence

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

39 During 2020/21, CQC inspection activities at the Trust included regular engagement calls and virtual monitoring meetings. An infection control assessment post COVID-19 wave 1 was undertaken based on the NHS England framework and CQC reported back they were fully assured.

40 The CQC's overall rating of the Trust remains "Good".

41 The Trust Board has assessed itself in compliance with the relevant aspects of the NHS provider licence at its meeting in May 2021. This assessment was reached following an internal review of the Trust's corporate governance framework.

42 With respect to condition FT4 (NHS Foundation

Trust governance arrangements), the Board reviews the terms of reference of its Assurance Committees on an annual basis to ensure their effectiveness and last did so in May 2021. The Trust has an Audit Committee consisting of Non-Executive Directors. The Audit Committee regularly meets with the internal and external auditors without the presence of executive directors or staff. In addition, the Local Counter Fraud specialist presents a report to every meeting of the Audit Committee on measures to tackle Fraud, Bribery and Corruption and also the importance of reporting concerns as appropriate. The Trust also has a Remuneration and Nominations Committee consisting of the Non-Executive Directors, joined when appropriate, by the Chief Executive, the Director of People and Culture and the Director of Corporate Affairs. In addition, the Board has established a number of Assurance Committees which focus on key aspects of the Trust's work. Each Committee is chaired by a Non-Executive Director. All Committees and sub Groups undertake an annual self-assessment of their effectiveness, which is reported to the Board (or the appointing Committee in the case of sub groups). The Audit Committee also submits an Annual Report to the Trust Board and regularly reviews the Standing Financial Instructions and Scheme of Delegation.

43 The terms of reference also serve to define the responsibilities, accountabilities and reporting lines of each Assurance Committee. The Board receives a report following each Assurance Committee meeting, written or approved by the Non-Executive Director Chair, and is therefore able to both receive assurance but also challenge any of the decisions made. Each Assurance Committee also has one identified lead Executive Director. The responsibilities of the Board and its Directors are defined in the Trust's Standing Orders and Standing Financial Instructions, which were reviewed in May 2020.

44 The Board has an annual schedule of business, which is reviewed at each formal meeting of the Board. The schedule defines when reports will be submitted, ensuring that the Board can operate timely and effective scrutiny of its operations. Key performance reports covering corporate, clinical, quality, workforce, finance and operational performance are received at each formal meeting of the Board and are made available on the Trust's website.

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

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

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

48 The Trust has not been rated by the CQC since 2019. During the course of the year, a control issue was identified and reported to all relevant regulatory bodies in respect of the Trust medicines management and compliance with MHRA regulations as described at paragraph 31 under Managing Risks section. .

49 As a result, the medicines packing and distribution function will be moving to a newly created pharmacy department, led by the Chief Pharmacist. In order to comply with GDP, the following is underway and due for completion in 2021:

- A staff restructure has been commissioned and recruitment and induction are underway for General Pharmaceutical Council (GPhC) registered staff for the day-to-day management of the function. All pharmacy assistant staff have been enrolled in training programmes as determined by the Pharmacy Order 2010 and an enhanced internal training programme has been developed which will be delivered by pharmacy technicians. All medicines delivery drivers will be undertaking the medicines management training course for drivers.

- A new medicines packing and distribution site is being constructed in accordance with that stipulated in the 'Rules and Guidance for Pharmaceutical Manufacturers and Distributors (commonly known as the Orange Guide), 2017'.
- A new inventory management system has been purchased to provide full information of the traceability, use of medicines, expedited recalls, control of expired medicines at our fingertips.
- Automated temperature monitoring system has been installed into all static medicines storage areas to provide accurate and timely assurance of the storage of medicines within the conditions stipulated

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

## Roles and Responsibilities

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

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

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

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

- the review of risk and risk registers is maintained in accordance with Trust strategy
- all staff have the ability to identify risks and propose they are assessed and entered onto the relevant section of the Trust Risk Register
- monitoring and timely review of the Risk Management Strategy and associated policies
- provision of expert advice into the incident reporting process
- all managers within their directorate are familiar and act in accordance with Trust policies
- incidents are reported and investigated in accordance with the Trust's Incident Reporting Process.
- learning is shared and embedded through a range of modalities including Core Skills Refreshers, Clinical Update and Insight bulletins and podcasts.

55 There were a number of changes to the Trust's senior personnel in 2020/21:

- Kim Nurse joined the Trust in the role of Interim Director of People and Culture in November 2020, replacing Ali Layne-Smith.
- Trisha Bain left the role of Chief Quality Officer in February 2021 and was replaced by John Martin in March 2021 as the Trust's new Chief Paramedic and Quality Officer.
- Fergus Cass' term of appointment as Non-Executive Director and Chair of the Trust's Finance and Investment Committee came to an end at the end of February 2021, at which point he left the Trust.
- Jill Anderson was appointed as an Associate Non-Executive Director with effect from 1 June 2020.

56 The Board Assurance Committees and Executive Committee sub- provide a process for the escalation and delegation of assurance and risk throughout

57 The purpose of the Executive Committee (ExCo) is to lead and manage the performance of the Trust within the strategic framework established by the Trust Board. The ExCo makes proposals to the Trust Board on key policy and service issues for Trust Board decision. The ExCo meets in a number of different forms throughout each month to focus on different aspects of the Trust's operations. As the Portfolio Management Board, it manages the portfolio of programmes and projects in place to deliver the Trust's Business Plan; as the Strategic

Workforce Planning Group, it focuses on the actions required to ensure that the Trust will have the resources it requires to deliver its Strategy; and as the Performance Review Meeting, it retains detailed oversight of every aspect of the Trust's performance.

58 The ExCo has also established the following sub-groups:

- the Risk Compliance and Assurance Group (RCAG) – to oversee the governance of the risk management process and management of risks rated greater than 15;
- the Information Governance Group (IGG) – to ensure that London Ambulance Service NHS Trust has clear direction of and management support for the activities required to comply with data quality principles; Caldicott principles; Information Security Management (ISO/IEC 17799 / ISO/IEC 27001); data protection legislation; the Freedom of Information Act 2000; the Data Security and Protection Toolkit; records management as defined by the Care Quality Commission (CQC); the Public Records Act; and the Information Governance Alliance Records Management Code of Practice for Health and Social Care.
- The Supply Chain Management Board – monitor compliance with standing orders, standing financial instructions and scheme of delegation regarding procurement and management of the supply chain and oversee development and implementation of third party supply category strategy plans.

59 The Audit Committee monitors risks and reviews the BAF. It critically reviews and reports on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

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

61 The Quality Assurance Committee has responsibility for providing the Trust Board with assurance on the achievement of strategic objectives in relation to the provision of a high quality, safe, and effective service. The Trust's definition of quality encompasses three equally important elements:

- Care that is safe – working with patients and their families to reduce avoidable harm and improve outcomes.
- Care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients and their families.
- Care that provides a positive experience – to patients and their families.

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

63 Throughout 2020/21 the Logistics and Infrastructure Committee had responsibility for providing the Trust Board with assurance on and overseeing strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate. Consideration is currently being given to incorporating the remit of this Committee into that of the Finance and Investment Committee during 2021/22.

64 The Board has also established a time-limited Digital 999 Programme Assurance Committee, to provide assurance on the delivery of the Trust's Digital 999 Programme (replacement of the Computer Aided Dispatch system and implementation of the Electronic Patient Record Form).

## Public Stakeholder involvement

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

66 The Trust Board meets at least six times a year in public and its papers are available on the Trust website. During 2020/21, in light of social distancing restrictions associated with COVID-19, the majority of Board meetings took place virtually. From September 2020 these meetings were available to the public for viewing on YouTube. The Board seeks to have as a regular item of business either 'a patient story' or 'a staff story' that enables members of the public or staff

to present their experiences to the Board. There is also the opportunity, either through the Trust website or at the meeting on the day, to pose questions to the Trust Board on any matter of concern. This supports the Board's desire to be as open and transparent as possible. All matters are discussed or determined in public unless the matter would not be disclosed under Freedom of Information regulations.

67 In January 2020, the Board finalised plans to launch the London Ambulance Service Public and Patients Council (LASPPC). The aim of the LASPPC is to bring together a wide range of patients and the public representatives from across London at regular intervals to provide feedback on the services we provide and to help shape the way care is delivered. It will also advise the Trust on ways to gain broader engagement, as necessary. Dame Christine Beasley was appointed as an interim Chair of the LASPPC and its first meeting took place in June 2020. The LASPPC has also established eight sub-groups which focus on key areas of our work, including plans to transform our estate.

68 In September 2020, the Board agreed a new 'patients and communities engagement and involvement strategy' which was developed in partnership with the LASPPC and sets out a range of priorities to further enhance the way we involve and listen to patients and communities. This includes working with Healthwatch England, local Healthwatch and the LASPPC to co-design a visits (enter and view) programme – giving patient and public representatives access to our 999,111 and ambulance services so they can provide constructive feedback. The strategy will also see the establishment of a London Ambulance Service Youth Empowerment Squad – supporting young people to learn more about our work, share their feedback and influence our decision-making.

69 In addition to the above the Trust engages with the Greater London Assembly and other appropriate Health Overview and Scrutiny Committees (HOSCs), and also local Healthwatch organisations across London. This has included providing updates throughout the COVID-19 pandemic about our response to the crisis.

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

71 The Trust's comprehensive internet website provides the public with access to information across all areas of Trust activity and the organisation also uses its newsletter for members to inform the public of new developments and items of interest. We also issue a range of bulletins to our partners and key stakeholders.

## Corporate Governance Statement

72 The Trust, under Condition FT4 of its Licence, is required to submit to NHS Improvement a Corporate Governance Statement by and on behalf of the Board of Directors confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. The Statement was drafted and approved by the Trust Board and submitted to the Regulator within the prescribed timescales. The Regulator received the statement and did not require a statement from its auditors either:

- confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or;
- setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

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

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

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

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

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

### NHS Pension Scheme

78 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

### Culture, Diversity and Inclusion

79 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Statutory measures for the Workforce Race Equality Scheme (WRES), the Workforce Disability Equality Scheme and the Gender Pay Gap are all shared with the People and Culture Committee and then Trust Board. Trust wide trajectories and progress will be reported on a quarterly cycle.

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

81 COVID-19 has given us the opportunity to innovate within the Culture, Diversity and Inclusion work-stream moving forward. Our strategy will focus on hearing the voice of our patients and public.

82 We will learnt and embedded new ways of working from the lessons learnt during COVID-19. We have received positive feedback from Corporate Services staff working flexibly and remotely. There is still further work to be undertaken to understand the needs of all our staff, some of whom have also shown an interest in a blended approach to working from home and in the office.

83 We have received positive responses from staff and volunteers about our Wellbeing Hub, which has reinforced the necessity to undertake regular wellbeing conversations with staff; conversations which need to be normalised in our PDR and staff welfare discussions. Our response to the challenge of coordinating and vaccinating our staff and volunteers has been significant, and we have worked across the NHS to communicate with key stakeholder groups to address concerns in some cultural groups.

84 The Trust has responded to staff who are vulnerable, shielding or who are suffering from long COVID-19 conditions by making reasonable accommodations such as alternative duties and working from home.

85 We have now appointed an Associate Director of Culture, Diversity and Inclusion who will lead on aspects of Culture, Diversity and Inclusion with staff, patients and volunteers in 2021.

86 We are working towards ensuring our workforce better reflects the diversity of the population it serves in London. We end 2020/21 having recruited more than 200 BME staff, representing over 34% of all our new starters. We now have more than 1,100 BME staff which is 18% representation. There is still more to do to increase these numbers and we will continue to put time effort and attention into this work.

87 We have also worked hard to increase gender diversity and in 2020/21 49% of our senior leadership team (including Trust Board) is female. Overall our female representation Trust wide has increased to 49%

88 Work has taken place with the College of Paramedics to improve BME admissions onto paramedic science degree courses across the country.

89 We are now in the third year of our Workforce Race Equality Action Plan (WRES) to address our

ongoing challenges in this area. The WRES Action Plan Group, which is chaired by the CEO, meets quarterly to focus on driving this work forward.

90 The Trust has started on a journey to ensuring that the right organisational culture is in place to support its patients and staff. During 2020/21, in partnership with the LAS B-ME Network, we undertook activities in response to staff and patient concerns highlighted by the Black Lives Matter movement, including:

- Communication to all staff and volunteers from our Chair and CEO reinforcing that there is no place for racism in our organisation
- Drop-in sessions for BAME colleagues to offer a space for sharing, healing and learning
- During the summer "Silence is not the Answer" workshops, hosted by our CEO, were held for our managers. The purpose was to educate our managers about colleagues' lived experience of racism, to provide a safe environment to listen and talk about racism and to enable managers to have conversations about racism with their teams
- Staff attended workshops to learn about how to be an ally to BAME colleagues and the importance of allies in encouraging effective dialogue around racism.
- Work was done to review disciplinary cases to investigate the disparity in likelihood of entering the formal disciplinary process between white and BAME staff.
- A Black Lives Matter Delivery Plan was formed with the aim of making improvements to the working lives of BAME staff and to improve our performance against the metrics measured as part of the Workforce Race Equality Standard (WRES).

91 The safety of female colleagues was brought to the fore following the murder Sarah Everard. The Trust took actions, including:

- Our Wellbeing Hub offered support and advice
- Our Chair and female Executive Directors held drop-in sessions for female staff to share their experiences and concerns about working for the LAS
- We are reviewing the general risk assessment processes and are developing a new risk assessment training course
- Work is underway to form a Women's Staff Network

92 Other key events for 2020/21 included:

- Recognised and celebrated religious events.
- Created a cultural calendar with our Communications Team.
- Started a Cultural Audit of the Trust.
- Work with People and Culture colleagues to introduce our new Resolution Framework.
- Made progress on our WRES and WDES metrics.
- Created a new Recruitment and Selection training programme, including dedicated Recruitment and Selection training for BAME staff to support our aim to increase the diversity of recruitment panels.
- Work with universities to increase the diversity of LAS applicants in their education programmes.
- Analysis of 2020 Staff Survey results.
- Reviewing our Equality, Diversity and Inclusion Policy and enabling policies such as Disability, Recruitment and Menopause policies.
- Started work with AACE and our Communications Team to create an anti-racism campaign due to launch this summer.
- Put together a proposal for a scorecard to report CDI metrics.
- Engaged with Grant Thornton, who undertook an audit to provide assurance over the Trusts' Equality and Diversity control environment and to provide recommendations in line with good practice.

### Carbon Reduction

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

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

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

- A well-established policy framework (including Standing Financial Instructions)
- An organisational structure which ensures accountability and challenge through the committee structure
- A clear planning process
- Effective corporate directorates responsible for workforce, revenue and capital planning and control

- Detailed monthly financial reporting including progress on achievement of Cost Improvement Programmes and year-end forecasting.

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

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

97 The Trust's response to the COVID-19 pandemic involved the suspension of some of these measures during COVID-19 parts of 2020/21. The COVID-19 expenditure arrangements were reviewed by internal audit in February 2021 providing a finding of significant assurance with some improvement required. The improvement area identified has now been addressed.

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

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

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

101 External auditors, internal auditors and counter fraud report to each meeting of the Audit Committee, and also meet the members of the Audit Committee without management present.

## Information governance

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

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

104 Dependent on the nature of the incident, the

information provided on the DSPT is sent to the Information Commissioner's Office, the Department of Health and Social Care, NHS England and the National Cyber Security Centre. In 2020/21, three information governance incidents were notified via the DSPT. One of these was reported to the ICO. No action was taken by the ICO as a result of this.

105 Due to the outbreak of COVID-19, NHS Digital, who have responsibility for the DSPT assessment, have declared its submission deadline as 30th June 2021.

## Data quality and governance

106 Data quality and governance within the Trust is headed up by the Data Quality Assurance team. In addition to its regular Integrated Performance Report to its Board, the Trust has in place a Data Quality Strategy which includes a governance structure, policy and implementation plan. Following the development of a rigorous methodology, Data Quality Reviews were carried out on 11 key systems and reporting arrangements used by the Trust during 2020/21. The reviews assessed the quality of data and actions were developed based on the findings and recommendations. Progress on these actions has been regularly monitored by the Trust's Information Governance Group (IGG) and the Quality Assurance Committee (QAC).

107 An internal audit on Data Quality was carried out during November 2020. The audit reviewed the design and operation of the Data Quality control environment and concluded that the process has provided a significant level of assurance, the highest possible rating.

## Review of effectiveness

108 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.

109 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.

110 The Trust received the following Head of Internal Audit Opinion for 2020/21:

"Our overall opinion for the period 1 April 2020 to 31 March 2021 is that based on the scope of reviews undertaken and the sample tests completed during the period, **Substantial assurance with some improvement required** can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The level of non-compliance in certain areas puts some system objectives at risk. We identified significant weaknesses which put system objectives at risk in relation to the Cyber Security Audit.

We also reported one high priority recommendation as part of our Fleet Logistics Audit. We also issued 4 partial assurance with improvement required reports, which identified weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Overall we have concluded that, with the exception of cyber security, those activities and controls that we examined were operating with sufficient effectiveness to provide partial assurance that the related risk management objectives were achieved during the period under review."

111 The Trust has taken, and continues to take, robust

steps to address the weaknesses identified in relation to Cyber Security. The risks, mitigations and related actions in this area are monitored at the Trust Board level through a specific strategic risk on the Board Assurance Framework. Whilst a number of issues have been addressed in year, full compliance has extended into the 2021/22 financial year due to issues relating to the number of legacy devices and addressing areas where limited controls had previously been in place. The auditors drew particular attention to the Trust's compliance with Data Security and Protection Toolkit (DSPT). The DSPT is an annual self-assessment and submission to NHS Digital against the 10 National Data Guardian (NDG) data security standards. The Trust is working towards achieving the required DSPT standards however, due to the disruption caused by the Coronavirus pandemic in 2020, it is unlikely to achieve compliance for the revised 30 June 2021 deadline. The Trust has put in place a strong action plan to deliver the necessary infrastructure and systems improvements required to complete all of the 37 mandatory assertions of the DSPT within the 10 NDG standards by no later than the end of the 2021/22 financial year.

112 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 Performance Report to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions.

113 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.

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

## Conclusion

115 Whilst the Trust continues to work to improve its control environment, as set out above, two significant control issues were identified during 2020/21. The first issue was in relation to licence requirements with MHRA, with work continuing to mitigate this risk. The second issue was in relation to due diligence of the management of the transfer arrangements between previous providers under the Occupational Health contract.

116 A comprehensive action plan was developed in relation to contractual monitoring, procurement, recording and management of immunisation records. The work continues to strengthen the control arrangements in place. The Trust will complete delivery of the work programme and look to embed new processes as part of the retendering of its Occupational Health contract.

Garrett Emmerson, 25 June 2021

**Chief Executive**

# REMUNERATION AND STAFF REPORT

# 3 REMUNERATION AND STAFF REPORT

**3.1 Remuneration**

Our Remuneration and Nominations Committee consists of the Chair and the seven 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 99 to 102.

**Banded remuneration analysis**

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2020/21 was in the range of £230,001 to £235,000 on an annualised basis. The pay multiplier in 2020/21, based on annualised salary, was 6.0 times the median remuneration of the workforce, which was £38,846. In 2019/20, the banded remuneration of the highest paid director was in the range of £215,001 to £220,000. The pay multiplier in 2019/20, based on annualised salary, was 5.98 times the median remuneration of the workforce, which was £36,399.

The increase in the median figure in comparison to 2019/20 is due to an increase in overtime and incentive payments.

In 2020/21, one employee received remuneration in excess of the highest-paid director. Remuneration was in the range of £285,001 to £290,000 (2019/20 £260,001 to £265,000).

The range of staff remuneration is £20,001 to £290,000 (2019/20 £20,001 to £265,000).

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

The appointment and remuneration of the 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 in the Salary and Pension Entitlement of Senior Managers has been audited by our external auditors.

## Salary and pension entitlements of senior managers

### A) Remuneration 2020/21

| Name and Title | Salary (bands of £5,000) | Expense payments (taxable) total to nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay and bonuses (bands of £5,000) | All pension related benefits (bands of £2,500) | Total (bands of £5,000) |
|---|---|---|---|---|---|---|
| Heather Lawrence, Chairman | £35,001-£40,000 | £0 | £0 | £0 | £0 | £35,001-£40,000 |
| Rommel Pereira, Non-Executive Director | £10,001-£15,000 | £0 | £0 | £0 | £0 | £10,001-£15,000 |
| Jill Anderson, Non-Executive Director (from 1st June 2020) | £5,001-£10,000 | £0 | £0 | £0 | £0 | £5,001-£10,000 |
| Fergus Cass, Non-Executive Director (from 1st April 2020 to 28 February 2021) | £10,001-£15,000 | £0 | £0-£5,000 | £0 | £0 | £10,001-£15,000 |
| Sheila Doyle, Non-Executive Director | £10,001-£15,000 | £0 | £0-£5,000 | £0 | £0 | £10,001-£15,000 |
| Jayne Mee, Non-Executive Director | £10,001-£15,000 | £0 | £0-£5,000 | £0 | £0 | £10,001-£15,000 |
| Amit Khutti, Associate Non-Executive Director | £10,001-£15,000 | £0 | £0 | £0 | £0 | £10,001-£15,000 |
| Karim Brohi, Non-Executive Director | £10,001-£15,000 | £0 | £0-£5,000 | £0 | £0 | £10,001-£15,000 |
| Mark Spencer, Non-Executive Director | £10,001-£15,000 | £0 | £0-£5,000 | £0 | £0 | £10,001-£15,000 |
| Garrett Emmerson, Chief Executive Officer | £210,001-£215,000 | £0 | £20,001-£25,000* | £0 | £0 | £230,001-£235,000 |
| Lorraine Bewes, Chief Finance Officer | £155,001-£160,000 | £0 | £0 | £0 | £0 | £155,001-£160,000 |
| John Martin, Chief Quality Officer (from 1st March 2021) | £10,001-£15,000 | £0 | £0 | £0 | £45,001-£47,500 | £55,001-£60,000 |
| Fenella Wrigley, Chief Medical Officer | £115,001-£120,000 | £4,700 | £5,001-£10,000 | £0 | £197,501-£200,000 | £325,001-£330,000 |
| Patricia Bain, Chief Quality Officer (from 1st April 2020 to 28 February 2021) | £125,001-£130,000 | £0 | £5,001-£10,000 | £0 | £0 | £130,001-£135,000 |
| Khadir Meer, Chief Operating Officer | £150,001-£155,000 | £0 | £0-£5,000 | £0 | £17,501-£20,000 | £175,001-£180,000 |

The performance pay payments relate to the financial year 2019/20. *Includes bonus payment of £10,490 paid twice in error which will be recovered in 2021/22.

## Salary and pension entitlements of senior managers (continued)

### A) Remuneration 2019/20

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

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

## 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 2021 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2020 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2021 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| Heather Lawrence, Chairman | ** | ** | ** | ** | ** | ** | ** | ** |
| Jill Anderson, Non-Executive Director (from 1st June 2020) | ** | ** | ** | ** | ** | ** | ** | ** |
| Fergus Cass, Non-Executive Director (from 1st April 2020 to 28 February 2021) | ** | ** | ** | ** | ** | ** | ** | ** |
| Sheila Doyle, Non-Executive Director | ** | ** | ** | ** | ** | ** | ** | ** |
| Jayne Mee, Non-Executive Director | ** | ** | ** | ** | ** | ** | ** | ** |
| Amit Khutti, Associate Non-Executive Director | ** | ** | ** | ** | ** | ** | ** | ** |
| Karim Brohi, Non-Executive Director | ** | ** | ** | ** | ** | ** | ** | ** |
| Mark Spencer, Non-Executive Director | ** | ** | ** | ** | ** | ** | ** | ** |
| Rommel Pereira, Non-Executive | ** | ** | ** | ** | ** | ** | ** | ** |
| Garrett Emmerson, Chief Executive Officer | * | * | * | * | * | * | * | * |
| Lorraine Bewes, Chief Finance Officer | * | * | * | * | * | * | * | * |
| Fenella Wrigley, Chief Medical Officer | £7,501-£10,000 | £22,501-£25,000 | £55,001-£60,000 | £130,001-£135,000 | £882,333 | £187,482 | £1,100,860 | £15,703 |
| John Martin, Chief Quality Officer (from 1st March 2021) | £0-£2,500 | £0-£2,500 | £25,001-£30,000 | £50,001-£55,000 | £370,611 | £743 | £404,158 | £1,558 |
| Patricia Bain, Chief Quality Officer (from 1st April 2020 to 28 February 2021) | * | * | * | * | * | * | * | * |
| Khadir Meer, Chief Operating Officer*** | £0-£2,500 | £0 | £30,001-£35,000 | £50,001-£55,000 | £391,380 | £24,612 | £422,645 | £12,839 |

*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.
***The pension data for Khadir Meer is only for 7 months as he left the scheme on 31/10/2020, because the full year information was not provided by the NHS Pensions Agency as it was not requested by the Trust during the prescribed annual window for such requests, owing to a lack of clarification in the guidance, to allow the full pensions benefit disclosures to be made, and that information cannot now be obtained retrospectively.
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 2020/21

| 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 |
|---|---|---|---|---|---|---|---|---|
| | | £000s | | £000s | | £000s | | £000s |
| £10,000 - £25,000 | | | | | | | | |
| £50,001 - £100,000 | 1 | 100 | | | 1 | 100 | | |
| £100,001 - £150,000 | 1 | 127 | | | 1 | 127 | | |
| £150,001 - £200,000 | 1 | 160 | | | 1 | 160 | | |
| Totals | 3 | 387 | | | 3 | 387 | | |

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

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

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

| Reporting of other compensation schemes – Exit packages | Agreements Number | Total value of agreements £000s |
|---|---|---|
| Voluntary redundancies including early retirements contractual cost | 0 | 0 |
| Mutually agreed resignations (MARS) contractual costs | 0 | 0 |
| Early retirements in the efficiency of the service contractual costs | 0 | 0 |
| Contractual payments in lieu of notice | 2 | 57 |
| Exit payments following Employment Tribunals or court orders | 0 | 0 |
| Non-contractual payments requiring MHT approval | 0 | 0 |
| Total | 2 | 57 |

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

## Off-payroll engagements

### Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last longer than six months:

| | Number |
|---|---|
| Number of existing engagements as of 31 March 2021 | 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 2020 and 31 March 2021, 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 2020 and 31 March 2021 | 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 2020 and 31 March 2021.

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

## Staff report

### Average Staff Numbers

The average number of staff has increased over last year 6,218 (2019/20 5,797) as the trust continues to recruit additional paramedics.

| Staff Category | Total Number | Permanently employed Number | Other Number |
|---|---|---|---|
| Medical and Dental | 9 | 5 | 4 |
| Ambulance Service | 2,962 | 2,913 | 49 |
| Administration and estates | 1,801 | 1,696 | 105 |
| Healthcare assistants and other support staff | 1,414 | 1,388 | 26 |
| Nursing, midwifery and heath visiting staff | 28 | 26 | 2 |
| Scientific, therapeutic and technical | 3 | 3 | 0 |
| **Total** | **6,218** | **6,032** | **186** |

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

## Staff Composition

At the end of March 2021, we had a workforce of 6,497 staff, made up of 3,234 men and 3,263 women. This was broken down as follows:

| | Total | Female | Male |
|---|---|---|---|
| Directors | 20 | 10 | 10 |
| Senior Managers | 283 | 118 | 165 |
| Employees | 6,194 | 3,135 | 3,059 |
| **Total** | **6,497** | **3,263** | **3,234** |

Over the course of the year, a total of 540 people left the service – a turnover rate of 8.1%, compared to 9.5% in 2019/20.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 216 paramedics left during 2020/21.

## Staff Sickness

Information on sickness can be found on the NHS Digital site (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates).

## Staff Policies

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

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

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

- patients and customers receive fair and equal access to our healthcare service;

- everyone is treated with dignity and respect; and
- staff experience fairness and equality of opportunity and treatment in their workplace.

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

As an employer, we are focusing on:

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

## Staff Survey

Our 2020 staff survey achieved a response rate of 72%, matching the record set last year. This compares exceptionally well to the average response rate of 56% for other ambulance trusts. Overall, 4,427 staff completed the survey, which is 212 more than last year.

We have seen statistically positive movement in 30 questions, but have gone backwards in 4. In the remaining 41 questions we've stayed about the same. Our overall staff engagement score, which tells us how staff feel about the organisation generally, has increased slightly from 6.1 last year to 6.2 (on a scale of 1-10), comparing with an average of 6.3 for ambulance trusts. We've made progress in our areas of focus: Your Manager (immediate manager/senior manager); Health & Wellbeing (bullying or abuse from managers & colleagues) and Safety Culture (reporting of and learning from near misses and errors).

55% of staff would recommend the LAS as a place to work, 75% would be happy with the standard of care provided by the LAS if a friend or relative needed treatment and 61% believe care of patients/service users is the organisations top priority.

Analysis shows we are below average in seven of the ten survey themes, when compared with other ambulance trusts. The graph below shows there is still significant work to do if we want to be an employer of choice in the ambulance sector.

## Work done since last year's survey

Following the publication of 2019's staff survey results, we focussed on engagement with and development of our core leaders/managers. We also improved the visibility of our senior managers through LAS TV Live and local operational briefings, as well as through the delivery of six sector conferences attended by the CEO, executive team members, and local senior managers (ADO/LGMs/CTMs). As a result, the 'Immediate Manager' and 'Senior Manager' scores (Questions 8a-9d) have all improved, as can be seen below. We shall therefore continue to focus on this area.

Throughout the last year and a result of COVID-19, we have also put considerable effort into improving the health and wellbeing offering to our staff. We have set up a wellbeing hub providing wayfinding support to staff; provided staff COVID-19 testing and immunisations; introduced tea trucks for operational staff; provided free food and drinks; assisted with accommodation needs.

## Improvements

Significant improvements were made in 30 questions when compared to last year's scores. Our most improved questions are:

- In the last three months have you ever come to work despite not feeling well enough to perform your duties? – a fall of 10.3%
- There are enough staff at this organisation for me to do my job properly – score increased by 8.7%
- My organisation treats staff who are involved in an error, near miss or incident fairly – score increased by 4.5%
- I know who my senior managers are – increased by 3.8%
- I am able to meet all the conflicting demands on my time at work – increased by 4.8%

## Where more work is required

The following questions received the lowest scores, when compared with the average for ambulance trusts:

- 42% of staff have not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public.
- 76% of staff have not experienced discrimination from patients/service users, their relatives or other members of the public
- 49% of staff have adequate materials, supplies and equipment to do their work
- 57% of staff have not experienced physical violence from patients/service users, their relatives or other members of the public
- 35% of staff reported their last experience of harassment, bullying or abuse.

## Next steps

- Safe environment – violence: an ongoing public awareness campaign; introduction of body warn cameras and violence reduction officers. However, more needs to be done in this area to ensure staff understand what is not acceptable and report incidents so that action can be taken to secure police action where appropriate.
- Equality, Diversity & Inclusion: we have now recruited an Associate Director of Culture, Diversity and Inclusion who will be focussing on all aspects of EDI across the Trust. A cultural audit is underway; gender pay gap analysis is being completed; and a new inclusion policy is being created.
- Health & Wellbeing: we have recruited a permanent Head of Wellbeing to continue the progress we made over the last year in this area (moving from a score of 4.7 to 5.1). We are also re-tendering our Occupational Health provision.
- Safe environment – bullying & harassment: we will be continuing to focus on the development of our 'core leaders' and introducing a new resolution framework to create a just and learning culture with empowered managers across the organisation.

## Expenditure on Consultancy

In 2020/21 the trust spent £0.3m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer:
Garrett Emmerson, Chief Executive Officer
Organisation: London Ambulance Service NHS Trust

Garrett Emmerson, 25 June 2021

**Chief Executive**

| Q | Your Managers | 2019 | 2020 | Change |
|---|---|---|---|---|
| Q8a | My immediate manager encourages me at work | 62% | 64% | +2% |
| Q8b | Immediate manager can be counted on to help with difficult tasks | 68% | 70% | +2% |
| Q8c | Immediate manager gives clear feedback on my work | 59% | 60% | +1% |
| Q8d | Immediate manager asks for my opinion before making decisions that affect my work | 40% | 42% | +2% |
| Q8e | Immediate manager supportive in personal crisis | 70% | 75% | +5% |
| Q8f | Immediate manager takes a positive interest in my health & well-being | 61% | 65% | +4% |
| Q8g | Immediate manager values my work | 62% | 63% | +1% |
| Q9a | I know who senior managers are | 69% | 75% | +6% |
| Q9b | Communication between senior management and staff is effective | 30% | 35% | +5% |
| Q9c | Senior managers try to involve staff in important decisions | 23% | 25% | +2% |
| Q9d | Senior managers act on staff feedback | 26% | 28% | +2% |

# INTRODUCTION

## SECTION THREE: ANNUAL ACCOUNTS

# 2020/21 Introduction to the Annual Accounts

### Financial Performance

For the financial year 2020/21 the Trust reported a surplus of £3.462m. The Trust had planned to report a £2.394m surplus. The improvement was due to in year non recurrent income. The following table summarises the key elements of the financial performance of the Trust in 2020/21.

| | Plan £m | Actual £m | Variance £m |
|---|---|---|---|
| **Income** | 524.3 | 570.3 | 46.0 |
| **Expenditure** | (521.9) | (566.8) | (44.9) |
| **Surplus** | 2.4 | 3.5 | 1.1 |
| **EBITDA Surplus** | 24.1 | 22.7 | (1.4) |
| | | | |
| **Gross Capital Expenditure** | 44.2 | 44.0 | 0.2 |
| **External Financing Limit (EFL)** | (2.1) | 31.7 | 33.8 |
| **Cash** | 18.8 | 39.8 | 21.0 |

The Trust was operating under an adjusted financial framework up to M6 which involved pausing business planning (including Cost Improvement Programmes) and contracting and commissioning processes (including CQUIN). The framework involved the Trust receiving block contract income in advance as determined by NHSE/I, along with a standard monthly top-up amount and retrospective top ups to breakeven financial performance positions. This allowed expenditure on the Trust's response to the COVID-19 pandemic to be funded.

From month 7 onward, this framework was replaced with fixed income envelopes which are being managed at STP or ICS level, and required the achievement of financial efficiencies by the Trust of £2.4m based on that plan. Additional efficiencies were also required to match new approved spend bringing the total efficiency targeted and achieved to £8.3m, and further income was provided by Commissioners towards the latter end of the year to support costs arising from the Trust's response to COVID variants arising, and from NHSE in relation to COVID pressure on annual leave costs.

Total COVID expenditure incurred across the financial year (excluding centrally provided consumables and equipment) was £85.8m, primarily in relation to additional resourcing to meet COVID requirements in Ambulance Services and IUC, and operational support services.

The Trust continued to invest in new equipment, spending £44m on new vehicles to help improve the age profile of the fleet, IM&T system expansion, renewal and improvement, estates modernisation and expansion, and additional clinical equipment, with a significant proportion of this capital spend related to the Trust's COVID-19 response.

| | £m |
|---|---|
| Capital Expenditure | 44.0 |
| Less: | |
| Charitable Donations and Grants | (0.5) |
| NBV of Disposals | (0.5) |
| Charge Against Capital Resourcing Limit (CRL) | 43.0 |

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 2021. The results outlined in this section relate to the full 12 month period of 1 April 2020 to 31 March 2021. 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% of turnover under the agreed limit. Exceeding these limits requires prior approval. Trusts are permitted to undershoot their EFL targets.

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

The original planned EFL was (£2.1m) i.e. a net borrowing requirement of £2.1m. The Trust had an under spend on its EFL of £33.8m due to higher than planned year-end cash balances £21.0m, self-funded additional capital spend £11.8m and an underspend of £1.1m on central funded capital funding. The Trust is permitted to under spend its EFL and therefore met its statutory duty.

**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 3% and 4%.

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 £44m before disposals on a range of projects, including new vehicles to help improve the age profile of the fleet, IM&T system expansion, renewal and improvement, estates modernisation and expansion, and additional clinical equipment, with a significant proportion of this capital spend related to the Trust's COVID-19 response. The Trust therefore utilised the full £44m capital funding available. In addition to the capital expenditure, the Trust also received £0.5m on donated assets, and had disposals of £0.5m. The capital programme was primarily funded internally, but was augmented with £11.6m of external support from the Department of Health and Social Care.

**Apply the Better Payment Practice Code**

This regulatory duty requires NHS Trusts to pay all supplier invoices within 30 days. The Trust paid 94% of its trade invoices by volume within 30 days. This is slightly below the 95% target set by the Department of Health and Social Care and an improvement on last year's performance of 89%.

**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 2021/22**

Due to COVID-19 the Department of Health and Social Care has asked organisations to complete limited financial planning for the first half of 2021/22. In line with this, temporary funding arrangements are in place to ensure liquidity of NHS organisations in 2021/22. The arrangements involve payment of block centrally calculated funding amounts, along with fixed top ups and COVID support payments as were in place for the second half of 2020/21 in relation to amounts spent on COVID-19 response initiatives. The Trust understands and is working under the assumption that the current or a similar regime will remain in force until the end of the year.

**Financial risk**

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

**International Financial Reporting Standards (IFRS)**

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

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2021 for all land and buildings. The net loss on revaluation was £7.7 million and the total impairments were £6.0 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 outstanding of £10.5 million for the current financial year (£5.7 million in 2019/20).

**Subsequent events after the balance sheet date**

COVID-19 continues to have a material effect on the 2021/22 financial statements, however there are no events after the reporting period that need to be disclosed in the financial statements.

**Other information**

Ernst and Young LLP were the Trust's external auditor for the year ended 31st March 2021. The Trust paid £140,000 (£86,000 in 2019/20) for audit services relating to the statutory audit, of which £105k relates to the 20/21 audit fee and the balance relates to 19/20 which increased from the planned fee due to a general increase and additional risk requiring additional testing identified as a result of COVID. All issues relating to financial audit and financial governance are overseen by our Audit Committee. Ernst and Young LLP have not undertaken any non-audit work for the Trust during the year ended 31st March 2021.

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

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

The London Ambulance Service is an NHS Trust established under the National Health Service Act 2006. The Secretary of State for Health has directed that the financial statements of NHS Trusts will meet the accounting requirements of the NHS Trusts Manual for Accounts, which will be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2019/20 Group Accounting Manual issued by the Department of Health and Social Care.

The financial statements for the year follow.

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

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

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

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

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

Garrett Emmerson, 25 June 2021
**Chief Executive**

## STATEMENT OF THE DIRECTORS RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

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

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

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

By order of the Board

Garrett Emmerson, 25 June 2021
**Chief Executive**

Lorraine Bewes, 25 June 2021
**Chief Finance Officer**


ABOUT US

## 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 2021 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 33. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2020/21 HM Treasury's Financial Reporting Manual (the 2020/21 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2020/21 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 2021 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 (as amended by the Health and Social Care Act 2012) 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.

**Conclusions relating to going concern**
In auditing the financial statements, we have concluded that the Directors use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of 15 months to 30 September 2022 from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

**Other information**
The other information comprises the information included in the annual report set out on pages 1-79, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report.

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.

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 course of 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 themselves. 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 National Health Service Act 2006**
**Basis for qualification on the Remuneration Report**
The Remuneration Report set out on pages 99 to 104, does not include the full year figures for the Chief Operating Officer within the disclosure of Table B: Pension Benefits for the year ending 31 March 2021 because the information was not provided by NHS Pensions Agency as it was not requested by the Trust during the prescribed annual window, and that information cannot now be obtained retrospectively.

**Qualified opinion on the Remuneration Report**
Except for the reasons set out in the basis for qualification on the Remuneration Report, in our opinion the part of the Remuneration Report subject to audit has been prepared properly in accordance with requirements of the National Health Service Act 2006.

**Opinion on the Staff Report**
In our opinion the part of the Staff Report to be audited has been properly prepared in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

**Opinion on Other Information**
In our opinion, the Other Information for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**
We are required to report to you if:
- in our opinion the governance statement does not comply with the NHS 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 2021.

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 115, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Directors are 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 they either intend to cease operations, or has 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 ensuring that the financial statements are prepared in a format directed by the Secretary of State and 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.

***Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud***
Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.
- We understood how London Ambulance Service NHS Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, Head of Internal Audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Trust's board minutes, through enquiry of employees to verify Trust policies, and through the inspection of HR policies and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified: manipulation of reported financial

performance (through improper recognition of revenue); inappropriate capitalisation of revenue expenditure; and management override of controls to be our fraud risks.
- To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Trusts manual year end income accruals, challenging assumptions and corroborating the income to appropriate evidence.
- To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trusts capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.
- To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://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 reporting criteria issued by the Comptroller and Auditor General in April 2021, as to whether the Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria 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 2021.

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**
Delay in certification of completion of the audit
We cannot formally conclude the audit and issue an audit certificate until we have completed our procedures on the Trust's value for money arrangements for the year ended 31 March 2021. We are satisfied that this work does not have a material effect on the financial statements.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

**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.

E. Jackson
Ernst & Young LLP

Elizabeth Jackson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Luton
25 June 2021


# ANNUAL ACCOUNTS

# 3 ANNUAL ACCOUNTS

## London Ambulance Service NHS Trust

## Annual accounts for the year ended 31 March 2021

## Statement of Comprehensive Income

| | Note | 2020/21 £000 | 2019/20 £000 |
|---|---|---|---|
| Operating income from patient care activities | 3 | 499,119 | 428,408 |
| Other operating income | 4 | 71,204 | 10,151 |
| Operating expenses | 5, 7 | (563,081) | (433,604) |
| **Operating surplus/(deficit) from continuing operations** | | **7,242** | **4,955** |
| Finance income | 10 | 9 | 189 |
| Finance expenses | 11 | 36 | (45) |
| PDC dividends payable | | (3,432) | (4,846) |
| **Net finance costs** | | **(3,387)** | **(4,702)** |
| Other gains / (losses) | 12 | (393) | (59) |
| **Surplus / (deficit) for the year** | | **3,462** | **194** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Impairments | 6 | (6,043) | 297 |
| Revaluations | 15 | 322 | 3,112 |
| **Total comprehensive income / (expense) for the period** | | **(2,259)** | **3,603** |
| **Adjusted financial performance (control total basis):** | | | |
| Surplus / (deficit) for the period | | 3,462 | 194 |
| Remove net impairments not scoring to the Departmental expenditure limit | | 1,473 | (55) |
| Remove I&E impact of capital grants and donations | | (480) | 35 |
| Remove 2018/19 post audit PSF reallocation (2019/20 only) | | | (125) |
| Remove net impact of inventories received from DHSC group bodies for COVID response | | (1,896) | |
| **Adjusted financial performance surplus / (deficit)** | | **2,559** | **49** |

## Statement of Financial Position

| | Note | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 13 | 13,090 | 8,183 |
| Property, plant and equipment | 14 | 194,052 | 177,183 |
| **Total non-current assets** | | **207,142** | **185,366** |
| **Current assets** | | | |
| Inventories | 16 | 6,440 | 4,508 |
| Receivables | 17 | 29,305 | 22,270 |
| Cash and cash equivalents | 18 | 39,787 | 25,964 |
| **Total current assets** | | **75,532** | **52,742** |
| **Current liabilities** | | | |
| Trade and other payables | 19 | (81,002) | (46,815) |
| Provisions | 22 | (7,557) | (6,584) |
| Other liabilities | 20 | (251) | (193) |
| **Total current liabilities** | | **(88,810)** | **(53,592)** |
| **Total assets less current liabilities** | | **193,864** | **184,515** |
| **Non-current liabilities** | | | |
| Borrowings | 21 | (107) | (107) |
| Provisions | 22 | (8,381) | (8,436) |
| **Total non-current liabilities** | | **(8,488)** | **(8,543)** |
| **Total assets employed** | | **185,376** | **175,972** |
| | | | |
| **Financed by** | | | |
| Public dividend capital | | 77,840 | 66,178 |
| Revaluation reserve | | 47,907 | 55,620 |
| Other reserves | | (419) | (419) |
| Income and expenditure reserve | | 60,047 | 54,593 |
| **Total taxpayers' equity** | | **185,376** | **175,972** |

The notes on pages 128 to 165 form part of these accounts.

Garrett Emmerson, 25 June 2021
**Chief Executive**

## Statement of Changes in Equity for the year ended 31 March 2021

| | Public dividend capital | Revaluation reserve | Financial assets reserve | Other reserves | Merger reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2020 – brought forward** | **66,178** | **55,620** | **-** | **(419)** | **-** | **54,593** | **175,972** |
| **At start of period for new FTs** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| Surplus/(deficit) for the year | - | - | - | - | - | 3,462 | **3,462** |
| Other transfers between reserves | - | (1,992) | - | - | - | 1,992 | - |
| Impairments | - | (6,043) | - | - | - | - | **(6,043)** |
| Revaluations | - | 322 | - | - | - | - | **322** |
| Public dividend capital received | 11,662 | - | - | - | - | - | **11,662** |
| **Taxpayers' and others' equity at 31 March 2021** | **77,840** | **47,907** | **-** | **(419)** | **-** | **60,047** | **185,376** |

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

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

## Information on reserves

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

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

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

**Other reserves**
This reserve was created when London Ambulance Service became a NHS Trust. The negative reserve balance wascaused 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 | 2020/21 £000 | 2019/20 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus / (deficit) | | 7,242 | 4,955 |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 5.1 | 14,548 | 11,535 |
| Net impairments | 6 | 1,473 | (55) |
| Income recognised in respect of capital donations | 4 | (539) | - |
| (Increase) / decrease in receivables and other assets | | (6,292) | 4,643 |
| (Increase) / decrease in inventories | | (1,932) | (1,871) |
| Increase / (decrease) in payables and other liabilities | | 29,804 | 4,054 |
| Increase / (decrease) in provisions | | 963 | 1,352 |
| Other movements in operating cash flows | | - | - |
| **Net cash flows from / (used in) operating activities** | | **45,267** | **24,613** |
| **Cash flows from investing activities** | | | |
| Interest received | | 19 | 199 |
| Purchase of intangible assets | | (9,179) | (1,755) |
| Purchase of PPE and investment property | | (30,257) | (16,039) |
| Sales of PPE and investment property | | 25 | 46 |
| Receipt of cash donations to purchase assets | | 488 | - |
| **Net cash flows from / (used in) investing activities** | | **(38,904)** | **(17,550)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 11,662 | 1,822 |
| Other interest | | (10) | (20) |
| PDC dividend (paid) / refunded | | (4,192) | (4,620) |
| **Net cash flows from / (used in) financing activities** | | **7,460** | **(2,818)** |
| **Increase / (decrease) in cash and cash equivalents** | | **13,823** | **4,246** |
| **Cash and cash equivalents at 1 April – brought forward** | | **25,964** | **21,718** |
| **Cash and cash equivalents at 31 March** | **18** | **39,787** | **25,964** |

## 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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

**Accounting convention**

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

**Note 1.2 Going concern**

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM) which outlines the interpretation of IAS1 'Presentation of Financial Statements' as "the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the North West London Health and Care Partnership Integrated Care System (ICS). The ICS has published its Strategic Delivery Plan and NHS Long Term Plan response for the five year period 2020/21 – 2024/25. This plan includes the continued provision of services by the Trust. Nationally published documents such as the outcome of the spending review in March 2021 (including the announcement of an additional £7bn for the NHS COVID 19 recovery) and the proposed Health and Care Bill legislation were also referenced. No circumstances were identified causing the Directors to doubt the continued provision of NHS services.

This year the Trust continued to report a surplus, achieving a £1.12m surplus. Income from Commissioners was largely based on the simplified block payments system introduced in response to the COVID-19 pandemic, which improved liquidity and cash flow during the year. Additional costs due to the pandemic were supported on an actual cost reimbursement basis for the first half the year and on an advance block payment basis for the second half of the year.

For 2021/22 the current financial funding arrangements will remain in place for the first half of the year, with additional funding to support maintaining resilience and enabling transformation post COVID.

For the second half of the year the Trust has assumed that the recurrent level of expenditure will be funded at the required level with an increased level of efficiency required.

The Trust has produced its financial plans based on the assumption of continuity of service provision. This has been approved by the Trust Board. The plan includes the assumption that the control target for the 2021/22 year, as agreed with ICS, is a breakeven outturn, including a savings/operational efficiency target of £9.7m. This compares to efficiency targets of a similar value in years pre-COVID, and the Trust is therefore reasonably assured of the achievability of this financial targets.

Our going concern assessment is made up to 30/09/2022. This includes the first half of the 2022/23 financial year. NHS operating and financial guidance is not yet issued for that year, and so the Trust has assumed inflation, activity growth and efficiencies at pre-COVID levels on the basis these would better reflect the requirements of NHS organisations as planning and contracting is restarted. Even if these assumptions are incorrect, certain actions can be taken and through this mitigation we will have sufficient liquidity to provide services until the end of the going concern period.

Interim support can be accessed if it were required, but there is currently no such identified requirement.

In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

**Note 1.3 Revenue from contracts with customers**

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

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations

satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

**Revenue from NHS contracts**

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

**2020/21**

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a [Integrated Care System/Sustainability and Transformation Partnership] level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

**Comparative period (2019/20)**

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

<u>For 2020/21 and 2019/20</u>

**Revenue from research contracts**

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

**NHS injury cost recovery scheme**

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of

Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

**Note 1.4 Other forms of income**

**Grants and donations**

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

Donations are treated in the same way as government grants.

**Apprenticeship service income**

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

**Note 1.5 Expenditure on employee benefits**

**Short-term employee benefits**

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

**Pension costs**

*NHS Pension Scheme*

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

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

**Note 1.6 Expenditure on other goods and services**

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

**Note 1.7 Property, plant and equipment**

**Recognition**

Property, plant and equipment is capitalised where:

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

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

*Subsequent expenditure*

Subsequent expenditure relating to an item of

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

**Measurement**

*Valuation*

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

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

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

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

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

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

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

*Depreciation*

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

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

*Revaluation gains and losses*

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

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

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

*Impairments*

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

impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

**De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

**Donated and grant funded assets**

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

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

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

**Useful lives of property, plant and equipment**

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

| | Min life Years | Max life Years |
|---|---|---|
| Buildings, excluding dwellings | 3 | 99 |
| Plant & machinery | 5 | 15 |
| Transport equipment | 2 | 10 |
| Information technology | 3 | 8 |
| Furniture & fittings | 3 | 10 |

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

**Note 1.8 Intangible assets**

**Recognition**

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

*Internally generated intangible assets*

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

*Software*

Software which is integral to the operation of hardware, e.g. 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, e.g. application software, is capitalised as an intangible asset.

**Measurement**

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

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

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 lives in a manner consistent with the consumption of economic or service delivery benefits.

**Useful lives of intangible assets**

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

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

**Note 1.9 Inventories**

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

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

**Note 1.10 Cash and cash equivalents**

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

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

**Note 1.11 Financial assets and financial liabilities**

**Recognition**

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

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

**Classification and measurement**

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

**Financial assets and financial liabilities at amortised cost**

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

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any

impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

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

**Impairment of financial assets**

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

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

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

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

**Derecognition**

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

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

**Note 1.12 Leases**

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

**The trust as a lessee**

*Finance leases*

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

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

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

*Operating leases*

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

*Leases of land and buildings*

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

**Note 1.13 Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

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

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

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

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

**Clinical negligence costs**

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

**Non-clinical risk pooling**

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

**Note 1.14 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more

future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23 where an inflow of economic benefits is probable.

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

Contingent liabilities are defined as:

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

**Note 1.15 Public dividend capital**

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts- and-foundation-trusts.

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

**Note 1.16 Value added tax**

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and

input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

**Note 1.17 Losses and special payments**

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

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

**Note 1.18 Gifts**

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

**Note 1.19 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

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

**IFRS 16 Leases**

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust is working with Real Asset Management to develop an electronic lease register that will automate the accounting entries for leasing under the new standard. Financial procedures and controls are being modified to incorporate the changes arising from the new standard.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

**Other standards, amendments and interpretations**

The following list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2020-21.

- IFRS 14 Regulatory Deferral Accounts – Applies to first time adopters of iFRS after 1 January 2016. Therefore not applicable to DHSC group bodies. Not EU-endorsed.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. It is likely to be adopted in 2023/24.

**Note 1.21 Critical judgements in applying accounting policies**

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

**Note 1.22 Sources of estimation uncertainty**

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

***Asset Valuations***

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

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

The Trust have considered the 31 March 2021 valuation for material uncertainty arising from the developing economic impact of the COVID-19 pandemic as relevant to property valuation inputs. While we note this as a factor that reduces certainty in property valuations, we do not consider this to be a material uncertainty at 31 March 2021. An explanation of this assessment is provided in note 15.

***Provisions***

Provisions are made for liabilities that are uncertain in amount. These include provisions for the cost of pensions relating to other staff, legal claims, restructuring and other provisions. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. The carrying values of provisions are shown in note 22.

***Annual Leave Accrual***

The accrual is based on management's estimation of untaken leave as at 31 March 2021. The carrying value of the accrual is £10.52m within note 19 under accruals.

***Injury Cost Recovery Scheme Accrual***

The Trust receives income from the NHS injury cost recovery scheme for the recovery of ambulance journey costs relating to road traffic accidents. Accruals are made for receivables that are uncertain in amount. The receivables are based on management estimates supported by the number of cases supplied by hospitals. The carrying value of the receivable is £3.45m within note 17 under prepayments and accrued income.

**Note 2 Operating Segments**

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

**Note 3 Operating income from patient care activities**

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

| **Note 3.1 Income from patient care activities (by nature)** | **2020/21** | **2019/20** |
|---|---|---|
| | **£000** | **£000** |
| A & E income* | 474,640 | 415,053 |
| Patient transport services income | - | (11) |
| Other income | 1,022 | 1,203 |
| Additional pension contribution central funding** | 13,105 | 12,163 |
| Other clinical income *** | 10,352 | - |
| **Total income from activities** | **499,119** | **428,408** |

* As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes.

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

*** Other clinical income comprises income from NHSE to cover expenditure in relation to increased annual leave accruals due to the impacts of COVID-19 on resourcing (£4.8m) and the settlement for certain sections of the Flowers case (£5.6m).

**Note 3.2 Income from patient care activities (by source)**

| | **2020/21** | **2019/20** |
|---|---|---|
| **Income from patient care activities received from:** | **£000** | **£000** |
| NHS England | 31,017 | 26,296 |
| Clinical commissioning groups | 464,818 | 397,514 |
| Department of Health and Social Care | 20 | 39 |
| Other NHS providers | 550 | 113 |
| NHS other | 6 | 194 |
| Local authorities | - | (11) |
| Injury cost recovery scheme | 1,022 | 1,203 |
| Non NHS: other | 1,686 | 3,060 |
| **Total income from activities** | **499,119** | **428,408** |
| **Of which:** | | |
| Related to continuing operations | 499,119 | 428,408 |
| Related to discontinued operations | - | - |

**Note 4 Other operating income**

| | 2020/21 | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| | Contract income | Non-contract income | Total | Contract income | Non-contract income | Total |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Research and development | 275 | - | **275** | 213 | - | **213** |
| Education and training | 4,624 | - | **4,624** | 4,671 | - | **4,671** |
| Provider sustainability fund (2019/20 only) | | | - | 3,143 | | **3,143** |
| Financial recovery fund (2019/20 only) | | | - | 1,591 | | **1,591** |
| Reimbursement and top up funding* | 60,850 | | **60,850** | | | - |
| Income in respect of employee benefits accounted on a gross basis | 523 | | **523** | 533 | | **533** |
| Receipt of capital grants and donations | | 539 | **539** | | - | - |
| Charitable and other contributions to expenditure** | | 4,393 | **4,393** | | - | - |
| **Total other operating income** | **66,272** | **4,932** | **71,204** | **10,151** | **-** | **10,151** |
| **Of which:** | | | | | | |
| Related to continuing operations | | | 71,204 | | | 10,151 |
| Related to discontinued operations | | | - | | | - |

* As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. Standard and retrospective top up payments received in the first half of the year to support Trust costs (including COVID-19 response costs) are reflected here.

** In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective and medical equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £4,191k of PPE and £146k of medical equipment purchased by DHSC along with £56k of charitable contributions to expenditure. Income to reflect these contributions is included here.

**Note 5 Expenses**

**Note 5.1 Operating expenses**

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| Staff and executive directors costs | 381,790 | 312,595 |
| Remuneration of non-executive directors | 138 | 109 |
| Supplies and services - clinical (excluding drugs costs) | 34,885 | 17,580 |
| Supplies and services - general | 38,970 | 16,707 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 520 | 708 |
| Inventories written down | 182 | (25) |
| Consultancy costs | 293 | 385 |
| Establishment | 10,898 | 11,153 |
| Premises | 14,549 | 9,485 |
| Transport (including patient travel) | 35,738 | 28,723 |
| Depreciation on property, plant and equipment | 12,975 | 10,411 |
| Amortisation on intangible assets | 1,573 | 1,124 |
| Net impairments | 1,473 | (55) |
| Movement in credit loss allowance: contract receivables / contract assets | 165 | 18 |
| Increase/(decrease) in other provisions | 91 | 377 |
| Change in provisions discount rate(s) | 400 | 671 |
| Audit fees payable to the external auditor | | |
| audit services- statutory audit | 140 | 86 |
| other auditor remuneration (external auditor only) | - | - |
| Internal audit costs | 142 | 109 |
| Clinical negligence | 4,703 | 3,711 |
| Legal fees | 161 | 1,302 |
| Insurance | 920 | 564 |
| Research and development | 831 | 941 |
| Education and training | 8,535 | 7,733 |
| Rentals under operating leases | 6,693 | 4,724 |
| Redundancy | 929 | 13 |
| Car parking & security | 520 | 1,190 |
| Hospitality | - | 2 |
| Other | 4,867 | 3,263 |
| **Total** | **563,081** | **433,604** |
| **Of which:** | | |
| Related to continuing operations | 563,081 | 433,604 |
| Related to discontinued operations | - | - |

Significant additional expenditure has been incurred in relation to the Trust's response to COVID-19 in 2020/21 with £85.8m of related expenditure reported across the full year (2019-20 figures were only impacted for a short period). Notable items include £48.2m incorporated in Staff and executive directors costs (2019/20: £4.36m), £11.6m incorporated in Supplies and services – clinical (excluding drugs costs) (2019/20: £2.33m), £10.9m incorporates in Supplies and Services – general (2019/20: £0.2m) and £9.3m incorporated in Transport (including patient travel) (2019/20: £0.85m) above.

**Note 5.2 Other auditor remuneration**

There was no other auditor remuneration in 2020/21 (2019/20 nil).

**Note 5.3 Limitation on auditor's liability**

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

**Note 6 Impairment of assets**

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| **Net impairments charged to operating surplus / deficit resulting from:** | | |
| Loss or damage from normal operations | - | - |
| Over specification of assets | - | - |
| Abandonment of assets in course of construction | - | - |
| Unforeseen obsolescence | - | - |
| Loss as a result of catastrophe | - | - |
| Changes in market price | 1,473 | (55) |
| Other | - | - |
| **Total net impairments charged to operating surplus / deficit** | **1,473** | **(55)** |
| Impairments charged to the revaluation reserve | 6,043 | (297) |
| **Total net impairments** | **7,516** | **(352)** |

**Note 7 Employee benefits**

| | 2020/21 Total £000 | 2019/20 Total £000 |
|---|---|---|
| Salaries and wages | 306,591 | 243,662 |
| Social security costs | 32,186 | 27,216 |
| Apprenticeship levy | 1,415 | 1,216 |
| Employer's contributions to NHS pensions * | 43,194 | 39,998 |
| Pension cost - other | - | - |
| Other post employment benefits | - | - |
| Other employment benefits | - | - |
| Termination benefits | 929 | 13 |
| Temporary staff (including agency) | 6,817 | 8,521 |
| **Total gross staff costs** | **391,132** | **320,626** |
| Recoveries in respect of seconded staff | - | - |
| **Total staff costs** | **391,132** | **320,626** |
| **Of which** | | |
| Costs capitalised as part of assets | 1,161 | 1,314 |

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

**Note 7.1 Retirements due to ill-health**

During 2020/21 there were 2 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £57k (£202k in 2019/20).

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

**Note 8 Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

**Note 9 Operating leases**

**Note 9.1 London Ambulance Service NHS Trust as a lessee**
This note discloses costs and commitments incurred in operating lease arrangements where London Ambulance Service NHS Trust is the lessee.

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

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| **Operating lease expense** | | |
| Minimum lease payments | 6,693 | 4,724 |
| **Total** | **6,693** | **4,724** |

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| | £000 | £000 |
| **Future minimum lease payments due:** | | |
| - not later than one year; | 3,735 | 3,808 |
| - later than one year and not later than five years; | 7,084 | 7,370 |
| - later than five years. | 1,889 | 2,356 |
| **Total** | **12,708** | **13,534** |
| Future minimum sublease payments to be received | - | - |

**Note 10 Finance income**

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

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| Interest on bank accounts | (4) | 186 |
| Other finance income | 13 | 3 |
| **Total finance income** | **9** | **189** |

**Note 11 Finance expenditure Note 11.1 Finance expenditure**

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

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| **Interest expense:** | | |
| Interest on late payment of commercial debt | 9 | 20 |
| **Total interest expense** | **9** | **20** |
| Unwinding of discount on provisions | (45). | 25 |
| **Total finance costs** | **(36)** | **45** |

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

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| Total liability accruing in year under this legislation as a result of late payments | - | - |
| Amounts included within interest payable arising from claims made under this legislation | 9 | 20 |
| Compensation paid to cover debt recovery costs under this legislation | - | - |

**Note 12 Other gains / (losses)**

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| Gains on disposal of assets | 17 | - |
| Losses on disposal of assets | (410) | (59) |
| **Total gains / (losses) on disposal of assets** | **(393)** | **(59)** |

## Note 13 Intangible Assets

### Note 13.1 Intangible assets – 2020/21

| | Software licences | Licences & trademarks | Patents | Internally generated information technology | Development expenditure | Goodwill | Websites | Intangible assets under construction | Other (purchased) | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2020 – brought forward** | **3,361** | **-** | **-** | **18,699** | **-** | **-** | **-** | **5,615** | **-** | **27,675** |
| Additions | 2,400 | - | - | 611 | - | - | - | 3,724 | - | 6,735 |
| Reclassifications | 2,718 | - | - | 1,335 | - | - | - | (3,951) | - | 102 |
| Disposals / derecognition | - | - | - | (503) | - | - | - | - | - | (503) |
| **Valuation / gross cost at 31 March 2021** | **8,479** | **-** | **-** | **20,142** | **-** | **-** | **-** | **5,388** | **-** | **34,009** |
| | | | | | | | | | | |
| **Amortisation at 1 April 2020 – brought forward** | 2,569 | - | - | 16,923 | - | - | - | - | - | 19,492 |
| Provided during the year | 613 | - | - | 960 | - | - | - | - | - | 1,573 |
| Reclassifications | - | - | - | - | - | - | - | - | - | - |
| Disposals / derecognition | - | - | - | (146) | - | - | - | - | - | (146) |
| **Amortisation at 31 March 2021** | **3,182** | **-** | **-** | **17,737** | **-** | **-** | **-** | **-** | **-** | **20,919** |
| | | | | | | | | | | |
| **Net book value at 31 March 2021** | **5,297** | **-** | **-** | **2,405** | **-** | **-** | **-** | **5,388** | **-** | **13,090** |
| **Net book value at 1 April 2020** | **792** | **-** | **-** | **1,776** | **-** | **-** | **-** | **5,615** | **-** | **8,183** |

## Note 13.2 Intangible assets – 2019/20

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

## Note 14 Property, Plant and Equipment

### Note 14.1 Property, plant and equipment – 2020/21

| | 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 2020 – brought forward** | **52,232** | **64,362** | **-** | **21,883** | **20,429** | **56,920** | **20,064** | **1,165** | **237,055** |
| Additions | - | 4,731 | - | 24,908 | 1,635 | 2,220 | 3,350 | 401 | **37,245** |
| Impairments | - | (10,769) | - | - | - | - | - | - | **(10,769)** |
| Reversals of impairments | - | (34) | - | - | - | - | - | - | **(34)** |
| Revaluations | 275 | (80) | - | - | - | - | - | - | **195** |
| Reclassifications | - | 1,983 | - | (18,621) | 1,488 | 12,185 | 2,670 | 193 | **(102)** |
| Disposals / derecognition | - | (98) | - | - | (118) | (91) | (676) | - | **(983)** |
| **Valuation/gross cost at 31 March 2021** | **52,507** | **60,095** | **-** | **28,169** | **23,434** | **71,234** | **25,408** | **1,759** | **262,607** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2020 – brought forward** | **-** | **7** | **-** | **-** | **15,880** | **30,320** | **13,523** | **142** | **59,872** |
| Provided during the year | - | 3,453 | - | - | 1,252 | 5,644 | 2,457 | 169 | **12,975** |
| Impairments | - | (3,250) | - | - | - | - | - | - | **(3,250)** |
| Reversals of impairments | - | (37) | - | - | - | - | - | - | **(37)** |
| Revaluations | - | (127) | - | - | - | - | - | - | **(127)** |
| Reclassifications | - | - | - | - | - | - | - | - | - |
| Disposals / derecognition | - | (5) | - | - | (118) | (87) | (668) | - | **(878)** |
| **Accumulated depreciation at 31 March 2021** | **-** | **41** | **-** | **-** | **17,014** | **35,877** | **15,312** | **311** | **68,555** |
| | | | | | | | | | |
| **Net book value at 31 March 2021** | **52,507** | **60,054** | **-** | **28,169** | **6,420** | **35,357** | **10,096** | **1,448** | **194,052** |
| **Net book value at 1 April 2020** | **52,232** | **64,355** | **-** | **21,883** | **4,549** | **26,600** | **6,541** | **1,023** | **177,183** |

**Note 14.2 Property, plant and equipment – 2019/20**

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

**Note 14.3 Property, plant and equipment financing – 2020/21**

| | 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 2021** | | | | | | | | | |
| Owned - purchased | 52,507 | 60,054 | - | 28,169 | 6,372 | 35,249 | 10,096 | 1,448 | **193,896** |
| Owned - donated/granted | - | - | - | - | 48 | 108 | - | - | **156** |
| **NBV total at 31 March 2021** | **52,507** | **60,054** | **-** | **28,169** | **6,420** | **35,357** | **10,096** | **1,448** | **194,052** |

**Note 14.4 Property, plant and equipment financing – 2019/20**

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

**Note 15 Revaluations of property, plant and equipment**

A professional revaluation was undertaken on all land and buildings at 31 March 2021.

The valuation was carried out by District Valuer Services of the Valuation Office Agency, an executive arm of HMRC, out in accordance with the terms of the Royal Institution of Chartered Surveyors (RICS), insofar as these terms are consistent with the requirement of HM Treasury, the National Services and the Department of Health.

The valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021 on a desktop valuation basis.

This year the valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, our valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

a) Specialised In Use (Operational) assets – buildings valued using depreciated replacement cost methodology The majority of the trust buildings are valued using the depreciated replacement cost basis. There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19.

b) Non – Specialised In Use (Operational) assets including the land element of the depreciated replacement cost valuation of specialised assets
The trust has a few non-specialised in use buildings. There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. Their basis of valuation is however current value in existing use, having regard to comparable market evidence.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements.

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

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

The revaluation model set out in IAS 16 was applied to value the capital assets to fair value.
The following table summarises the gross carrying value of fully depreciated assets that are still in use.

**GROSS CARRYING VALUE OF ASSETS IN USE**

| | **2020/21** |
|---|---|
| | **£000** |
| Furniture & fittings | 56 |
| Transport equipment | 11,330 |
| Plant & machinery | 12,070 |
| Information technology | 9,264 |
| Total | **32,720** |

**Note 16 Inventories**

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Drugs | 333 | 150 |
| Consumables | 6,107 | 4,358 |
| **Total inventories** | **6,440** | **4,508** |
| **of which:** | | |
| Held at fair value less costs to sell | - | - |

Inventories recognised in expenses for the year were £12,355k (2019/20: £9,834k). Write-down of inventories recognised as expenses for the year were £182k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £4,191k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

## Note 17 Receivables

### Note 17.1 Receivables

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| **Current** | | |
| Contract receivables | 21,110 | 17,419 |
| Capital receivables | 96 | 51 |
| Allowance for impaired contract receivables / assets | (1,085) | (920) |
| Prepayments (non-PFI) | 7,069 | 4,805 |
| Interest receivable | - | 10 |
| PDC dividend receivable | 708 | - |
| VAT receivable | 617 | 468 |
| Other receivables | 790 | 437 |
| **Total current receivables** | **29,305** | **22,270** |
| **Non-current** | | |
| Contract receivables | - | - |
| Contract assets | - | - |
| Capital receivables | - | - |
| Allowance for impaired contract receivables / assets | - | - |
| Prepayments (non-PFI) | - | - |
| Interest receivable | - | - |
| VAT receivable | - | - |
| Other receivables | - | - |
| **Total non-current receivables** | **-** | **-** |
| **Of which receivable from NHS and DHSC group bodies:** | | |
| Current | 16,680 | 12,614 |
| Non-current | - | - |

### Note 17.2 Allowances for credit losses

| | 2020/21 Contract receivables and contract assets | All other receivables | 2019/20 Contract receivables and contract assets | All other receivables |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Allowances as at 1 April – brought forward** | **920** | **-** | **5,668** | **-** |
| Prior period adjustments | | | - | - |
| **Allowances as at 1 April – restated** | **920** | **-** | **5,668** | **-** |
| New allowances arising | 179 | - | 58 | - |
| Reversals of allowances | (14) | - | (40) | - |
| Utilisation of allowances (write offs) | - | - | (4,766) | - |
| **Allowances as at 31 Mar 2021** | **1,085** | **-** | **920** | **-** |

**Note 18 Cash and cash equivalents movements**

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

| | 2020/21 | 2019/20 |
|---|---|---|
| | £000 | £000 |
| **At 1 April** | **25,964** | **21,718** |
| Prior period adjustments | - | - |
| **At 1 April (restated)** | **25,964** | **21,718** |
| Net change in year | 13,823 | 4,246 |
| **At 31 March** | **39,787** | **25,964** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 9 | 8 |
| Cash with the Government Banking Service | 39,778 | 25,956 |
| Deposits with the National Loan Fund | - | - |
| Other current investments | - | - |
| **Total cash and cash equivalents as in SoFP** | **39,787** | **25,964** |
| Bank overdrafts (GBS and commercial banks) | - | - |
| Drawdown in committed facility | - | - |
| **Total cash and cash equivalents as in SoCF** | **39,787** | **25,964** |

## Note 19 Payables

### Note 19.1 Trade and other payables

| | 31 March 2020/21 £000 | 31 March 2019/20 £000 |
|---|---|---|
| **Current** | | |
| Trade payables | 5,409 | 6,807 |
| Capital payables | 13,279 | 8,786 |
| Accruals | 49,599 | 20,125 |
| Social security costs | 4,465 | 3,998 |
| Other taxes payable | 3,541 | 2,939 |
| PDC dividend payable | - | 52 |
| Other payables | 4,709 | 4,108 |
| **Total current trade and other payables** | **81,002** | **46,815** |
| **Non-current** | | |
| Trade payables | - | - |
| Capital payables | - | - |
| Accruals | - | - |
| Other taxes payable | - | - |
| Other payables | - | - |
| **Total non-current trade and other payables** | **-** | **-** |
| **Of which payables from NHS and DHSC group bodies:** | | |
| Current | 1,099 | 969 |
| Non-current | - | - |

**Note 20 Other liabilities**

| | 31 March 2020/21 £000 | 31 March 2019/20 £000 |
|---|---|---|
| **Current** | | |
| Deferred income: contract liabilities | 251 | 193 |
| **Total other current liabilities** | **251** | **193** |
| | | |
| **Non-current** | | |
| Deferred income: contract liabilities | - | - |
| **Total other non-current liabilities** | **-** | **-** |

**Note 21 Borrowings**

| | 31 March 2020/21 £000 | 31 March 2019/20 £000 |
|---|---|---|
| **Current** | | |
| Bank overdrafts | - | - |
| Other loans | - | - |
| **Total current borrowings** | **-** | **-** |
| | | |
| **Non-current** | | |
| Other loans | 107 | 107 |
| **Total non-current borrowings** | **107** | **107** |

**Note 21.1 Reconciliation of liabilities arising from financing activities – 2020/21**

| | Loans from DHSC | Other loans | Finance leases | PFI and LIFT schemes | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April 2020** | **-** | **107** | **-** | **-** | **107** |
| **Cash movements:** | | | | | |
| Financing cash flows - payments and receipts of principal | - | - | - | - | - |
| Financing cash flows - payments of interest | - | - | - | - | - |
| **Non-cash movements:** | | | | | |
| Additions | - | - | - | - | - |
| Application of effective interest rate | - | - | - | - | - |
| Change in effective interest rate | - | - | - | - | - |
| Changes in fair value | - | - | - | - | - |
| Early terminations | - | - | - | - | - |
| Other changes | - | - | - | - | - |
| **Carrying value at 31 March 2021** | **-** | **107** | **-** | **-** | **107** |

**Note 21.2 Reconciliation of liabilities arising from financing activities – 2019/20**

| | Loans from DHSC | Other loans | Finance leases | PFI and LIFT schemes | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April 2019** | **-** | **107** | **-** | **-** | **107** |
| Prior period adjustment | - | - | - | - | - |
| **Carrying value at 1 April 2018 – restated** | **-** | **107** | **-** | **-** | **107** |
| **Cash movements:** | | | | | |
| Financing cash flows - payments and receipts of principal | - | - | - | - | - |
| Financing cash flows - payments of interest | - | - | - | - | - |
| **Non-cash movements:** | | | | | |
| Additions | - | - | - | - | - |
| Application of effective interest rate | - | - | - | - | - |
| Change in effective interest rate | - | - | - | - | - |
| Changes in fair value | - | - | - | - | - |
| Early terminations | - | - | - | - | - |
| Other changes | - | - | - | - | - |
| **Carrying value at 31 March 2020** | **-** | **107** | **-** | **-** | **107** |

## Note 22 Provisions

### Note 22.1 Provisions for liabilities and charges analysis

| | Pensions: early departure costs | Pensions: injury benefits | Legal claims | Re-structuring | Equal Pay (including Agenda for Change) | Redundancy | Other | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **At 1 April 2020** | **1,234** | **7,771** | **320** | **-** | **-** | **-** | **5,695** | **15,020** |
| Change in the discount rate | 22 | 378 | - | - | - | - | - | **400** |
| Arising during the year | 12 | 148 | 256 | - | - | 829 | 2,904 | **4,149** |
| Utilised during the year | (154) | (417) | (216) | - | - | - | (814) | **(1,601)** |
| Reversed unused | - | - | (107) | - | - | - | (1,878) | **(1,985)** |
| Unwinding of discount | (6) | (39) | - | - | - | - | - | **(45)** |
| **At 31 March 2021** | **1,108** | **7,841** | **253** | **-** | **-** | **829** | **5,907** | **15,938** |
| **Expected timing of cash flows:** | | | | | | | | |
| - not later than one year; | 151 | 417 | 253 | - | - | 829 | 5,907 | **7,557** |
| - later than one year and not later than five years; | 603 | 1,710 | - | - | - | - | - | **2,313** |
| - later than five years. | 354 | 5,714 | - | - | - | - | - | **6,068** |
| **Total** | **1,108** | **7,841** | **253** | **-** | **-** | **829** | **5,907** | **15,938** |

Injury Benefits provision of £7,841k (2019/20 £7,771k) relates to staff injured at work, whilst the Early Departure Costs provision of £1,108k (2019/20 £1,234k) relates to staff who have taken early retirement. Both amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of -0.95% is applied.

The Legal Claims provision of £253k (2019/20 £320k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

There Redundancy provision of £829k (2019/20 nil) relates to management restructures within the Trust.

Other provisions of £5,907k (2019/20 £5,695k) includes £4,306k in relation to pending legal cases affecting calculation of holiday pay, £604k for pending employment tribunals, £306k in relation to whether team leader allowances are pensionable, £317k for potential service level penalty provisions and £374k in relation to relocation costs for recruitment of overseas paramedics.

**Note 22.2 Clinical negligence liabilities**

At 31 March 2021, £74,378k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of London Ambulance Service NHS Trust (31 March 2020: £64,277k).

**Note 23 Contingent assets and liabilities**

| | 31 March 2020/21 £000 | 31 March 2019/20 £000 |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (119) | (170) |
| Employment tribunal and other employee related litigation | - | - |
| Redundancy | - | - |
| Other | - | - |
| **Gross value of contingent liabilities** | **(119)** | **(170)** |
| Amounts recoverable against liabilities | - | - |
| **Net value of contingent liabilities** | **(119)** | **(170)** |
| **Net value of contingent assets** | **-** | **-** |

**Note 24 Contractual capital commitments**

| | 31 March 2020/21 £000 | 31 March 2019/20 £000 |
|---|---|---|
| Property, plant and equipment | 5,735 | 3,765 |
| Intangible assets | 3 | 279 |
| **Total** | **5,738** | **4,044** |

**Note 25 Financial instruments**

**Note 25.1 Financial risk management**

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

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

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

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

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

The Trust therefore has low exposure to interest rate fluctuations.

**Credit risk**
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

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

**Note 25.2 Carrying values of financial assets**

| Carrying values of financial assets as at 31 March 2021 | Held at amortised cost | Held at fair value through I&E | Held at fair value through OCI | Total book value |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Trade and other receivables excluding non financial assets | 20,911 | - | - | 20,911 |
| Other investments / financial assets | - | - | - | - |
| Cash and cash equivalents | 39,787 | - | - | 39,787 |
| **Total at 31 March 2021** | **60,698** | **-** | **-** | **60,698** |

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

**Note 25.3 Carrying values of financial liabilities**

| Carrying values of financial liabilities as at 31 March 2021 | Held at amortised cost | Held at fair value through I&E | Total book value |
|---|---|---|---|
| | £000 | £000 | £000 |
| Other borrowings | 107 | - | 107 |
| Trade and other payables excluding non financial liabilities | 68,676 | - | 68,676 |
| **Total at 31 March 2021** | **68,783** | **-** | **68,783** |

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

**Note 25.4 Maturity of financial liabilities**

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

| | 31 March 2021 | 31 March 2020 restated* |
|---|---|---|
| | £000 | £000 |
| In one year or less | 68,676 | 39,826 |
| In more than one year but not more than five years | 107 | 107 |
| In more than five years | - | - |
| **Total** | **68,783** | **39,933** |

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis, however there has been nil impact on balances reported.

**Note 25.5 Fair values of financial assets and liabilities**

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

**Note 26 Losses and special payments**

| | 2020/21 | | 2019/20 | |
|---|---|---|---|---|
| | Total number of cases | Total value of cases | Total number of cases | Total value of cases |
| | Number | £000 | Number | £000 |
| **Losses** | | | | |
| Cash losses | - | - | 1 | 5 |
| Bad debts and claims abandoned | - | - | 12 | 12 |
| Stores losses and damage to property | 2,076 | 1,083 | 2,320 | 927 |
| **Total losses** | **2,076** | **1,083** | **2,333** | **944** |
| **Special payments** | | | | |
| Ex-gratia payments | 25 | 802 | 19 | 584 |
| **Total special payments** | **25** | **802** | **19** | **584** |
| **Total losses and special payments** | **2,101** | **1,885** | **2,352** | **1,528** |
| Compensation payments received | | - | | - |

**Note 27 Related parties**

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

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

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

| | Payments to Related Party | Receipts from Related Party | Amounts owed to Related Party | Amounts due from Related Party |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| NHS Barking and Dagenham CCG | - | 11,307 | 8 | - |
| NHS Brent CCG | - | 16,454 | - | 730 |
| NHS Central London (Westminster) CCG | - | 64,285 | - | 2,500 |
| NHS City and Hackney CCG | - | 14,240 | 9 | - |
| NHS Ealing CCG | - | 15,030 | - | - |
| NHS England | 116 | 76,168 | 27 | 10,579 |
| NHS Havering CCG | - | 13,763 | 7 | - |
| NHS Hillingdon CCG | - | 14,539 | - | - |
| NHS Hounslow CCG | - | 17,673 | - | - |
| NHS Newham CCG | - | 15,743 | 9 | - |
| NHS North Central London CCG | (2) | 63,862 | - | 2 |
| NHS Redbridge CCG | - | 13,639 | 9 | 43 |
| NHS South East London CCG | 48 | 90,757 | - | 594 |
| NHS South West London CCG | - | 59,422 | - | - |
| NHS Tower Hamlets CCG | - | 16,201 | 8 | - |
| NHS Waltham Forest CCG | - | 12,082 | 10 | 674 |
| NHS West London (K&C & QPP) CCG | - | 10,512 | - | - |

The Trust has a number of staff who or volunteer for St John Ambulance Service. Transactions with St John Ambulance Service during the year comprised expenditure of £1,788k (2019/20 £1,858k), income of £Nil (2019/20 £Nil) and the amount payable by the Trust as at 31 March 2021 was £Nil (31 March 2020 £115k).

Fenella Wrigley has worked for the following organisations that have had transactions with the Trust during 2020/21. Receipts from related parties Home Office £1k (2019/20 £128k) and Barts Hospital £488k (2019/20 £60k). Payments to Barts Hospital was £120k (2019/20 £120k). Amounts due from Barts Hospital is £79k (2019/20 £45k) and Home Office is £Nil (2019/20 £35k).

The London Ambulance Service NHS Trust acts as corporate trustee for the London Ambulance Service Charity. During the financial year ending 31 March 2021 the Trust received grants of £142k (2019/20 £Nil).

**Note 28 Events after the reporting date**

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

**Note 29 Better Payment Practice code**

| | 2020/21 Number | 2020/21 £000 | 2019/20 Number | 2019/20 £000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total non-NHS trade invoices paid in the year | 57,095 | 284,756 | 53,149 | 191,362 |
| Total non-NHS trade invoices paid within target | 53,746 | 267,506 | 47,325 | 176,414 |
| Percentage of non-NHS trade invoices paid within target | 94.1% | 93.9% | 89.0% | 92.2% |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 448 | 3,390 | 380 | 2,506 |
| Total NHS trade invoices paid within target | 372 | 2,905 | 333 | 1,998 |
| Percentage of NHS trade invoices paid within target | 83.0% | 85.7% | 87.6% | 79.7% |

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

**Note 30 External financing limit**

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

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Cash flow financing | (2,161) | (2,511) |
| Finance leases taken out in year | - | - |
| Other capital receipts | - | - |
| **External financing requirement** | **(2,161)** | **(2,511)** |
| External financing limit (EFL) | 31,659 | 8,395 |
| **Under / (over) spend against EFL** | **33,820** | **10,906** |

**Note 31 Capital Resource Limit**

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Gross capital expenditure | 43,980 | 22,532 |
| Less: Disposals | (462) | (145) |
| Less: Donated and granted capital additions | (539) | - |
| Plus: Loss on disposal from capital grants in kind | - | - |
| **Charge against Capital Resource Limit** | **42,979** | **22,387** |
| Capital Resource Limit | 44,054 | 22,675 |
| **Under / (over) spend against CRL** | **1,075** | **288** |

**Note 32 Breakeven duty financial performance**

| | 2020/21 £000 |
|---|---|
| Adjusted financial performance surplus / (deficit) (control total basis) | 2,559 |
| Remove impairments scoring to Departmental Expenditure Limit | - |
| Add back non-cash element of On-SoFP pension scheme charges | - |
| IFRIC 12 breakeven adjustment | - |
| **Breakeven duty financial performance surplus / (deficit)** | **2,559** |

**Note 33 Breakeven duty rolling assessment**

| | 1997/98 to 2008/09 £000 | 2009/10 £000 | 2010/11 £000 | 2011/12 £000 | 2012/13 £000 | 2013/14 £000 | 2014/15 £000 |
|---|---|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | | 1,425 | 1,002 | 2,751 | 262 | 262 | 6,048 |
| Breakeven duty cumulative position | 2,569 | 3,994 | 4,996 | 7,747 | 8,009 | 8,271 | 14,319 |
| Operating income | | 279,864 | 283,617 | 281,731 | 303,109 | 303,827 | 324,052 |
| Cumulative breakeven position as a percentage of operating income | | 1.4% | 1.8% | 2.7% | 2.6% | 2.7% | 4.4% |

| | 2015/16 £000 | 2016/17 £000 | 2017/18 £000 | 2018/19 £000 | 2019/20 £000 | 2020/21 £000 |
|---|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | (4,405) | 6,143 | 5,758 | 6,958 | 174 | 2,559 |
| Breakeven duty cumulative position | 9,914 | 16,057 | 21,815 | 28,773 | 28,947 | 31,506 |
| Operating income | 319,992 | 355,507 | 364,598 | 388,978 | 438,559 | 570,323 |
| Cumulative breakeven position as a percentage of operating income | 3.1% | 4.5% | 6.0% | 7.4% | 6.6% | 5.5% |

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

# Appendix – Glossary of Terms

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

## STATEMENT OF COMPREHENSIVE INCOME

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

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

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

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

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

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

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

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

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

## STATEMENT OF FINANCIAL POSITION

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

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

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

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

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

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

## NOTES TO THE ACCOUNTS

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

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

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

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

### Prepayments
Where the Trust has paid in advance for goods or services – for example, quarterly payment in advance for telephone rentals.

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

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

## TERMINOLOGY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


London Ambulance Service
NHS Trust

# Annual Report & Accounts 2020/21

London Ambulance Service NHS Trust
Headquarters
220 Waterloo Road
London
SE1 8SD
www.londonambulance.nhs.uk