Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Annual Report • Quality Accounts • Financial Summary **2010-11**

Annual Report 2010-11

Contents

Mission, Vision and Values

Mission

Saving lives, caring for you

Vision

To provide an ambulance service for Yorkshire which is continuously improving patient care, high performing, always learning and delivers value for money.

Values

Working together for patients
We work with others to give the best care we can

Everyone counts
We act with openness, honesty and integrity – listening to and acting on feedback from patients, staff and partners

Commitment to quality of care
We always give the highest level of clinical care

Always compassionate
Our staff are professional, dedicated and caring

Respect and dignity
We treat everyone with dignity, courtesy and respect

Enhancing and improving lives
We continuously seek out improvements

Introducing Yorkshire Ambulance Service

Yorkshire Ambulance Service NHS Trust (YAS) was established on 1 July 2006 when the county's three former services merged.

We provide:

- **an access and response service where staff in our 999 communications centres deploy the most appropriate response to meet patients' needs**
- **an accident and emergency service in response to 999 calls**
- **a patient transport service which takes non-emergency patients to and from their hospital appointments**
- **a GP out-of-hours call handling service for some primary care trusts (PCTs) across Yorkshire and beyond.**

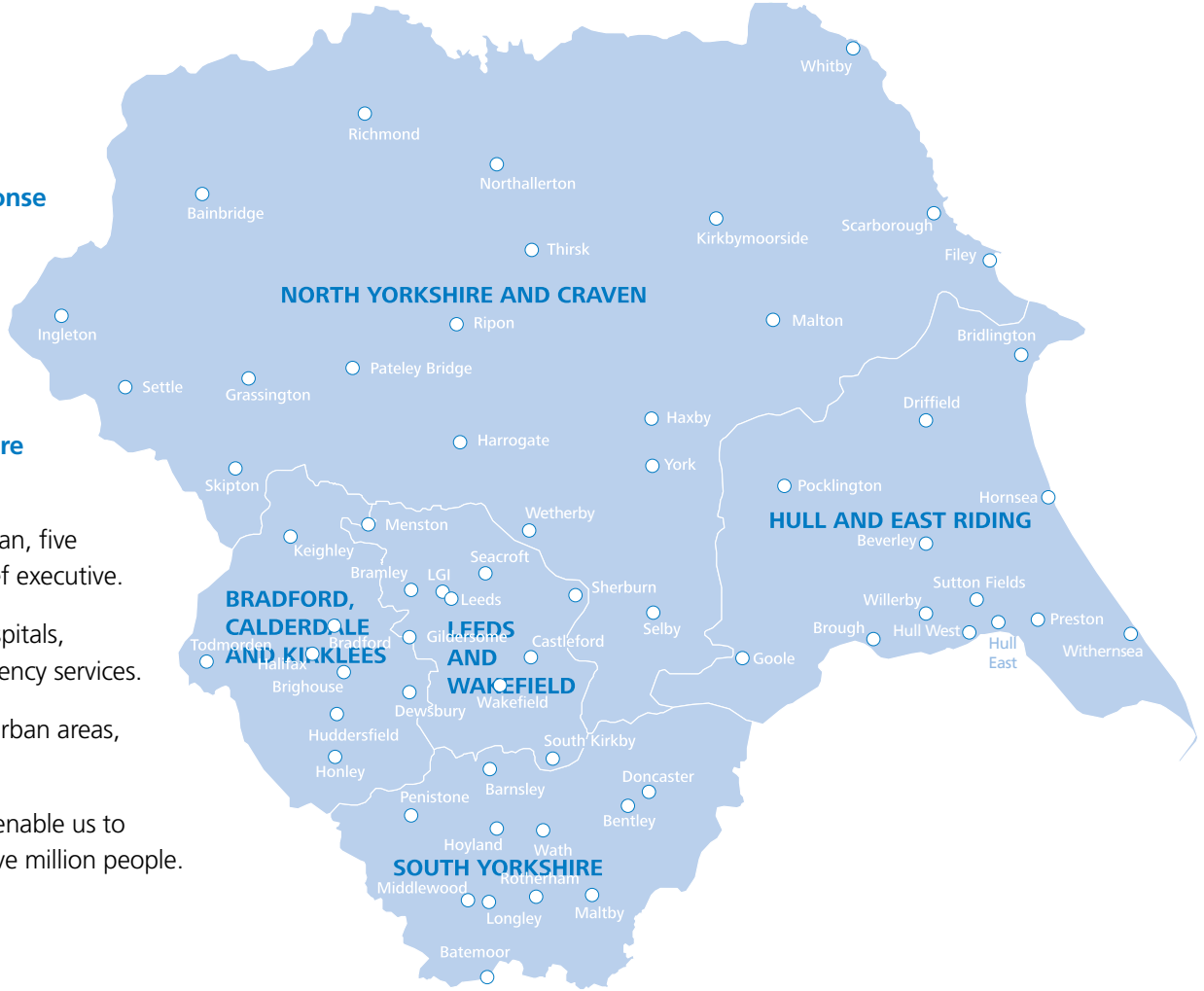
We are led by a Trust Board which comprises a non-executive chairman, five non-executive directors and six executive directors, including the chief executive.

As an integral part of the NHS in Yorkshire, we work closely with hospitals, health trusts and healthcare professionals as well as the other emergency services.

We cover the whole of Yorkshire, from isolated moors and dales to urban areas, coastline and inner cities.

We employ 4,463* staff, who together with over 3,517 volunteers, enable us to provide a 24-hour emergency and healthcare service to more than five million people.

**4,463 is a headcount figure. It equates to 3,843 full-time equivalents.*

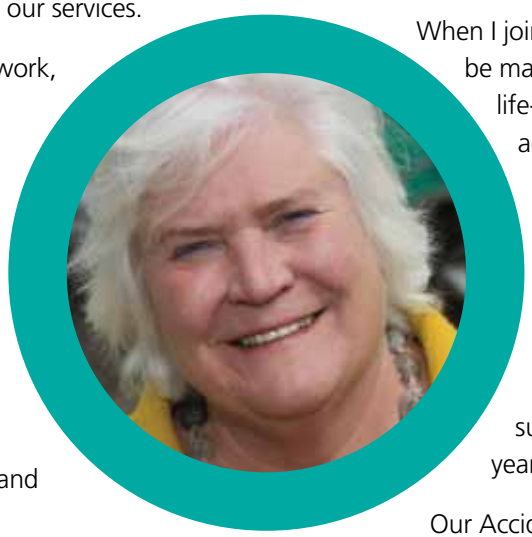



AMBULANCE

Chairman's Introduction

Welcome to Yorkshire Ambulance Service's Annual Report, Quality Accounts and Financial Summary for 2010-11 which aim to provide you with a good understanding of the progress that has been made during the last year by your local ambulance service and our priorities for the future. It has been a challenging year across all areas but the Trust has performed well against many of our key objectives for 2010-11, which included clinical excellence, quality, resilience and providing the best possible value for money for our services.

The Trust's numerous achievements are a tribute to the hard work, professionalism and expertise of staff and volunteers, from those who operate in often challenging circumstances on the frontline and in our 999 communications and call centres to those who work tirelessly behind the scenes in our support services. In recognition of the outstanding commitment and dedication of our staff, we held long service and retirement award ceremonies in November 2010 and February 2011 where 284 employees were honoured for reaching their 20, 30 and 40 year service milestones, and for retiring after a significant length of time with the ambulance service. The excellence, wellbeing and personal development of our staff and volunteers are key to the Trust's success and future plans.



An important part of our work programme this year has been to start the application process to become a Foundation Trust (FT). This process will give us greater freedoms, both from central government control and the way we spend our income. Becoming an FT will help us be more accountable to our staff and the public we serve.

During 2010-11 we made good progress in a number of key areas which contribute to our objective of improving quality, outcomes and the experience of our patients. We should all be proud of the fact that we have been ranked among the top ambulance services in the country for the clinical care we provide for conditions including ST Elevation Myocardial Infarction (STEMI - a type of heart attack), cardiac arrest, stroke, hypoglycaemia and asthma.

When I joined YAS on 10 May 2010, improvements were starting to be made in relation to the time it takes to reach patients with life-threatening illnesses or injuries (classified as Category A) against the national standard of 75% within eight minutes.

The exceptionally severe weather experienced in December 2010 and January 2011 effectively masked the significant improvements which had been made between April and November 2010. Our end-of-year position against the Category A target was 73.7%, compared to 70.8% the previous year, and is a positive reflection of the sustained focus on operational performance throughout the year. Well done to all staff for their efforts.

Our Accident and Emergency (A&E) service is commissioned and defined through a consortium arrangement of the 12 Yorkshire PCTs, led by NHS Bradford and Airedale. Many of our patients do not need to be taken to hospital for treatment and we are providing many of them with more appropriate care by treating more patients at home and offering more clinical advice over the telephone. We are looking forward to working with our commissioners to further develop this aspect of our service delivery.

There is increasing focus on our Emergency Preparedness team which plays a crucial role in our response to major incidents such as flooding, public transport accidents, pandemic flu and chemical incidents.

A key aim of the Trust is to embed environmental awareness and understanding into the organisation and we are well on the way to reducing our carbon footprint by 34% by 2015. A member of staff at each ambulance station and workplace has been appointed as a Carbon Champion to help the Trust reduce its carbon emissions. Many new initiatives and technologies have been introduced, including upgrading heating and boiler systems, replacing lighting, providing eco-driver training and participating in the Bikes for the NHS scheme.

We will be looking to develop the commercial focus of the organisation so that we are well placed to take advantage of opportunities that become available to us in the future.

Looking to the years ahead, the challenges and opportunities for ambulance trusts are numerous and we will all have to work hard to improve quality of care whilst reducing costs and maximising efficiency. As we make progress towards becoming an FT, 2011-12 is an important year in the preparation process and the needs of our patients will continue to be our motivation when determining the shape of our services for the future. I am confident that we can build on the well-deserved improvements we have made over recent years.

Della Cannings
Chairman

Chief Executive's Welcome

When I joined Yorkshire Ambulance Service on 1 February 2011 as the new Chief Executive, I was immediately struck by the overwhelming commitment of staff and the progress that has been made as a result of this dedication. I am looking forward to working with our staff and stakeholders to ensure we strive to deliver the highest quality of service for our patients.

A key focus of mine and our Board has been to develop our five-year strategic plan to set an ambitious and coherent strategy for the future. During our journey we plan to become an FT which is all about ensuring we are a well-governed organisation, with a clear strategy, focused on high quality, safe services and also ensuring we are financially viable for the long term.

On 1 April 2011 the emergency performance targets for ambulance services changed and we will now be measured by a set of clinical quality indicators (see page 38 of the Quality Accounts). This is excellent news as the effectiveness of our emergency service will not solely focus on our speed of response, but importantly the quality and safety of the care we provide, the clinical difference that care makes, and patients' experience of the services we provide.

Also during 2011-12, as with all other public sector organisations, we will have to make efficiency savings so that we are offering high quality services that represent good value for money. This means we will be looking to change the way in which we deliver our vital services, leading to improved levels of satisfaction from those who use our services and importantly to improve clinical outcomes for all our patients.

Significant progress has been made by everyone within the organisation despite it being a challenging year with increased demand for our services combined with one of the worst winters in recent times. We will build on the improvements that have been made and I am looking forward to a successful forthcoming year.

David Whiting
Chief Executive

Performance

A&E Operations

Significant improvements were made to our emergency response times in 2010-11 and between April and October we were reaching patients more quickly than ever before. This was recognised by the Care Quality Commission (CQC) in September.

Like the majority of the country, Yorkshire was hit by one of the worst winters in living memory with a prolonged period of snow, ice and sub-zero temperatures causing an increase in demand, treacherous road conditions and increased drive times for our frontline staff.

Our 999 A&E service had its busiest day on New Year's Day with 2,550 incidents, the most calls we have had in a day since the Trust was formed in 2006.

Staff worked tirelessly and, in many instances, went above and beyond the normal call of duty to help maintain our essential services, and we are also grateful for the support provided by mountain rescue teams, coastguard and a number of voluntary organisations such as St John Ambulance.

It took until March 2011 for the Trust to fully recover from the winter challenges.

In relation to the national target of reaching 75% of Category A patients with life-threatening illnesses or conditions within eight minutes, we finished the year at 73.7%. This was an increase of almost three percentage points on the previous year, making YAS one of the most improved ambulance services in England, despite a 2.8% overall increase in the number of incidents where patients required emergency or urgent medical assistance.

Whilst our prompt arrival at the scene of an incident makes a difference, the quality of care provided by our clinicians is just as important and we have been ranked among the top ambulance services in the country for the clinical care we give to patients.

We have continued to achieve top scores in the five nationally-agreed clinical performance indicators (CPIs) for cardiac arrest, asthma, stroke, hypoglycemia and ST Elevation Myocardial Infarction (a type of heart attack). This demonstrates an excellent joint effort from clinical and operational managers, clinical staff and training schools to ensure we can provide the very best clinical care.

YAS is continually developing its A&E Operations to ensure we can continue to provide a first-class service to patients.

Some of our achievements over the last 12 months include:

- **introducing new operational models which work on the basis of sending an initial rapid response vehicle (RRV) to most incidents and then determining, after assessment, the next level of care required**
- **new ways of mobilising ambulance clinicians to incidents to speed up our response to patients**
- **introducing improved pain relief for patients**
- **training enhancements for frontline staff, including the recruitment of additional paramedic practitioners**
- **the introduction of vehicle-based response bags to improve the clinical response to patients**
- **the introduction of an RRV with a paramedic and police officer responding to emergencies in Wakefield town centre. The purpose is to be able to treat patients on scene and reduce admissions to hospital emergency departments**
- **working closely with the Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Trust on significant service changes**
- **Airwave digital radio tracking for the Trust's cycle response units**
- **enhanced obstetric training for paramedics.**

As of 1 April 2011, ambulance services are now measured by a range of new clinical quality indicators, which look at the quality of care we provide, the patient experience we give, as well as our response times.

It is vital that there are effective systems and the right level of resource to cope with all patients who call 999. Continuing to improve the speed of our response to patients with the most serious injuries and illnesses will remain a priority and we will also be focusing on further enhancements to the quality of care we deliver in line with the 11 new indicators.

Accident and Emergency Performance

We received 725,349 urgent and emergency calls in 2010-11 - an average of over 1,980 calls a day. We responded to a total of 615,893 incidents of which 240,347 were categorised as immediately life-threatening.

	Target	2009-10	2010-11	Percentage Point Change
Category A 8 minute response	75%	70.84%	73.72%	**+2.88**
Category A 19 minute response	95%	96.71%	97.38%	**+0.67**
Category B 19 minute response	95%	91.10%	93.69%	**+2.59**

Calling for Medical Help - What Happens Behind the Scenes

The first point of contact for anyone needing to use our services is one of the Access and Response 999 communications centres in Wakefield or York.

Staff are on hand to deploy the most appropriate response to best meet patients' needs and, in order to do this effectively, they need the appropriate training and the latest technology.

There have been numerous developments in the Access and Response communications centres during 2010-11 including:

- **the introduction of a 'virtual call centre' so that any call in Yorkshire can be answered by either communications centre, providing a faster service, greater staffing flexibility and additional resilience**
- **improving the patient call cycle (the time it takes to answer the call and dispatch an ambulance) which is the lowest since Call Connect was introduced in 2008 - 107 seconds against a target of 105 seconds**
- **ongoing recruitment and training of staff**
- **completing the roll-out of digital radio which has enhanced the communications tools for frontline staff and provides inter-operability with other emergency services**
- **implementation of version 12.1 of the Advanced Medical Priority Dispatch System (AMPDS) to improve the non-clinical aspect of 999 call-answering services which is used to support the care of patients while waiting for the ambulance to arrive**
- **ongoing development of the Clinical Hub to provide the most appropriate care for patients with non life-threatening conditions, which could include clinical triage by YAS, nurse triage by NHS Direct, management of frequent callers, referral to alternative pathways and nursing and care home support. An electronic link with NHS Direct was introduced in October 2010 to enable a patient's data to be transferred seamlessly**
- **improvements to vehicle satellite navigation systems and mobile data terminals, which are used to pass details of jobs to the ambulance clinician and log relevant response times**
- **continued delivery of the GP Out-of-hours service for four PCTs in Hull, East Riding, North Yorkshire and Gateshead.**

Planning for an Emergency

With the current economic challenges, the continued threat from global terrorism, climatic changes, as well as the myriad of sporting stadiums, music festivals and major events across the region, the Emergency Preparedness department provides the guidance, plans, training and equipment to enable the Trust to respond to any untoward events and incidents that may occur.

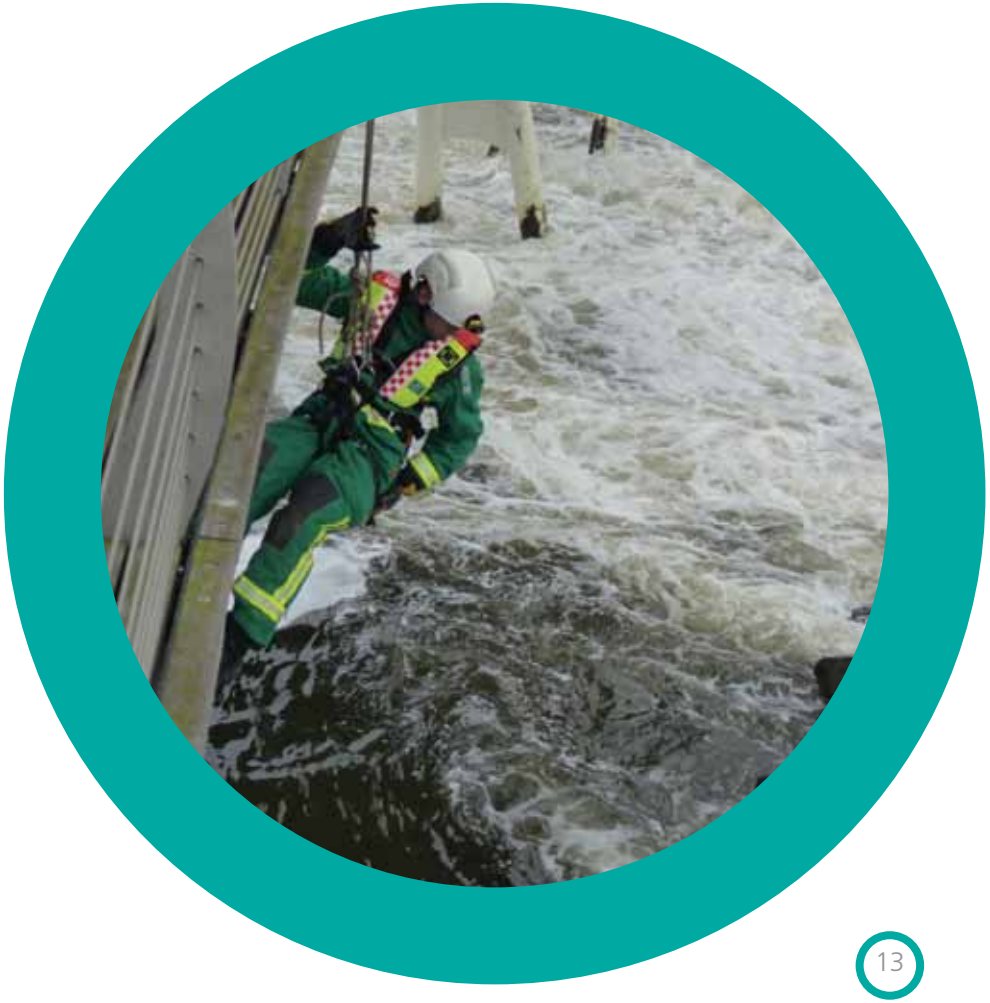
This year the Emergency Preparedness department developed specific contingency plans for the English Defence League demonstrations in Bradford in August 2010, the Liberal Democrat conference in Sheffield in March 2011 and provided guidance for the organisation during the prolonged adverse weather in December 2010.

Additional staff have been recruited to cope with the department's increasing workload which focuses on preparedness within the Trust and across stakeholder organisations to ensure planning, training programmes and response arrangements are coordinated and any areas for improvement are identified.

Our response capabilities are detailed in our Business Continuity Management programme which has seen significant developments over the last year with business continuity plans produced for all departments. This details the contingency plans which are in place to enable the Trust to deliver the normal emergency and non-emergency ambulance service to the public of Yorkshire in the event of a serious, major or extraordinary incident.

Training for all staff and managers across the Trust remains a priority. We continue to develop innovative ways of delivering emergency preparedness-related training, including e-learning and other interactive training models, in addition to the time-honoured classroom-based training. We also remain committed to working alongside our partners and being actively involved in multi-agency table-top and practical training exercises.

The Hazardous Area Response Team (HART) now has 42 members and continues to go from strength to strength. This specialist team has the equipment and training to care for patients in environments including collapsed buildings and underground as well as at incidents requiring breathing apparatus, which were previously only accessible by fire and rescue services.



Patient Transport Service

Our Patient Transport Service (PTS) is the second largest provider of non-emergency transport in the UK. We provide transport for people who are unable to use public or other transport because of their medical condition and include those:

- **attending hospital outpatient clinics**
- **being admitted to or discharged from hospital wards**
- **needing life-saving treatments such as chemotherapy or renal dialysis.**

It has been a productive year for PTS. Historically the service has been working to more than 50 different small contracts across the region - all with different standards, incomes and times, making it difficult to focus on best value for patients and improving waiting times. Our commissioners have worked tirelessly with us to reduce the contracts to four, which focus on the experience of patients and delivering a high quality, credible service.

We have experienced one of the toughest winters for many years and this has had a significant impact. Staff worked around the clock, seven days a week, in partnership with search and rescue agencies, the coastguard, police, fire and other ambulance providers to get to hard-to-reach patients and ensure life-saving treatment was received. We welcomed many positive comments and compliments from patients and hospitals over this period.

However, we find that our service is not always fully recognised for its resilience, protection of patient care and ability to provide patients and hospitals with real comfort in knowing that we will do everything we can to ensure patients get urgent treatment, whatever the conditions.

During 2010-11 there were many significant changes and improvements:

- **The PTS is now under a single system of operations, with the three former ambulance trust providers now fully integrated.**
- **The PTS Communications Centre (the call, booking and dispatch centre in Wakefield) has been fully upgraded - new technology has modernised our practice, improved the environment in which our staff work and the speed in which we can respond to patients' calls.**
- **There have been rapid improvements in call handling, thanks to the huge efforts of staff in implementing new ways of working. Last year the centre dealt with over 243,000 calls.**
- **We have employed 86 new staff and 29 apprentices.**
- **We have enlisted 21 new volunteer car drivers, making a total of 164.**

In addition, our Road Operations team, made up of 466 vehicles and 872 staff, undertook 1,074,331 journeys in 2010-11 and rolled out:

- **Airwave radio - a digital radio system that our 999 colleagues use - essential if a natural disaster or man-made terror event should affect the region**
- **Personal Digital Assistants (PDAs) - small computer units which help to capture more accurate data on performance and journey times and identify areas which require improvements so we can continue to enhance patients' experiences.**

Patient Transport Service Performance:

We made 1,074,331 journeys transporting patients to and from hospital and treatment centre appointments.

Plans for 2011-12 include:

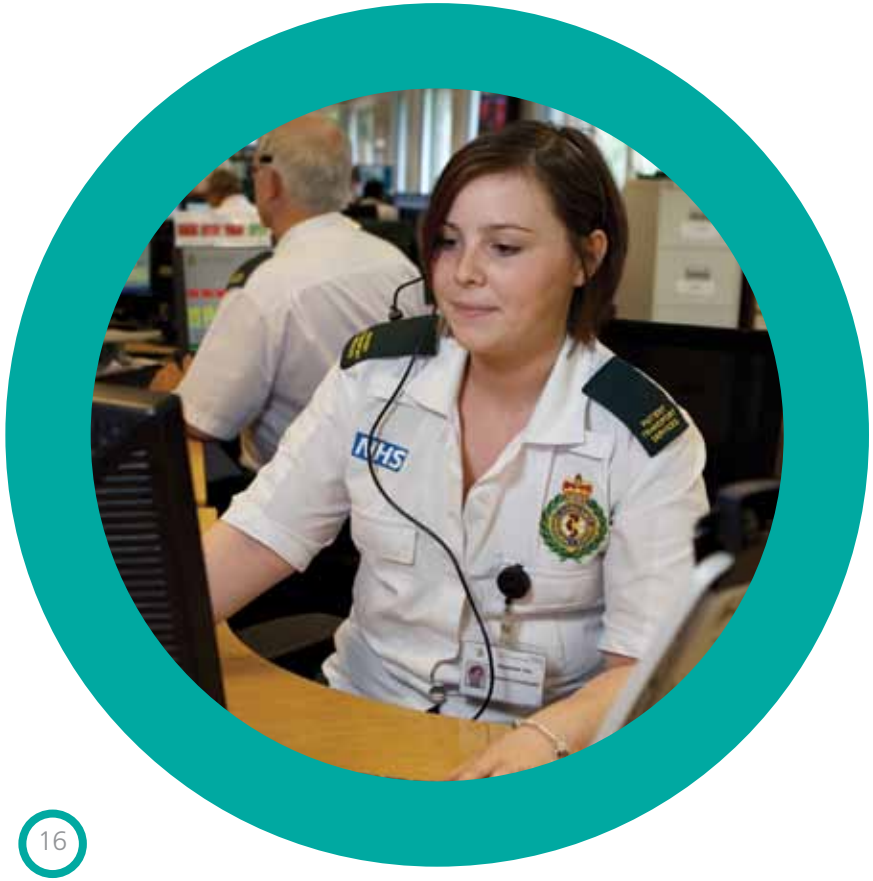
- **more effective use of PDAs**
- **upgrading of PDAs to capture the 'walk time' PTS staff do when conveying patients to clinics within hospitals - in order to decide whether to work with the hospitals to invest in portering duties to make our journey times and patient experience more effective**
- **introducing voice call recording for quality purposes**
- **more touch-screen systems to allow call and dispatch operators to function more quickly and effectively for the benefit of patients.**

Over the past year, we have looked at all of the different ways we spend our money and, for the first time, YAS PTS is able to demonstrate that it can be successful in its own right because:

- **we have improved both the way we buy resources and the way we utilise our staff**
- **we have introduced new roles and brought in apprentices**
- **we have worked jointly and successfully with our unions to bring about large-scale change to balance the books this year, whilst still striving for patient quality.**

PTS will continue to focus on its finances in 2011-12 and ensure we spend our resources wisely. Our big challenge now is to make further efficiencies to gain funding to replenish our vehicles. We have to invest in our vehicles to make sure we have a modern well-functioning fleet that supports good quality care for the people of Yorkshire and resilience for our 999 colleagues in the Trust.

Overall we are pleased with the performance of PTS this year. However, we are aware that there are still significant patient delays that need to be eliminated and we are working hard with our teams to do this. It is really important to us to reduce long waits after difficult and stressful treatments. Our own staff are only too aware of the impact this has on patients and we are all determined to improve this and our fleet profile next year.



Our Fleet and Equipment

We have continued to invest heavily to ensure we can provide efficient and comfortable transport for all our patients, whatever their needs.

During 2010-11, the Trust purchased:

- **40 new ambulances including medical kit**
- **two specialist 4x4 ambulances for use in remote locations, which are based in Craven**
- **five PTS stretcher vehicles**
- **89 defibrillators**
- **19 GP Out-of-hours cars.**

As part of our continued commitment to providing a first-class fleet to meet the needs of patients and staff, we will be leasing 106 replacement rapid response vehicles (RRVs) in 2011-12.

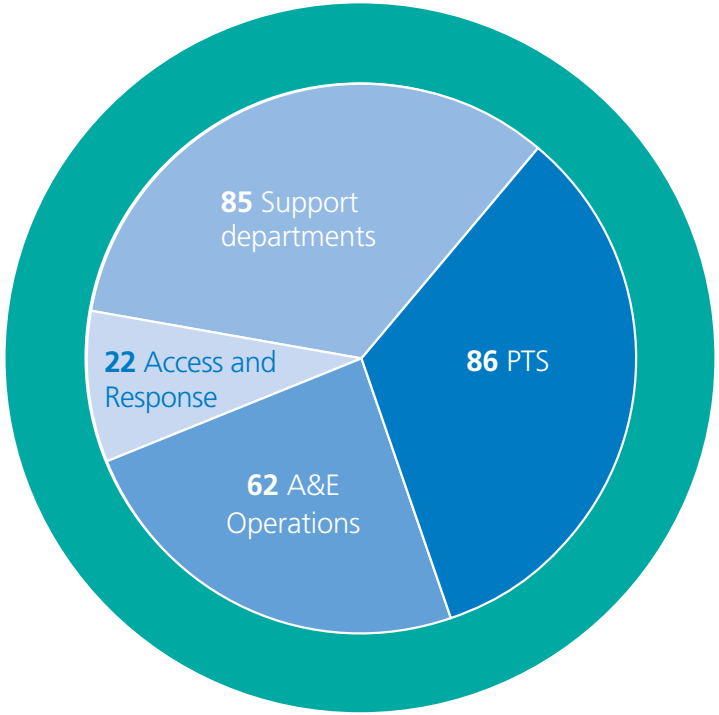
Much work has been carried out to look at ways of making YAS more environmentally-friendly. In July 2010, the YAS Carbon Management team ran the Emergency Services Eco Fleet Day at Elvington Airfield, near York, in conjunction with the region's fire and rescue services, police forces, army and Highways Agency. The event taught drivers economical and environmental driving techniques to improve their miles per gallon and save money.


AMBULANCE
1575
AMBULANCE

Our Staff

Recruitment

From 1 April 2010 to 31 March 2011, the Trust welcomed 255 new members of staff.



Supporting Staff

New initiatives have been introduced to enhance staff safety and wellbeing, including:

- **more opportunities for staff to provide feedback, offer suggestions for improvements and speak to management formally about concerns**
- **support for staff with musculo-skeletal conditions, including a new telephone advice service, exercise provision, 'hands on' treatment through the physiotherapy service, 'back care' advice in the statutory and mandatory workbook for all staff and moving and handling assessments on return to work**
- **a policy passport to keep staff informed of any new policies or updates**
- **improved stress management training sessions for staff and managers and a stress sub-group to address staff concerns and areas for improvement**
- **a review of Personal Development Reviews (PDRs) - to ensure they are meaningful and provide a framework for career development**
- **a staff counselling service providing one-to-one counselling support to enable return to work, sustain attendance at work and prevent absence**
- **seasonal and swine flu vaccinations with 1,460 members of staff vaccinated during the winter of 2010-11.**

Long Service and Retirement Awards ceremonies were held in November 2010 and February 2011 to recognise the dedication and commitment of 98 members of staff who had clocked up over 2,000 years of service between them.

Individuals who had reached their 20, 30 and 40 year milestones, as well as those who had retired after a long career with the ambulance service, were honoured at the events at Elland Road Football Stadium in Leeds and Sheffield United football ground at Bramall Lane.

The Employee Wellbeing Forum has continued to develop key health and wellbeing initiatives, the awareness of which has been highlighted by exhibitions at YAS workplaces and via a new 'Employee Wellbeing' intranet page with information about health, fitness, staff discounts and benefits, as well as tips for greener living.

In February 2011, Occupational Health services went out to tender to ensure that a consistent and high quality service is provided across the organisation. The new Occupational Health service is expected to be launched in 2011-12.

Key Human Resources policies recently developed or updated have included:

- **Managing Stress in the Workplace**
- **Professional Registration and Recruitment Checks**
- **Anti-bullying and Harassment**
- **Smoke-free**
- **Maternity Support**
- **Organisational Development Strategy - to help create and maintain a high-performing organisation which will achieve its ambition of becoming a Foundation Trust.**

Sickness Absence

The table below shows the overall absence figures for each month of 2010-11 for comparison with 2009-10.

The Trust has worked hard to reduce sickness absence through the introduction of a new policy, training workshops for managers and improved and earlier occupational health and wellbeing interventions.

During the year we undertook a workforce stress audit to identify the factors affecting stress in the workplace. From the information gathered we compiled an action plan which included specific training for our management team, stress awareness workshops and we also ran a series of health and wellbeing roadshows across the Trust.

Keeping Staff Safe

All our staff have the right to a healthy and safe working environment. This is why we exercise zero tolerance in relation to violent or aggressive acts, whether they are physical or verbal, and we encourage staff to report incidents so the appropriate action can be taken.

Our staff were subjected to 291 recorded incidents involving physical and verbal abuse between 1 April 2010 and 31 March 2011, compared to 391 during the previous year.

During 2010-11 there were 21 successful prosecutions as a result of assaults on staff which resulted in sanctions ranging from fines and police cautions through to community service and prison sentences.

	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009-10	4.90%	4.58%	4.49%	5.90%	5.98%	5.79%	6.60%	6.38%	6.34%	6.34%	6.28%	6.01%
2010-11	**5.49%**	**5.30%**	**5.15%**	**5.36%**	**5.76%**	**5.44%**	**5.60%**	**5.93%**	**6.92%**	**6.99%**	**5.74%**	**5.54%**
+/-	0.59%	0.72%	0.66%	-0.54%	-0.22%	-0.35%	-1.00%	-0.44%	0.58%	0.65%	-0.54%	-0.47%

Listening to Staff

YAS undertakes an annual NHS Staff Survey to gather the views and opinions of staff about a range of issues affecting their working lives.

In the 2010 NHS Staff Survey the response rate was 57% compared with 59% in 2009. The top four ranking scores where YAS achieved above the national average for ambulance trusts were:

- **staff motivation at work**
- **the percentage of staff having well-structured appraisals in the last 12 months**
- **the percentage of staff appraised with personal development plans in the last 12 months**
- **the percentage of staff agreeing that their role makes a difference to patients.**

The bottom four ranking scores where YAS achieved below the national average for ambulance trusts were:

- **support from immediate managers**
- **percentage of staff able to contribute towards improvements at work**
- **quality of job design (clear job content, feedback and staff involvement)**
- **percentage of staff experiencing discrimination at work in the last 12 months.**

In 2011-12 we will continue to work on these areas as well as focusing on new themes with the aim of continuing to improve our staff satisfaction scores.

Equality and Diversity

A new Equal Opportunities Policy reflecting new and changing legislation has been introduced which has led to:

- **all YAS staff receiving equality, diversity and human rights training**
- **a multilingual emergency phrasebook distributed to all staff in A&E Operations to help with patients who do not speak English**
- **cross-cultural communication training for clinical team educators.**

YAS has retained its 'two-tick' disability symbol, which is awarded by Jobcentre Plus to employers who are positive about employing disabled people.

Training

Education and Development Sessions

A range of education and updating programmes have been delivered for ambulance clinicians including:

- **Clinical Team Educator (CTE) Away Days** - covering subjects from new drugs to cross-cultural guidelines and from inline nebulisation to Care Quality Commission requirements
- **Clinical Update Courses** - 482 staff attended the courses organised for all A&E staff to update and refresh their skills
- **Institute of Healthcare and Development (IHCD) Paramedic Programmes** - 12 students successfully completed the programme
- **Assistant Practitioner Programmes** - 15 students were successful
- **Technician to Advanced Technician** - 89 staff completed the one-week uplift course
- **Student Paramedic Programme** - 60 students completed their second year and became eligible for paramedic registration, 41 new students entered the programme and 31 students entered their second year and will be eligible for registration at the end of 2011-12
- **Technician to Paramedic Conversion** - 48 students enrolled in the one-year programme at Sheffield Hallam University
- **Paramedic Practitioner** - 37 staff started the programme with Sheffield Hallam University
- **Foundation Degree Top-up** - 38 staff completed the programme which was set up with Teesside University to move existing IHCD paramedics to a Higher Education Institution (HEI) qualification and a further 72 are expected to complete before August 2011. Original applications for this programme were in excess of 280 and further courses are planned for 2011-12.

Apprenticeships

YAS supports the National Apprenticeship Scheme and has increased the number of apprenticeship opportunities. In 2010-11 YAS provided 87 new apprenticeship opportunities in:

- **PTS**
- **Finance and Payroll**
- **Information, Communications and Technology**
- **Training**
- **Human Resources**
- **Fleet.**

Learning Technology

Since the launch of the National Learning Management System (NLMS) in 2010, YAS staff have completed over 2,400 e-learning courses. This makes YAS the eighth highest NHS trust user of NLMS e-learning in the country.

In 2010-11, YAS 247 - a new virtual learning environment designed and developed exclusively for YAS staff - was launched. It provides staff with a wide range of clinical and non-clinical 'learning on demand', including:

- **news streaming from NHS Evidence (NHS Library) and other public health sources to signpost staff to further reading**
- **a wide range of online video content, podcasts, software simulations and image galleries**
- **quizzes, forums and links to online resources**
- **webcasting (online classrooms).**

Commercial Training

Ambulance services in Yorkshire have provided commercial first aid training for more than 15 years, with all profits reinvested back into the frontline service.

In 2010-11 the Commercial Training team trained more than 4,000 people from PCTs, councils and Yorkshire-based businesses on a variety of courses including:

- **First Aid at Work**
- **Cardio-pulmonary Resuscitation (CPR)**
- **Health and Safety**
- **Automated External Defibrillation**
- **Anaphylaxis Awareness.**

During the year, the team also led a national consortium of ambulance service commercial training providers to successfully secure a contract from a leading UK supermarket to provide first aid training to over 1,000 staff nationwide.

In the next 12 months the team will focus on more clinical training, driver training and building the business in core areas.

The team is also developing a range of education and training materials to teach primary schoolchildren about the appropriate use of 999 services and what to do in an emergency.


COMMERCIAL TRAINING
SERVICES
Yorkshire Ambulance Service NHS Trust

Partnership Working

Air Ambulance

YAS continues to work in partnership with the Yorkshire Air Ambulance (YAA) charity to provide paramedics for an airborne response to emergencies. The Air Support Unit at Sheffield Airport closed in January 2011 with the two helicopters based at Leeds Bradford International Airport and Bagby, near Thirsk.

BASICS Doctors

YAS continues to support 44 British Association for Immediate Care (BASICS) doctors who provide support to ambulance crews at serious road accidents and other trauma incidents across the region. We are looking forward to developing this valued asset in the year ahead, particularly across South Yorkshire.

Twenty-five BASICS doctors have now undertaken an emergency driving course to improve the speed of their response.

2011 will see the BASICS doctors become integrated within YAS governance arrangements.

Volunteer Responders

We currently have 3,353 volunteer responders across Yorkshire who belong to 391 community responder, co-responder and static schemes.

These community-based volunteers have attended over 6,000 incidents during the year; their quick response means they are on hand in the first few moments of an emergency to provide life-saving treatment.

Partnership working arrangements have continued with mountain rescue teams, HM Coastguard on the East Coast and many police custody suites which now have access to a defibrillator. Sixty medical students at the Hull York Medical School have also been trained to become community first responders.

In January 2011 a new initiative was introduced to use SMS messaging as the method of activation for volunteer responders to further improve the speed of their response to patients.

In a bid to raise awareness of the importance of CPR in the event of a sudden cardiac arrest, staff and volunteers from YAS took part in a 24-hour CPR relay challenge. A team of six carried out non-stop CPR on a training mannequin in the entrance of a supermarket in Pudsey on 24 September 2010 and raised £1,500 for the British Heart Foundation and YAS Charitable Fund.

Our Estate

Work has continued throughout the year with a number of upgrade and refurbishment work projects to ensure that the estate is maintained in good condition and compliant with appropriate building regulations.

During 2010-11 there were a number of significant capital schemes completed including:

- **roof replacements at Longley and Rotherham ambulance stations**
- **replacement of old heating systems with modern energy-efficient units at Gildersome, Rotherham, Wakefield and Bradford ambulance stations and at the Training School in Wakefield**
- **fire alarm system upgrades at Thirsk, Todmorden, Withernsea, Kirkbymoorside, Preston, Leeds, Maltby and Ripon ambulance stations**
- **emergency lighting upgrades at Batemoor, Bradford, Driffield, Filey, Harrogate, Huddersfield, Preston, Whitby and Todmorden ambulance stations and York Administration and Communications Centre**
- **installation of new bunkered fuel sites across Yorkshire to increase our fuel resilience and deliver cost savings through bulk buying. We also upgraded existing fuel installations in Wakefield and Sheffield**
- **Halifax Ambulance Station was closed for eight weeks while it underwent a major refurbishment, including a new roof and heating system. We worked closely with West Yorkshire Fire and Rescue Service to share its stations and facilities to ensure that our operational response remained unaffected.**

The £30,000 lighting upgrade project to install the most efficient lighting on the market and activity sensors is expected to save more than £12,000 per year in fuel bills and reduce carbon emissions by 29.39 tonnes per year.

The £305,000 heating efficiency improvement project is expected to save around £19,000 a year in fuel bills and reduce carbon emissions by 97.67 tonnes every year.

How We Work

Openness and Accountability Statement

The Trust complies with the Code of Practice on Openness in the NHS and has various channels through which the public can obtain information about its activities.

We are committed to sharing information within the framework of the Freedom of Information Act 2000 and all public documents are available on request.

We hold a public Trust Board meeting every two months. An Annual General Meeting is held in September each year. In common with the Trust Board meetings this is open to the public with specific time set aside for questions.

We always welcome comments about our service so we can improve performance.

If you have a compliment, complaint or query, please do not hesitate to contact us.

Environmental Policy

YAS aims to ensure that our buildings and all the goods and services we buy are manufactured, delivered, used and managed at the end of their useful life in an environmentally and socially acceptable way. YAS is committed to reducing the carbon footprint of its buildings, fleet and staff whilst not compromising the core aspects of the emergency service.

All our tenders are evaluated using whole-life costs, where applicable, to assess the environmental costs over the life of the products or services offered. Our suppliers and those seeking to tender for business are made aware of the requirements of our Environmental Policy.

We also work to minimise the health, safety and environmental risks to our patients, staff and visitors, in accordance with health and safety at work and fire legislation and the Disability Discrimination Act 1995.

The Trust's carbon footprint has been measured in line with the Carbon Trust methodology and the baseline results are shown below:

YAS Carbon Footprint Calculation
The carbon footprint for 2010-11 is 16,065 tonnes of CO_2

Year	Total CO_2 emissions (tonnes)	CO_2 emissions from building (tonnes)	CO_2 emissions from transport (tonnes)	CO_2 emissions per employee (tonnes)
2008-09	16,674	4,929	11,745	4.93
2009-10	17,052	5,707	11,345	4.30
2010-11	**16,065**	**5,104**	**10,961**	**3.58**

In 2010, the Carbon Management Plan was drawn up by the Carbon Management team to identify and highlight areas of YAS which can reduce the carbon emissions as well as make huge cost savings. The plan identified CO_2 savings to be made within Estates, IT and the Fleet departments. YAS has pledged to reduce its carbon footprint by 30% by 2015 based on the 2007 baseline.

Information Governance

YAS aims to ensure that the personal data it holds is accurate and held securely in accordance with the appropriate legislation and standards outlined in the NHS Information Governance Toolkit.

Summary of personal data-related incidents in 2010-11		
Category	Nature of Incident	Total
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	Nil
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS Premises	One
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS Premises	Nil

The Senior Information Risk Owner for YAS during 2010-11 was Keeley Townend, the Director of Information, Communication and Technology (ICT).

The Trust Board

The Trust Board 2010-11

Chairman

Della Cannings *(from 10 May 2010)*

Dr Nick Varey held this post up to 10 May 2010.

Chief Executive

David Whiting *(from 1 February 2011)*

Martyn Pritchard held this post up to 11 June 2010, before being seconded to NHS Yorkshire and the Humber, and left the Trust on 30 November 2010.

Simon Worthington was Acting Chief Executive from 14 June 2010 to 31 January 2011.

Director of Finance and Deputy Chief Executive

Simon Worthington

Caroline Wood was Acting Director of Finance from 14 June 2010 to 31 January 2011 while Simon Worthington was Acting Chief Executive.

Simon Worthington left the Trust on 10 June 2011 to take up the post of Deputy Director of Finance at South London Healthcare NHS Trust.

Director of Operations - A&E

Keith Prior *(Keith's secondment with the Trust ended on 3 June 2011)*

Medical Director

Dr Alison Walker

Director of Organisation Development and Human Resources

Wendy Foers *(Wendy held this post until 11 February 2011)*

Director of Information, Communication and Technology (ICT)

Keeley Townend

Director of Operations - PTS

Sarah Fatchett

Director of Standards and Compliance

Steve Page

Review of Corporate Structure

In April 2011 the Trust's corporate structure and director portfolios were changed to assist us in the delivery of our strategic aims over the next five years and ensure that we are appropriately constituted in our preparation to become a Foundation Trust.

The key change was the establishment of a new Director of Operations post that encompasses a range of emergency, non-emergency and support functions which was effective from 2 May 2011.

These changes mean that the posts of Director of ICT and Director of Operations - PTS no longer exist.

The post of Director of Organisation Development and Human Resources has changed to Director of Workforce and Strategy.

Trust Board 2011-12

Chairman
Della Cannings

Chief Executive
David Whiting

Executive Director of Finance and Performance*
Rod Barnes
(from October 2011)

Executive Director of Workforce and Strategy
Stephen Moir

Executive Director of Standards and Compliance
Steve Page

Executive Medical Director
Dr Alison Walker

Executive Director of Operations
Sarah Fatchett

**This role was held by Simon Worthington from 1 April - 10 June 2011 when Caroline Wood took over on a temporary basis until the arrival of Rod Barnes in October 2011.*

Non-executive Directors

Nina Wrightson OBE is a Chartered Safety Practitioner and a former Chairman of the British Safety Council. She was a Risk Management Director for Northern Foods plc and has also worked for the Health and Safety Executive, the Government Office for Yorkshire and the Humber and Nestlé Rowntree. Nina is also a board member of the NHS Litigation Authority.

Richard Roxburgh is a chartered management accountant with extensive financial and commercial experience. Former roles include Finance and Commercial Director with Arriva Trains Wales and Finance Director with Arriva Trains North. Earlier career experience includes senior financial positions with BT Cellnet (now O_2), and BT Business Division throughout the UK.

Roger Holmes CB is a former Chief Executive of St John Ambulance and a current council member of the South and West Yorkshire branch. Roger has held senior posts in the Department of Trade and Industry and a number of large commercial organisations, including Dunlop and the Chloride Group where he was a main board director, and the Royal Mint where he was Chief Executive.

Elaine Bond has extensive commercial experience of developing strategies from major restructuring initiatives. She is experienced in improving efficiency in manufacturing logistics and supply chains. She was previously Group Operations Director at UK Greetings Ltd, a leading designer, manufacturer and supplier of greetings cards and related stationery products.

Elaine took up this post on 5 June 2011, replacing Paul Osborne who was a Non-executive Director until 31 March 2011.

Patricia Drake has extensive experience in the NHS from her role as the Assistant Chief Nurse at Bradford Teaching Hospitals NHS Foundation Trust before she retired in 2006. She is currently the Director of Innovate and Development Ltd, an independent lay member of the Kirklees Community Health Service and a Justice of the Peace in Calderdale.

Patricia took up this post on 4 October 2010, replacing Nancy Murgatroyd who was a Non-executive Director until 30 September 2010.

Trust Board - Declaration of Interests

Name	Nature of Interest	Organisation
Della Cannings QPM	Deputy Chairman	National Information Governance Board for Health and Social Care
Dr Nick Varey	Medical Director	YorkTest Laboratories Ltd
Roger Holmes	Council member	St John Ambulance (South and West Yorkshire)
Nina Wrightson	Board member Chairman (up to 31 October 2010)	NHS Litigation Authority British Safety Council
Patricia Drake	Director Independent Lay Member	Innovate and Develop Ltd Kirklees Community Health Service
Paul Osborne	Employee	Telefonica O_2 (UK) Ltd

Quality Accounts 2010-11

Contents

Statement on Quality from the Chief Executive

For everyone at Yorkshire Ambulance Service (YAS), providing high quality patient care is our highest priority. This applies to our ambulance clinicians responding to emergency calls, to our Patient Transport Service (PTS) crews taking patients to and from their planned hospital appointments, to our managers developing new care pathways or ways of working, and to our Trust Board making decisions about the future of our Trust.

The progress we have made has been acknowledged by the Care Quality Commission (CQC) which agreed in September that we had met the full requirements for registration with them. This means that we are achieving all of the essential standards of quality and safety.

The Board has been leading our focus on quality and has given significant time to developing our Quality Governance Framework. This will ensure that quality is at the centre of all our systems and structures, and enable the investment in our staff, managers and leaders to build a culture of quality. Demonstrating strong quality governance will be essential as we work towards achieving foundation trust status, our systems and structures will be subject to close scrutiny as we progress our application. We welcome this process as it will provide us with additional challenges in setting ambitious objectives and supporting innovation.

In 2010-11 we made improvements in important areas of quality including incident reporting, management of serious untoward incidents (SUIs), safeguarding vulnerable adults and children, and the development of new care pathways. We have continued to measure the quality of our clinical care using the national Clinical Performance Indicators (CPIs). CPI results are regularly shared with frontline clinicians and local teams. This empowers clinical leaders to take responsibility for driving up achievement in their areas, and identifying where they can learn from colleagues in other areas.

2011-12 will be a challenging year for all healthcare providers as the health care reforms are implemented. We will be exploring and implementing new and more efficient ways of working which will enable us to improve the quality of our care, whilst also reducing the cost to the taxpayer. To achieve this we will work in partnership with our healthcare partners, our patients and local communities to listen and agree local priorities and concerns if we are to ensure our services are responsive to their needs.

We know from the thank you letters and telephone calls we receive from patients and their families that many people receive an outstanding service thanks to the skill, care and dedication of all our staff. We want this to be the experience of every patient and will continue to strive towards this goal.

Statement of Accountability

The Trust Board is accountable for quality. It oversees the development and delivery of the Trust's strategy which puts quality of patient care at the heart of all the Trust's activities.

As Accountable Officer and Chief Executive of this Board I have responsibility for maintaining the standard of the Trust's services and creating an environment of continuous improvement.

This report is in the format required by the Health Act 2009. It contains the sections mandated by the Act and also measures that are specific to YAS that demonstrate our work to drive up standards. We have chosen these measures based on feedback from our patients, members of the public, health overview and scrutiny committees, staff and commissioners.

As Accountable Officer I confirm that, to the best of my knowledge, all the information in this Quality Account is accurate. I can provide this assurance based on our internal data quality systems and the opinion of our internal auditors.

David Whiting

Chief Executive

Priorities for Improvement 2011-12

Recording Performance Against Clinical Quality Indicators

We know that for patients with certain life-threatening conditions, getting to them quickly saves lives and is vital to achieving the best possible clinical outcomes.

The nationally-set targets for 2010-11 were to reach:

- **75% of Category A patients (immediately life-threatening) within eight minutes**
- **95% of Category A patients within 19 minutes**
- **95% of Category B patients (serious but not life-threatening) within 19 minutes**

Although it is important to get there quickly, this is not the only factor in providing a high quality service.

Based on Lord Darzi's definition, quality means providing a service that is safe, clinically effective and results in a positive patient experience.

For ambulance services this means measuring the outcomes of our clinical care in addition to our response time. This is why 11 new ambulance clinical quality indicators (CQIs) have been set by the Department of Health for 2011-12.

The new indicators were developed by the National Ambulance Director, working with colleagues from across the ambulance service, including people from YAS.

The 11 new indicators keep the same requirements to reach Category A patients, but replace the Category B target. This has been agreed by the medical directors for the 11 English ambulance services because the Category B target was not based on clinical evidence. It is recognised that the most important factor for patients requiring ambulance assistance is the time it takes for them to get the right treatment for their condition. Often attending the nearest hospital emergency department is not the fastest way to get this treatment and, increasingly, ambulance clinicians are able to refer patients to alternative sources of care or to take them directly to specialist treatment centres. These new ways of working also help us to ensure that we have ambulances available, to respond immediately to patients with conditions such as cardiac arrest where a fast response is proven to be life-saving.

To understand how well our care improves the health of our patients we need to record the clinical outcomes for those patients. Using the new indicators we started to do this from April 2011 for patients suffering from cardiac arrest, heart attack (ST Elevation Myocardial Infarction) and stroke.

We will also be reporting the number of patients whose calls we are able to resolve with telephone advice or whose conditions we can manage without transport to a hospital emergency department.

To check how these decisions affect safety and patient experience we will be monitoring the numbers of patients who then need to call 999 again and surveying patients' opinions.

In 2010-11 we set up the systems that will enable us to report against the 11 new CQIs for 2011-12:

1. **Service experience (feedback from service-users)**
2. **Outcome from ST Elevation Myocardial Infarction (STEMI)**
3. **Outcome from cardiac arrest: return of spontaneous circulation**
4. **Outcome from cardiac arrest: recovery to discharge from hospital**
5. **Outcome following stroke for ambulance patients**
6. **Proportion of calls closed with telephone advice or managed without transport to A&E**
7. **Re-contact rate following discharge of care**
8. **Call abandonment rate**
9. **Time to answer calls**
10. **Time to treatment by an ambulance-dispatched health professional**
11. **Category A eight-minute response time.**

Ambulance Response Times

Getting to patients with life-threatening conditions as quickly as possible saves lives and is a vital part of achieving the best possible clinical outcomes.

In 2010-11 we made improving our response times our highest priority. We took every opportunity to learn from good practices in other services and we developed a detailed A&E Operational Improvement Plan to ensure we reached and continued to maintain the required standards.

In September 2010 the CQC agreed that our performance in responding to patients with life-threatening (Category A) conditions had improved significantly and was now in line with national targets. We are now fully registered with the CQC without conditions. More details of this work are included in our Annual Report.

Our ambulance response times for 2010-11 measured against national targets are reported on pages 56-58. This shows that we met our national targets up to November 2010 when our performance was significantly affected by the extended period of adverse weather. With the milder weather in February and March 2011 we were able to improve our response times again.

Aims

In 2011-12 we will:

maintain our response times to patients with life-threatening (Category A) conditions in line with the nationally-agreed indicator to reach 75% of patients within eight minutes.

Developing Patient Pathways

We know that the best care for patients is not always provided by transporting them to hospital and that people with some conditions can be better supported by referral to specialist teams. Our progress in 2010-11 to develop pathways for diabetes, falls and patients at the end of their lives is reported on pages 64-65.

Aims

In 2011-12 we will:

1. **work with healthcare partners to develop our referral processes and establish pathways that meet patient needs and link effectively with local services**
2. **work with healthcare partners to develop processes for referring patients to alternative care pathways that are the same in all areas of Yorkshire. Having consistent procedures will promote high standards and allow comparisons to be made across the region and with other regions**
3. **introduce a monitoring process for the care provided to patients referred via the diabetes and end-of-life care pathways throughout the full patient journey.**

Working with Partners to Ensure Appropriate Care and Management of 'Frequent Callers'

Some of the people who most frequently call our 999 service require help - but not necessarily the attendance of A&E ambulance clinicians. Since 2009 we have worked with local primary care trusts (PCTs) to identify frequent callers (either individuals or care homes) and review their care needs via multi-agency case conferences. This helps identify potential gaps in the care they are receiving in their communities and how this care could be improved. By putting in place alternative sources of care which better meet individuals' needs, this reduces the number of times they call 999 for an ambulance, leaving resources free for others who need them. This work earned Clinical Hub Team Leader Annette Strickland, our YAS lead for the programme, a Success in Partnership Working Award at the 2010 Yorkshire and the Humber Health and Social Care Awards.

Aims

In 2011-12 we will:

1. **continue to identify the top ten most frequent individual callers and care home callers by commissioned area**
2. **work with other healthcare providers to review cases, agree action plans and monitor the impact of these plans**
3. **analyse past cases to identify early warning indicators for potential frequent callers and work with healthcare partners to develop procedures for early action so at-risk individuals can get the care they need before resorting to the 999 service.**

Improving Patient Transport Service (PTS) Performance

Our PTS provides transport for people who are unable to use public or other transport because of their medical condition and includes those:

- attending hospital outpatient clinics
- being admitted to or discharged from hospital wards
- needing life-saving treatments such as chemotherapy or renal dialysis.

The measures we used to monitor PTS service quality and our performance in 2010-11 are set out on pages 59-60. Some of our patients have been telling us that, in the past year, they have too often experienced extended waiting times for transport home after their appointments.

Aims

We are working to improve this and in 2011-12 we will:

1. **agree a target with each of the four PTS commissioning consortia for the percentage of patients who should be collected for their return journeys within 60 minutes of the hospital/clinic advising that they are ready to travel**
2. **measure our performance against these quality targets and work towards reducing waiting times for all patients.**

In order to reduce waiting times for homeward journeys and improve patients' overall experience of our service we need to have better knowledge of the timings of individual clinics. At the moment we plan our journeys based on an appointment time of one-and-a-half hours for every clinic. In 2011-12 we will:

3. **map the timings of individual clinics and use this to plan return journeys that better match patients' appointment times.**

Developing Clinical Leadership and Assessment Skills

In order to improve the quality of our care in line with the new ambulance CQIs we need to ensure that our clinical staff have the skills and confidence to make good, clinically sound decisions about treatment and referral. By supporting our staff to develop their clinical assessment and decision-making skills we aim to increase the number of appropriate referrals to appropriate alternative care pathways.

Aims

In 2011-12 we will:

1. **develop and deliver a clinical leadership and skills-development project**
2. **monitor the numbers of staff who have increased their clinical skills through the clinical leadership and skills-development project**
3. **improve the standard of clinical record-keeping by increasing the number of patient report forms where all essential fields are complete.**

Providing Ambulance Clinicians with 24/7 Access to Clinical Advice

Our ambulance clinicians work 24 hours a day, seven days a week, 365 days a year. The nature of their jobs mean that they deliver care in peoples' homes and in public places where they do not have the same access to reference sources or advice from colleagues as people who work in hospitals or clinics. We want to provide our clinicians with better access to clinical advice and guidance on the available alternative care pathways. To do this we will be developing our 'Clinical Hub'.

The Clinical Hub is staffed by clinical advisors (specially-trained nurses and paramedics). Currently their role is to take calls from patients with non-life-threatening conditions and assess their needs using a clinical triage system. The clinical adviser may then be able to provide advice about self-care, arrange a home visit by a healthcare professional such as a district nurse, GP or emergency care practitioner or refer the patient to an appropriate care pathway.

Aims

In 2011-12 we will:

1. **develop our Clinical Hub to provide a new clinical advice and guidance service for ambulance clinicians**
2. **monitor the number of incidents where clinicians working in ambulances and rapid response vehicles access the Clinical Hub**
3. **increase the satisfaction of clinicians with the service provided by the Clinical Hub. We will monitor this through surveys of staff opinions.**

Measuring and Improving Patient Experience

Listening to and acting on feedback from patients is a vital part of providing a high quality service. By listening to what our patients are saying we can reduce the risk of missing the warning signs of poor care.

In 2010-11 we developed new ways to measure the experience of our patients and started to record our level of achievement. Details of this work and some early results are reported on page 74.

Aims

In 2011-12 we will:

1. **increase the overall level of feedback given by patients and other service-users as a proportion of those using our services**
2. **review the diversity of those providing feedback on our services compared to the diversity of our service-users and use this information to increase the opportunities for all groups to make their views known**
3. **develop the mechanisms through which patient feedback influences and improves our services**
4. **keep records of work showing how feedback from patients has been used to develop and improve our services.**

Statements of Assurance from the Board

The National Health Service (Quality Accounts) Regulations 2010 require the Trust Board to make a number of Statements of Assurance. These are common to all providers, so our accounts can be compared with those of other organisations. The statements confirm the total number of services we provide, that we have participated in research and national audits and that we are registered with the Care Quality Commission.

Review of Services

During 2010-11 YAS provided five NHS services:

- **Accident and Emergency response (including Yorkshire-wide emergency preparedness and an Emergency Care Practitioner service in Sheffield).**
- **Patient Transport Service.**
- **GP Out-of-hours call handling service for:**
  - **NHS South of Tyne and Wear**
  - **NHS North Yorkshire and York**
  - **NHS East Riding of Yorkshire**
  - **NHS Hull.**
- **Private and Events service.**
- **Vehicles and drivers for the Embrace neonatal transport service.**

YAS has reviewed all the data available on the quality of care in all five of these services.

The income generated by the NHS services reviewed in 2010-11 represents 100% of the total income generated from the provision of NHS services by YAS for 2010-11.

In addition to Board reports and scrutiny at the Integrated Governance and Business Delivery committees, directors also participate in 'Listening Watch' visits. Listening Watch is an annual programme which covers all geographic areas, frontline services and support services. It gives directors the opportunity to hear from staff about a wide range of issues and to discuss safety and quality-related matters. After every visit directors record their learning from Listening Watch and a regular report is presented to the Executive Team. Key issues are discussed and actions agreed. Wherever possible feedback is provided to staff on actions taken by the Executive Team as a result of their visits.

PARTICIPATION IN CLINICAL AUDITS

During 2010-11 two national clinical audits and one national confidential enquiry covered NHS services that YAS provides.

During that period we participated in 100% of national clinical audits and 100% of national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2010-11 are as follows:

National Clinical Audits:

- **Myocardial Ischemia National Audit Project (MINAP) - this is a national database gathering information on all patients who have had a heart attack or who have acute coronary syndromes.**
- **National Infarct Angioplasty Project (NIAP) - this is an audit of patients referred for an angioplasty surgical procedure.**

National Confidential Enquiries:

- **Centre for Maternal and Child Enquiries (CMACE) - Confidential Enquiry into Head Injury in Children (completion of required data submission).**

The national clinical audits and national confidential enquiries that YAS participated in, and for which data collection was completed during 2010-11, are listed on the right.

National Clinical Audit/National Confidential Enquiry	Number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry
MINAP and NIAP	The MINAP process requires ambulance trusts to validate data submitted by acute trusts. There is no direct submission of data by YAS. At the moment we are able to validate the data submitted by one out of the 15 trusts who submit data on YAS patients.
CMACE - Head Injury in Children	Rather than submitting a required number of cases to this audit, CMACE requests information about specific patients. YAS provided information to CMACE about 130 patients.

We also submitted data to the national ambulance services' audit of Clinical Performance Indicators. The results of these audits are reported on pages 29-30.

YAS participated in the trial of the National Patient Safety Agency Community Suicide Prevention Toolkit Ambulance Audit Tool. The comments we submitted will be used to develop the toolkit in 2011.

The reports of two national clinical audits (MINAP and NIAP) were reviewed by the provider in 2010-11 and YAS intends to take the following actions to improve the quality of healthcare provided:

- **Enhance data collection, sharing and validation with acute trusts.**
- **Continue with staff education and awareness regarding Acute Coronary Syndrome management.**
- **Develop links with Primary Percutaneous Coronary Intervention (PPCI) centres, audit local pathways and improve awareness of best practice amongst YAS clinicians.**

These initiatives will build on our work as part of the Ambulance Service Cardiovascular Quality Initiative, which aims to improve the delivery of pre-hospital care for cardiovascular disease, acute myocardial infarction and stroke. In 2010-11 we received funding from this initiative for a quality improvement fellow to support teams of clinicians to work together to develop proposals for improving care for patients suffering from a heart attack or stroke.

As well as participating in national clinical audits, we undertake our own, local audits to measure our clinical practice against best practice standards. The results from these audits are provided to local teams every month to help them improve the quality of their service. They are also reported to the Trust Board.

Our local audits include:

- **monthly audits of compliance with the five national Clinical Performance Indicators (see pages 61-63)**
- **audit of care provided to patients suffering neck of femur fracture.**

The reports of 15 local audits were reviewed by the provider in 2010-11.

YAS intends to take the following actions to improve the quality of healthcare provided:

- **Continue to undertake local audit (including peer review) of completed patient report forms (PRFs).**
- **Continue with staff education and awareness of clinical audit and engagement of frontline clinicians in reviewing the results.**
- **Build on the best practice and learning from the Ambulance Service Cardiovascular Quality Initiative.**

RESEARCH

Commitment to research as a driver for improving the quality of care and patient experience

Participating in clinical research demonstrates that an organisation is committed to improving the quality of care it provides and to making a contribution to wider health improvement.

YAS is committed to participating in clinical research that leads to better care for patients. Like all ambulance services, we are relatively new to the field of research. We continue to build our skills, experience and partnerships and look forward to developing our research programme further in the year ahead.

In 2010-11 we took part in three observational research studies approved by a research ethics committee. Two of these studies were related to our staff where researchers invited them to provide information about the barriers and benefits when treating certain groups of patients:

- **Understanding how ambulance services achieve effective engagement from ambulance clinicians to improve the delivery of pre-hospital care for cardiovascular disease; primarily acute myocardial infarction and stroke.**
- **Understanding to what extent the Mental Capacity Act (MCA) and its guidance are effective in providing a clear framework for the protection and empowerment of those who are judged to lack capacity.**

The third research study was the final phase of a multi-national study that aims to identify variables that might act as predictors of survival in emergency medical patients:

- **Development And Validation of Risk-adjusted Outcomes for Systems of Emergency Medical Care (the DAVROS project).**

The number of patients receiving NHS services provided or sub-contracted by YAS in 2010-11 that were recruited during that period to participate in research approved by a research ethics committee was 1452.

In 2010-11 we also:

- **supported 20 ambulance clinicians to become research champions to promote and encourage the principles and benefits of research**
- **worked with three Comprehensive Local Research Networks (CLRNs) and two Higher Education Institutes to develop and carry out clinical research. These were:**
  - West Yorkshire CRLN
  - South Yorkshire CRLN
  - North East Yorkshire and North Lincolnshire CRLN
  - University of Sheffield School of Health and Related Research
  - University of Bradford.
- **had three peer-reviewed articles published related to research, audit and innovation activity:**
  - J Taylor: *The role of ambulance clinicians in management and leadership.* Journal of Paramedic Practice, January 2011, vol/is 3/1 34-37
  - N Roberts, S Curran, V Minogue, J Shewan, R Spencer, J Wattis: *A pilot of the Impact of NHS Patient Transportation on Older People with Dementia.* International Journal of Alzheimer's Disease, Volume 2010 (2010), Article ID 348065, 9 pages
  - JT Gray, K Challen, L Oughton: *Does the pandemic medical early warning score system correlate with disposition decisions made at patient contact by emergency care practitioners?* Emergency Medical Journal, December 2010, vol/is 27/12 943-947.

GOALS AGREED WITH COMMISSIONERS

£2.3m (1.2%) of YAS's income in 2010-11 was conditional on achieving quality improvement and innovation goals agreed between YAS and our PCT commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

We achieved all our CQUIN goals for 2010-11 which related to our performance against clinical performance indicators, increasing referrals to alternative care pathways, developing new alternative care pathways and increasing referrals to specialist services for safeguarding children and vulnerable adults.

£2.7m (1.3%) of our income in 2011-12 is conditional on achieving our CQUIN goals. These are closely aligned to the new ambulance outcome measures and the priorities for improvement in these Quality Accounts.

Full details of our CQUIN goals are available electronically at:
http://www.yas.nhs.uk/Publications/cquin.html

WHAT OTHERS SAY ABOUT US

Care Quality Commission

YAS is required to register with the CQC and our current registration status is 'full registration'. The CQC has not taken enforcement action against YAS during 2010-11.

In April 2010 YAS was registered with the CQC with one condition: 'to ensure that by 31 October 2010 it is responding to emergencies defined as immediately life-threatening promptly in line with national requirements in order that people who use the services receive safe and appropriate care, treatment and support'. This condition was lifted by the CQC on 3 September 2010 on the basis of our improved ambulance response times.

YAS has not participated in any periodic or special reviews or investigations by the CQC during 2010-11.

NHS Litigation Authority

On 11 November 2010 we were assessed for compliance with the NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts at Level 1. The assessors looked at 50 key policies and all 50 were accepted as meeting the required standard. This shows a significant improvement since our last assessment in 2008 when 40 out of 50 policies met the required standard.

DATA QUALITY

Good quality information helps the effective delivery of patient care and is essential in our work to improve the quality of our care.

We place a high priority on maintaining effective, secure data management systems. This means that both ourselves and our partners can have confidence that the information we use to measure the quality of our services is reliable and accurate.

In 2010-11 we took the following actions to maintain and improve our data quality:

- **Delivered data quality training workshops to ensure that managers and staff in key data-processing roles understand their responsibilities and have the necessary skills.**
- **Our Management Information team developed weekly data quality reports to help managers to monitor and improve reporting and data quality in their teams.**
- **Our managers responsible for our 'KA34' performance report to the Department of Health work together to ensure that any changes to our information technology are assessed for their impact on reporting systems.**
- **Internal and external auditors carried out checks on our data quality systems.**

In 2011-12 we will be taking the following actions to improve data quality:

- **We will continue to develop data quality reports for managers to help them monitor and improve data quality in their teams.**
- **We will continue to raise awareness of data quality amongst all staff and managers and to embed best practice throughout the Trust.**

Our attainment against the NHS Information Governance (IG) Toolkit assessment provides an overall measure of the quality of our data systems, standards and processes.

Our Information Governance Assessment Report score for 2010-11 was 66% and we were graded as 'satisfactory', which means that we reached the required level against all of the 35 indicators. Each year the standards within the IG Toolkit are strengthened, challenging NHS organisations to improve their systems and processes. This means that the standards are higher than in 2009-10 when we achieved a score of 72%.

The Health Act 2009 requires us to make the following statements:

YAS did not submit records during 2010-11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

YAS was not subject to the Payment by Results clinical coding audit during 2010-11 by the Audit Commission.

Review of Quality Performance in 2010-11

How we selected our indicators

In our 2010-11 Quality Accounts we set ourselves six priorities for improvement. As this was our first Quality Accounts we chose these priorities ourselves based on the quality elements of our 2010-11 Business Plan and the CQUIN targets we agreed with our commissioners.

We report a summary of our performance against each of our 2010-11 priorities in the table on pages 53-55.

During the past year we have engaged our staff and stakeholders in discussions about service quality and their views on the content of our Quality Accounts. These activities included:

Staff Engagement

- **Presentations and workshops at our October management 'time-out' event. Our time-outs are held twice a year and are an opportunity for all our managers to meet each other in a single location, hear from the Chief Executive and the Executive Team about progress over the past year and plans for the year ahead. Workshops focus on key priorities and allow managers to share best practice and learn from each others' experience.**
- **To build awareness of YAS's responsibilities to maintain high quality services and the role of the CQC, the Director of Standards and Compliance visited managers and teams from frontline and support services. Staff were able to discuss what quality meant to them in their roles, put forward their views and ask questions.**

Engagement with Partners

- **We have a monthly Clinical Review Group attended by the YAS Medical Director, Director of Standards and Compliance and PCT commissioners to review service quality and performance against CQUINs.**
- **We work closely with the Yorkshire-wide Local Involvement Network (LINk) Ambulance Group. All LINks are invited to participate in this group which is a forum for members to raise concerns, identify common experiences across areas and receive responses from YAS managers.**
- **When issues are specific to an individual LINk we also engage directly with them to provide detailed information and, where possible, resolve problems.**

- **We acknowledge the important feedback provided via our 13 Yorkshire Health Overview and Scrutiny Committees (HOSCs). Our directors and assistant directors have attended meetings of most committees over the course of the year to report on performance and receive feedback on local issues.**
- **All LINks and HOSCs were given the opportunity to provide input on the content of our 2010-11 Quality Accounts through a questionnaire and, where possible, meetings with councillors or presentations to committee meetings.**

Engagement with Patients and the Public

- **We have a Critical Friends Network made up of patients and members of the public who have said they are willing to work with us on different aspects of our service provision and development. We asked all Critical Friends to give us their views on the content of our 2010-11 Quality Accounts by filling in a questionnaire.**

From the results of this engagement we learned that while some of the indicators we had chosen in 2009-10 were important to our patients and stakeholders, others that were not included last year were considered more important. We have chosen our indicators for the Review of Quality Performance based on this feedback from stakeholders.

Performance against all 2010-11 priorities is included in the table on pages 53-55. Other indicators, including our performance against national response time targets and the performance of our PTS, are included this year in response to the feedback we received.

Context

When looking at the information presented in this section, it is important to remember the numbers of patients who use our services each year. In summary, in 2010-11 we:

- **received 725,349 urgent and emergency calls**
- **responded to a total of 638,033 incidents of which 239,614 were immediately life-threatening**
- **made 1,074,331 journeys transporting patients to and from their planned hospital appointments.**

Performance Against 2010-11 Priorities for Improvement

Patient Safety		Achieved	Summary of achievement	Reference for further detail
1a	To increase the number of referrals made to specialist services for safeguarding children and vulnerable adults.	✔	1408 child referrals were made in 2010-11 compared to 783 in 2009-10. This is an increase of 80%. 1061 adult referrals were made in 2010-11 compared to 610 in 2009-10. This is an increase of 74%.	
1b	To ensure the Trust works closely with other agencies to respond effectively to all Serious Case Reviews (SCRs).	✔	Contributed to 13 SCRs, working with other organisations through the SCR panels.	
1c	To ensure all Independent Management Reports (IMRs) required as part of Serious Case Reviews are completed on time, to the necessary standard and all relevant recommendations are implemented.	✔	All reports were submitted on time.	
2a	For every emergency patient's patient report form (PRF) to be fully completed.		In 2010-11 we started two pieces of work to improve PRF completion rates. We now monitor the percentage of records for which the boxes for date, vehicle and staff details and geographical area are correctly completed. This is the information needed to ensure all PRFs can be found from the archives if needed. Local systems are now in place to review the quality of clinical information recorded on PRFs and report the results back to teams and individuals.	
2b	For no investigation following a Serious Untoward Incident to identify inadequate clinical assessment as a root cause.	✗	Two SUI investigations have identified issues with clinical assessment. These relate to spinal immobilisation and misinterpretation of ECG results. Actions have been taken as a result of these incidents and our plans to develop clinical assessment skills in 2011-12 will help reduce the risk of future incidents.	

Objective achieved *Objective partially achieved* *Objective not achieved*

Clinical Effectiveness		Achieved	Summary of achievement	Reference for further detail
3a	To maintain the current level of achievement of greater than 90% for recording of clinical observations for patients with stroke.	✔	All CPIs for stroke achieved above 90%.	Full CPI performance: pages 61-63
3b	To maintain the current level of achievement of greater than 95% for management of patients with hypoglycaemia and 95% for management of patients suffering STEMI heart attacks.	✔	All CPIs for hypoglycaemia achieved above 95%. All CPIs for STEMI improved compared to 2009 scores.	Full CPI performance: pages 61-63
3c	To achieve performance that is no worse than 1.8 standard deviations below the average score for all English ambulance services for response to patients with cardiac arrest and treatment of patients with asthma.	✔	Response to cardiac arrest: z score = -0.29 Treatment of patients with asthma: z score = 0.66	Full CPI performance: pages 61-63
3d	To make improvements against the CPIs for patients suffering STEMI heart attacks: recording of two pain scores and administration of analgesia.	✔	May 2009 results: recording of pain scores = 60.34, analgesia given = 38.14 May 2010 results: recording of pain scores = 85.40, analgesia given = 75.2	Full CPI performance: pages 61-63
3e	To make improvements in the recording of peak flow readings for patients with asthma.	✔	Sept 2009 result: peak flow recording = 45.34 March 2010 result: peak flow recording = 54.50	Full CPI performance: pages 61-63
4a	To increase the percentage of eligible patients referred to the hypoglycaemia care pathway by 5%.	✔	To achieve a 5% increase 1500 referrals were required during the year. 1949 referrals were made in 2010-11.	
4b	To increase the percentage of eligible patients over the age of 65 referred to the falls care pathways.	✔	173 referrals were made in April 2010 and a target of 210 referrals per month was set. The target was met every month from July 2010 onwards. The average number of referrals per month was 447.	

Objective achieved *Objective partially achieved* *Objective not achieved*

Patient Experience		Achieved	Summary of achievement	Reference for further detail
5	To identify new ways to measure the experience of our patients and start recording our level of achievement.	✔	Satisfaction surveys carried out with users of our Patient Transport Service. New patient experience survey for A&E patient developed. Experience survey of users of diabetes care pathway completed.	
6	To increase the number of patients requiring palliative care being referred to a district nursing service following assessment by our crews.	✔	Trial of end-of-life pathway completed in Wakefield and results assessed. Agreement from PCTs to roll out Yorkshire-wide.	

Objective achieved *Objective partially achieved* *Objective not achieved*

Indicator 1: **Ambulance Response**

In 2010-11 our nationally set targets were to respond to:

- **75% of Category A patients (immediately life-threatening) within eight minutes**
- **95% of Category A patients within 19 minutes**
- **95% of Category B patients (serious but not life-threatening) within 19 minutes.**

The funding for our services is provided by PCTs and we work with our PCT commissioners to negotiate a level of funding that will allow us to achieve the national Category A response time indicator, on average, over the PCT area (see pages 57-58).

In 2010-11 we made significant progress in improving our response times to patients requiring emergency ambulance attention. This was recognised by the CQC and the condition on our registration, which related to our ability to meet our Category A targets, was removed in September 2010.

However between November and January our performance was significantly affected by the snow and freezing conditions which increased demand for our services and extended the journey times for our ambulances. This affected our response times in this period and our overall achievement in 2010-11. More information about our response to the adverse weather is included in our Annual Report.

We continue work with our PCT commissioners to ensure we reach patients in all areas of Yorkshire - both urban and rural - as quickly as possible. This means looking carefully at the numbers and types of staff and vehicles we have in each area, and the way they operate, to best meet the needs of local communities.

In outlying rural areas, where it is not always possible to get an emergency vehicle to a patient with a life-threatening condition within the first few vital minutes, we support many local Community First Responder (CFR) schemes. CFRs are trained in basic life support skills, the use of an automated external defibrillator and administering oxygen. They can provide treatment in the first few vital minutes before an ambulance arrives. We are also developing partnerships with other organisations, such as the Coastguard and Mountain Rescue services.

Our patients and stakeholders also asked us to state in our Quality Accounts the time it took us to answer 999 calls. This is the time between the call being connected to our 999 communications centre by BT and the call being answered by one of our trained call-takers.

Time from Call Connect to Call Answer (seconds)

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Target	4	4	4	4	4	4	4	4	4	4	4	4
Actual	4	4	3	3	2	2	3	3	7	4	3	3

	ACTIVITY							
Target	CATEGORY A				CATEGORY B			
PCT	Commissioned	Actual	Difference	% Variance	Commissioned	Actual	Difference	% Variance
NHS NORTH YORKSHIRE AND YORK	30797	33397	2600	8.4%	28018	28838	820	2.9%
NHS EAST RIDING OF YORKSHIRE	14966	15881	915	6.1%	12516	12387	-129	-1.0%
NHS HULL	15195	15753	558	3.7%	14862	15121	259	1.7%
NHS BRADFORD AND AIREDALE	26683	27915	1232	4.6%	24674	24299	-375	-1.5%
NHS CALDERDALE	8835	9393	558	6.3%	9011	9366	355	3.9%
NHS KIRKLEES	16994	17856	862	5.1%	17890	18193	303	1.7%
NHS WAKEFIELD DISTRICT	16302	17251	949	5.8%	16303	17165	862	5.3%
NHS LEEDS	36377	37968	1591	4.4%	38009	38269	260	0.7%
NHS BARNSLEY	10904	11469	565	5.2%	9861	10114	253	2.6%
NHS DONCASTER	14602	15305	703	4.8%	14076	14254	178	1.3%
NHS ROTHERHAM	11961	12167	206	1.7%	11220	11066	-154	-1.4%
NHS SHEFFIELD	23928	25259	1331	5.6%	25270	25131	-139	-0.6%
TOTAL	**227544**	**239614**	**12070**	**5.3%**	**221710**	**224203**	**2493**	**1.1%**

	PERFORMANCE					
Target	CATEGORY A 8 MINUTE		CATEGORY A 19 MINUTE		CATEGORY B 19 MINUTE	
PCT	% incidents attended in 8 minutes	% Variance	% incidents attended in 19 minutes	% Variance	% incidents attended in 19 minutes	% Variance
NHS NORTH YORKSHIRE AND YORK	68.2%	-6.8%	93.6%	-1.4%	91.0%	-4.0%
NHS EAST RIDING OF YORKSHIRE	68.4%	-6.6%	93.1%	-1.9%	89.6%	-5.4%
NHS HULL	87.4%	12.4%	99.5%	4.5%	97.9%	2.9%
NHS BRADFORD AND AIREDALE	70.9%	-4.1%	97.2%	2.2%	91.4%	-3.6%
NHS CALDERDALE	75.8%	0.8%	97.5%	2.5%	91.8%	-3.2%
NHS KIRKLEES	72.4%	-2.6%	98.1%	3.1%	92.8%	-2.2%
NHS WAKEFIELD DISTRICT	76.5%	1.5%	98.5%	3.5%	93.7%	-1.3%
NHS LEEDS	73.0%	-2.0%	98.5%	3.5%	94.5%	-0.5%
NHS BARNSLEY	75.7%	0.7%	98.8%	3.8%	96.5%	1.5%
NHS DONCASTER	73.4%	-1.6%	98.6%	3.6%	95.8%	0.8%
NHS ROTHERHAM	75.4%	0.4%	98.8%	3.8%	96.0%	1.0%
NHS SHEFFIELD	77.5%	2.5%	99.1%	4.1%	95.8%	0.8%
TOTAL	**73.7%**	**-2.2%**	**97.4%**	**2.0%**	**93.7%**	**-1.3%**

Indicator 2: **Patient Transport Service Performance**

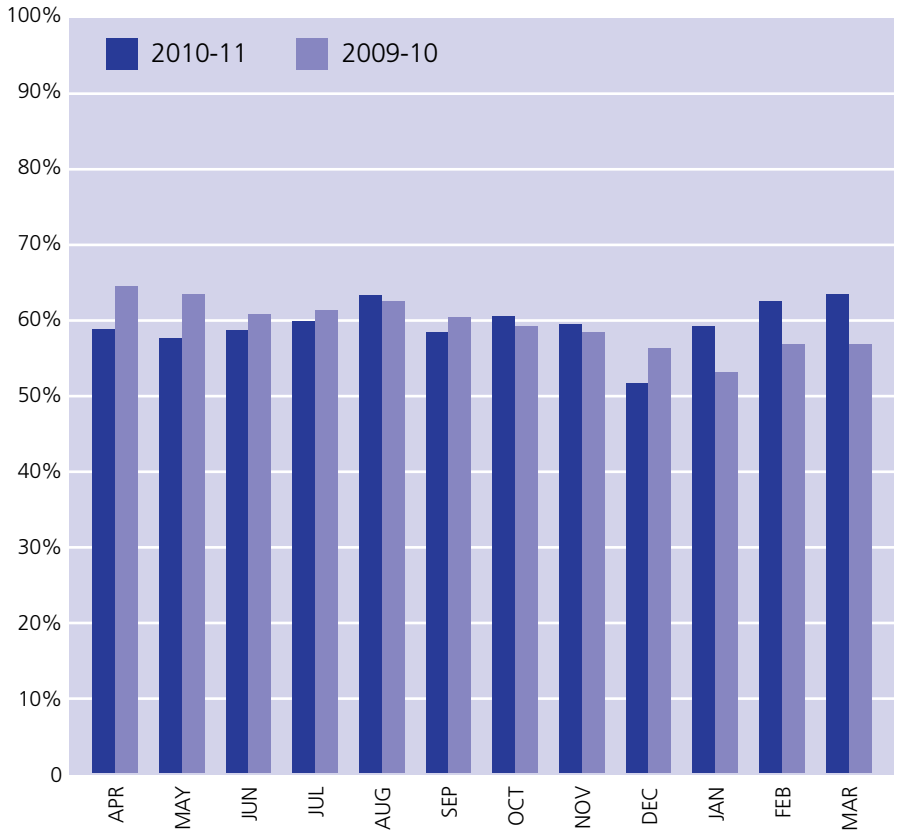
Our PTS is provided by trained staff working to high standards of quality, safety and professionalism.

In addition to Trust-wide indicators of quality, we measure the standard of our PTS operational performance using three measures:

- **Punctuality:** whether patients arrive in time for their appointments. We aim to get patients to their clinic between 0 and 60 minutes before their appointment time.
- **Waiting time:** how long patients have to wait for their return transport after the clinic tells us that the patient is ready to travel. We aim to pick up patients for their return journey within 60 minutes of being told by the clinic that they are ready to travel.
- **Journey times:** how long patients spend on the vehicle. We aim for journey times to be below 60 minutes.

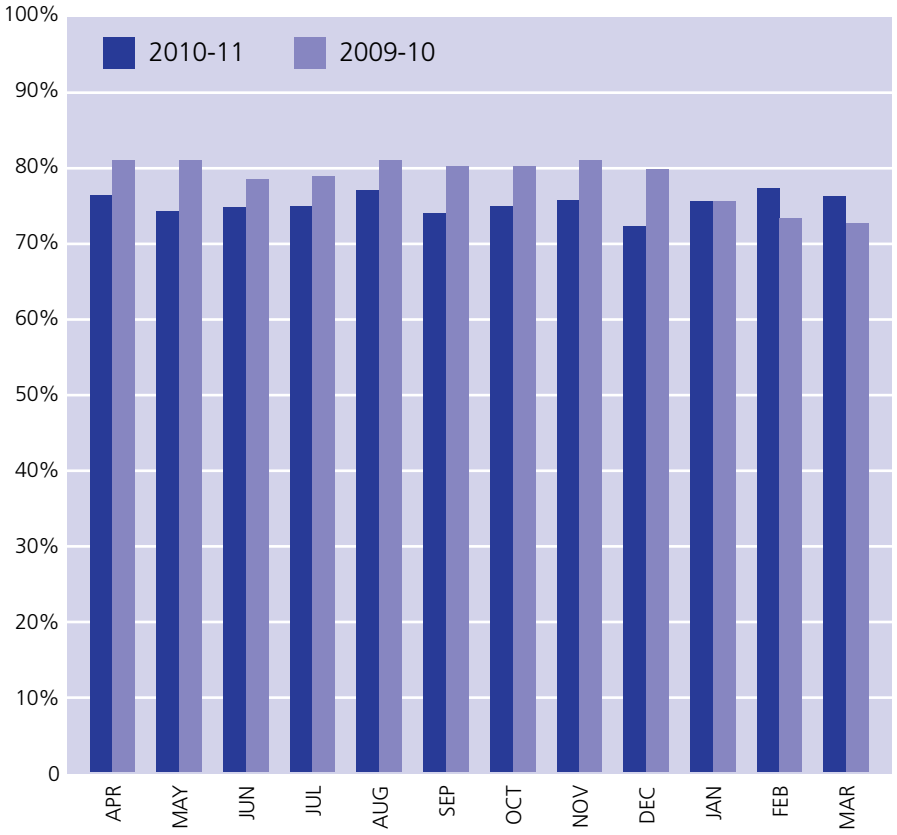
For each of the above measures we have agreed performance targets with local commissioners.

PTS Punctuality - Arrive within 60 minutes before appointment

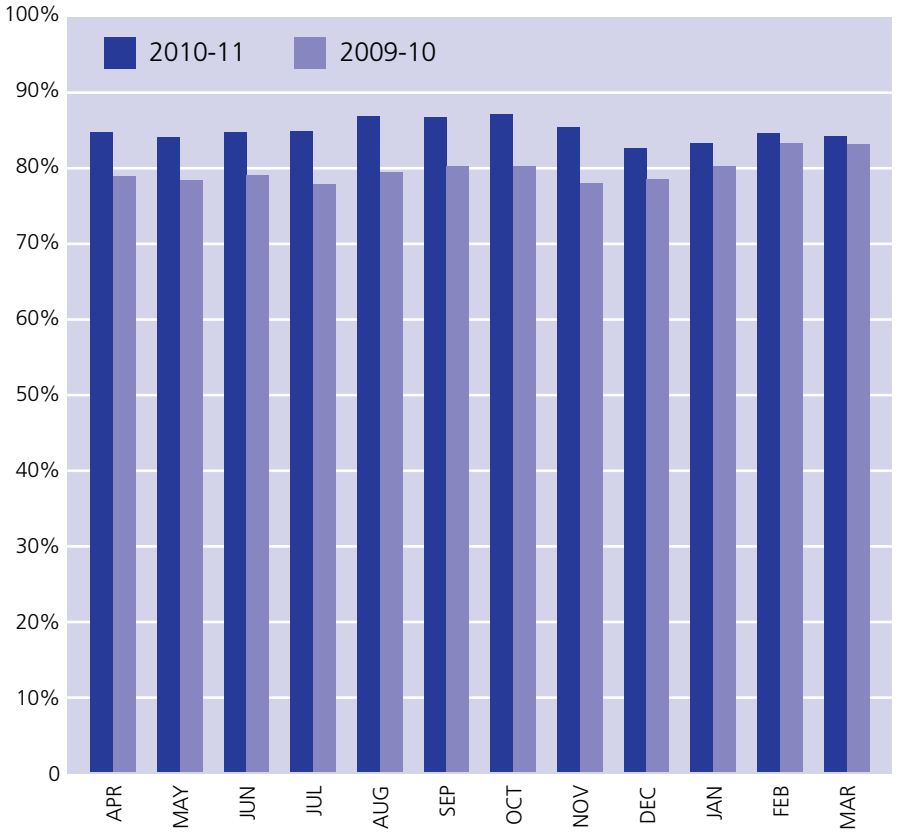


Indicator 2: **Patient Transport Service Performance**

PTS Waiting Time - Less than 60 minutes for transport home



PTS Journey Time - Less than 60 minutes on PTS vehicle



Indicator 3: **Clinical Performance Indicators**

There are five nationally-agreed clinical performance indicators (CPIs) which relate to conditions where the care of ambulance clinicians can make a significant difference to patient outcomes. For each indicator there are agreed actions that should be completed for every patient with that condition and we audit our patient report forms (PRFs) to identify whether these were carried out. Our performance is reported as the percentage of cases for which our ambulance clinicians carried out these actions.

Our scores are also compared with those of other English ambulance services and a measure calculated for how close we are to the national average score. The z-score describes how many standard deviations above or below the mean score a trust is positioned. The standard agreed by national ambulance directors of clinical care is that a z-score of -2 or above indicates that a trust is performing within acceptable limits in comparison with other trusts, whereas a score of below -2 indicates underperformance in relation to other trusts.

In 2011-12 these CPIs will be included in the nationally-agreed ambulance CQIs (see page 39).

In 2010-11 we improved our performance against all five of the CPI areas. This shows that more patients than ever are getting the best possible care for their conditions.

As well as submitting information to the national CPI audits we now also carry out local audits every month. The results of the local audits are sent to local teams so that our clinicians can see where they are doing well, where they may be able to improve and where they may be able to learn from teams in other areas. The results are also reported every month to the Trust Board.

Summary of CPI Results 2010-11

Condition	Number of CPIs relating to the management of patients with this condition	Achievement of national standards for CPIs
Heart Attack (STEMI)	5	*Met in 5 areas*
Cardiac Arrest	3	*Met in 3 areas*
Stroke	3	*Met in 3 areas*
Hypoglycaemia	3	*Met in 3 areas*
Asthma	5	*Met in 5 areas*

Full CPI Results 2010-11

ST Elevation Myocardial Infarction (STEMI)	Nov 2009 Results %	National Average	z-score	**May 2010 Results %**	**National Average**	**z-score**
M1 - Aspirin administered	95.65	93.99	0.26	**98.5**	**96.9**	**0.57**
M2 - GTN administered	79.35	90.04	-1.56	**93.0**	**92.2**	**0.13**
M3 - Two pain scores recorded	80.00	77.56	0.72	**85.4**	**79.9**	**0.79**
M4 - Morphine alone given	58.44	64.94	0.47	**67.6**	**72.1**	**0.59**
M5 - Analgesia given	67.11	66.36	0.57	**75.2**	**73.3**	**0.67**

Cardiac Arrest	Dec 2009 Results %	National Average	z-score	**June 2010 Results %**	**National Average**	**z-score**
C1 - Return of spontaneous circulation on arrival at hospital	16.16	18.92	-0.34	**15.3**	**21.1**	**-0.55**
C2 - Advanced life support provider in attendance	92.61	95.55	-0.65	**99.4**	**97.8**	**0.77**
C3 - Response to cardiac arrest < 4 minutes	19.21	24.39	-0.60	**21.1**	**23.4**	**-0.29**

Stroke	Jan 2010 Results %	National Average	z-score	**July 2010 Results %**	**National Average**	**z-score**
S1 - Face, Arm, Speech Test (FAST) recorded	96.74	95.12	0.35	**95.2**	**95.6**	**-0.07**
S2 - Blood glucose recorded	96.60	90.89	0.92	**94.6**	**92.5**	**0.50**
S3 - Blood pressure recorded	98.98	98.45	0.25	**100**	**98.6**	**0.59**

Full CPI Results 2010-11

Hypoglycaemia	Feb 2010 Results %	National Average	z-score	**Aug 2010 Results %**	**National Average**	**z-score**
H1 - Blood glucose recorded before treatment	99.3	98.9	0.22	**98.0**	**98.8**	**-0.57**
H2 - Blood glucose recorded after treatment	97.7	97.0	0.35	**96.9**	**93.3**	**0.39**
H3 - Treatment for hypoglycaemia recorded	99.3	96.9	0.48	**99.0**	**95.3**	**0.40**

Asthma	Mar 2010 Results %	National Average	z-score	**Sept 2010 Results %**	**National Average**	**z-score**
A1 - Respiratory rate recorded	98.8	98.49	0.29	**100**	**97.4**	**0.82**
A2 - Peak flow recorded before treatment	54.5	41.74	0.86	**56.3**	**50.0**	**0.39**
A3 - Oxygen saturation recorded before treatment	84.6	90.80	-0.65	**92.8**	**92.8**	**0.00**
A4 - Beta 2 agonist recorded	99.2	96.12	0.73	**98.3**	**96.0**	**0.53**
A5 - Oxygen administered	99.2	92.90	0.56	**99.0**	**93.6**	**0.47**

Indicator 4: **Developing Alternative Care Pathways**

Our priorities for improvement in 2010-11 included increasing the number of patients referred by our ambulance clinicians to care pathways for stroke, falls and end-of-life care.

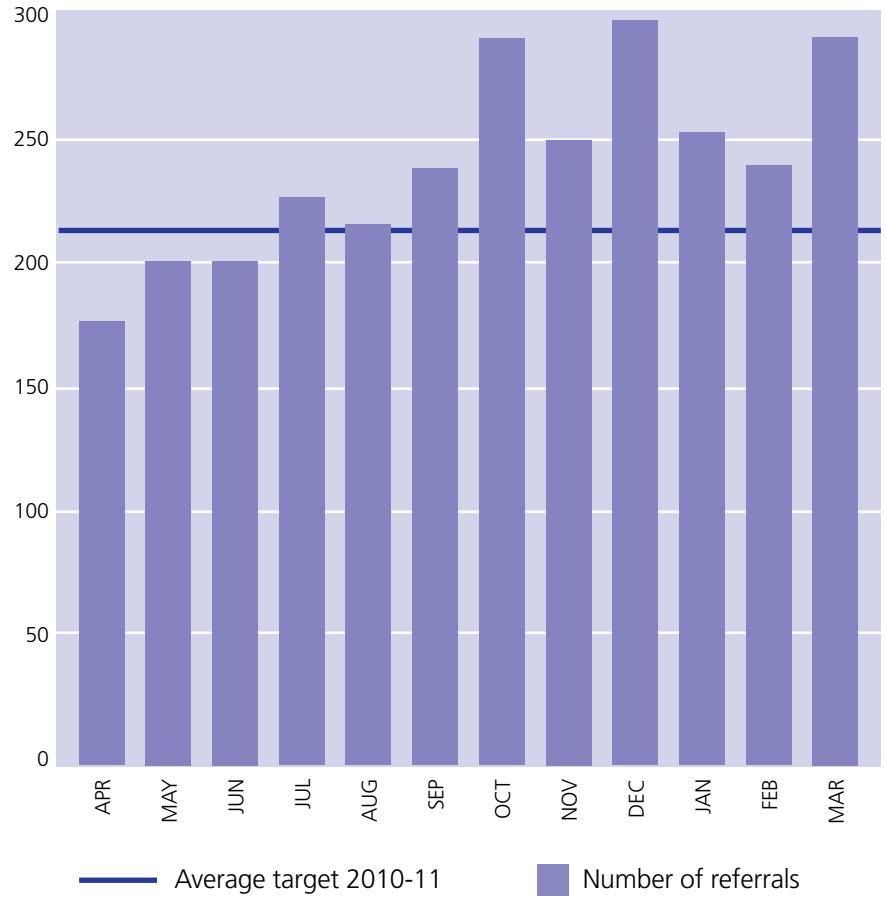
Quite often patients who have fallen do not need to be transported to hospital for treatment. However it is important that they receive follow-up assessment to try to prevent them falling again in the future. In 11 out of 12 of the Yorkshire PCT areas, falls pathways are in place where ambulance clinicians can arrange for the patient to be visited by a member of a community falls team. We are in discussions with NHS Sheffield, the remaining PCT, about developing a pathway in this area.

Following a 999 call for a hypoglycaemic episode (where blood sugar has fallen very low), patients across much of Yorkshire are referred to diabetes specialist nurses who provide follow-up care. Referral may not be appropriate for all patients attended, but those referred in this way have reported that it helped them understand the importance of monitoring their blood sugar and how to prevent problems in the future.

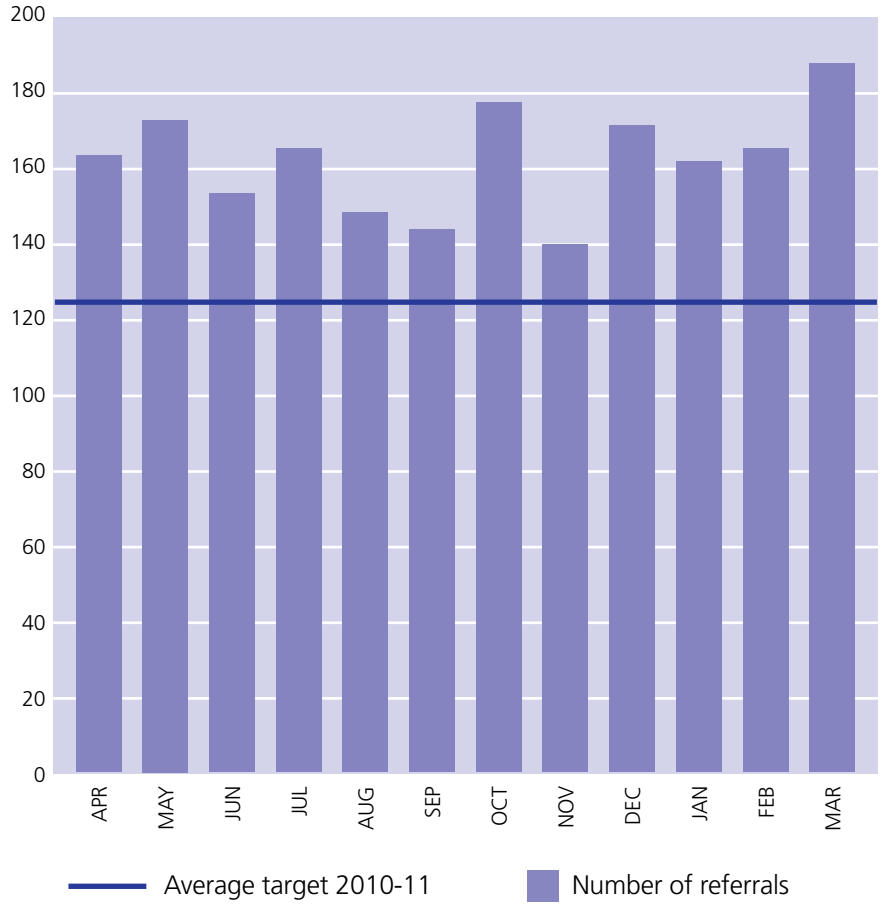
We set a target to increase the number of referrals made by our ambulance clinicians by 5% compared to 2009-10. This required us to make 1500 referrals during the year. In 2010-11 we made 1949 referrals.

Working with our PCT colleagues we carried out a survey to ask patients about their experience of the diabetes care pathway. The results are reported on page 74 as part of Indicator 9.

Falls Pathway - Number of Referrals



Hypoglycaemia Pathway - Number of Referrals



Indicator 5: **Complaints, Concerns, Comments and Compliments**

Our staff work very hard to get the job right first time but, with a busy service, mistakes can happen and problems occur. When people tell us about their experiences we listen, if necessary put things right, and learn for the future.

As well as telling us when things go wrong, we are very pleased when people tell us about a good experience of our services. When this happens the member of our staff receives a personal letter from their director acknowledging their good service. That director also writes back to the person who sent in the compliment to thank them for taking the time to contact our service.

2010-11 - Complaints, Concerns and Comments

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Attitude - negative	21	11	13	19	13	19	16	15	17	16	17	24
Delayed, inappropriate, no response	125	89	127	113	91	144	122	73	78	110	99	122
Patient care	26	19	25	20	17	17	12	28	20	24	26	20
Driving Issues	6	4	8	9	12	9	5	6	13	4	8	7
Administrative	12	10	10	9	6	25	8	9	5	6	8	5
Other (procedural issues)	3	2	1	2	2	2	0	0	0	1	9	4
TOTAL negative	**193**	**135**	**184**	**172**	**141**	**216**	**163**	**131**	**133**	**161**	**167**	**182**
Compliments	**49**	**49**	**68**	**88**	**56**	**49**	**66**	**49**	**71**	**66**	**118**	**64**

2009-10 - Complaints, Concerns and Comments

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Attitude - negative	13	15	12	17	16	8	22	20	13	19	11	14
Delayed, inappropriate, no response	43	55	61	59	43	62	75	61	58	42	99	131
Procedural deviation	14	19	18	31	21	29	34	39	42	40	29	50
Road Traffic Collisions	1	0	0	0	0	0	1	0	0	3	0	0
Equipment Failure	0	2	0	0	0	0	2	1	1	1	0	0
TOTAL negative	**71**	**91**	**91**	**107**	**80**	**99**	**134**	**121**	**114**	**105**	**139**	**195**
Compliments	**20**	**44**	**37**	**38**	**13**	**18**	**49**	**58**	**25**	**40**	**46**	**53**

When people contact us to tell us about a problem we understand that they want us to respond to their concerns as soon as possible. For each person making contact with us we developed an individual resolution plan to record the issues raised and the outcome they were looking for and a timescale for resolution. In 2010-11 we received 1552 concerns and 67 formal complaints. Of these we resolved 620 (38%) within five working days.

During 2010-11 only one complainant asked the Parliamentary and Health Service Ombudsman to undertake an independent review of their complaint.

Learning lessons from complaints, concerns and comments is very important to us. Every two months we reported key issues, themes and trends to our Integrated Governance Committee (a sub-committee of the Trust Board) and how we are learning from these to improve our services in the future. Some of the improvements we made in 2010-11 as a result of issues highlighted through complaints, concerns and compliments were:

Patient Transport Service

- **In April, September and October 2010 we received high numbers of concerns and complaints from patients calling our PTS patient booking line. This service is provided for patients in North and East Yorkshire where patients are required to book their transport directly with us rather than having it done for them by their GP surgery or hospital clinic. As a result of the feedback we recruited and trained additional call-takers in the PTS communications centre.**
- **A number of patients told us that they had found that their transport home from hospital had been cancelled without their knowledge. This happened where the patients had made their own way to hospital after their booked transport had been late to collect them. As the journey to hospital was logged on our system as cancelled, this then meant that the return journey was automatically cancelled as well. As a result we changed our system so return journeys were not automatically cancelled in these circumstances. We also contact the clinic or surgery which is responsible for making the transport booking to ask them to check that the patient is still eligible for the service.**
- **A number of patients complained after receiving injuries whilst being transported in wheelchairs by PTS staff. As a result we developed new staff training and skills assessment. We are also improving the content of the statutory and mandatory training programme for PTS staff.**

Accident and Emergency Service

- **We received several complaints from patients which highlighted cases where clinicians had mistakenly diagnosed patients as suffering from panic attacks. To improve awareness of the potential clinical causes of hyperventilation (over-breathing), reminders about best practice were published in our weekly staff bulletin, *Operational Update*, and in the monthly *Clinical Catch-up* briefing.**
- **Following a complaint, we reviewed the case of an elderly patient who had fallen outdoors and had waited close to three hours for ambulance assistance. This happened at a time when we had declared a major incident due to the exceptional number of calls we were receiving as a result of adverse weather. As a result we developed a new system in our 999 communications centres. Now, during major incidents, a member of staff is responsible for checking the waiting times and clinical conditions of patients who have been waiting longer than usual for an ambulance.**

The other main themes from complaints and concerns that we continued to work with staff and managers to address were:

- the punctuality of PTS and long waiting times to go home after treatment
- negative experiences due to the attitude of YAS staff
- clinical staff not following the correct procedures for recording patients' basic clinical observations before taking them to the ambulance.

Indicator 6: **Adverse Incidents and Serious Untoward Incidents**

If errors are made which put patients at risk or if patients are harmed, we report and thoroughly investigate the incident to ensure lessons are learned for the future. The majority of incidents are reported internally according to Trust processes but in addition, the most serious are reported to our commissioners as Serious Untoward Incidents (SUIs).

Incident Reporting

In 2010-11 we did a lot of work to develop and improve the way we record and report incidents and how we use this information to identify issues, themes and trends requiring action. Every month we report the numbers of new incidents recorded and also, separately, the numbers of incidents relating to patient care, medication and staff.

The numbers of incidents reported in 2010-11 are shown in the table below. In the future we will be able to compare the figures with those of the previous year.

The figures show that numbers of incidents reported increased between November 2010 and January 2011. This was due to the period of sustained adverse weather when we received exceptionally high numbers of 999 calls and road and pavement conditions were treacherous for staff and vehicles. Frontline staff also reported that some clinical equipment did not work effectively in very cold conditions. Advice was quickly provided and, where necessary, new equipment sourced to address these issues.

Directorate	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Accident and Emergency	81	154	111	185	119	133	165	224	293	243	254	263
Access and Response Communications Centres	32	82	56	60	39	52	43	110	235	220	94	96
Patient Transport Service	12	32	30	31	28	38	38	25	55	50	51	66
Other (includes fleet, equipment and estates)	88	210	250	257	229	221	244	366	293	278	234	222
TOTALS	213	478	447	533	415	444	490	725	876	791	633	647

In our consultation with patients, public and our stakeholders, people said that they thought it was important for us to publish the numbers of medication-related incidents reported each month.

Medication-related incidents	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Totals	24	17	17	25	9	28	35	37	26	24	31	32

This year we have rolled out morphine for use by qualified clinicians in all areas of Yorkshire. We have very strict procedures for managing controlled drugs and any errors in recording stock levels or breaches of security procedures have to be reported. We have also changed the systems for managing drugs in West Yorkshire and some incidents have been reported as a result of the transition to the new procedures. All medication-related incidents are reviewed by our Medicines Management Committee which is chaired by an assistant medical director.

Serious Untoward Incidents

In 2010-11 we reported 21 SUIs. This compares to 23 in 2009-10.

Incident Category	2009-10
Delayed dispatch/ response	8
Road traffic collision	1
Clinical care	2
Equipment failure	4
Inappropriate response	1
Incidents involving other organisations	2
Medication related	1
Procedural deviation	1
Other	3
TOTAL	23

Incident Category	**2010-11**
Delayed dispatch/ response	**8**
Road traffic collision	**3**
Clinical care	**2**
Inadequate clinical assessment	**2**
Alleged assault	**3**
Data protection breach	**1**
Adverse media attention	**1**
Workplace safety	**1**
TOTAL	**21**

This year we have developed our procedures for managing SUIs to ensure that all incidents are reported and investigated in a thorough and timely manner, that action plans are agreed and monitored and that lessons are learned for the future. To support this we have provided training for managers in root cause analysis techniques and the management of incidents and SUIs.

Actions we have taken as a result of learning from SUIs include:

- developing a Trust-wide driving policy and a process for periodic assessment of individual drivers
- developing new routes for communicating essential clinical information and reminders to ambulance clinicians
- completing a review of replacement and maintenance programmes for all essential clinical equipment.

Indicator 7: **Referrals to Services for Safeguarding Vulnerable Adults and Children**

The welfare of children and vulnerable adults is an ongoing priority and we aim to ensure that patients in our care are safe and protected by effective intervention if they are thought to be suffering, or likely to suffer significant harm.

The numbers of referrals our staff make to specialist services show how vigilant they are being for signs of neglect and abuse and their confidence in the training they have received.

YAS is leading the way in developing best practice for safeguarding in ambulance services and we chair the National Ambulance Safeguarding Group. This group allows safeguarding managers to work together on common issues, share knowledge and experience and compare information between ambulance trusts.

In 2010-11 our staff made the following numbers of referrals, compared to 2009-10:

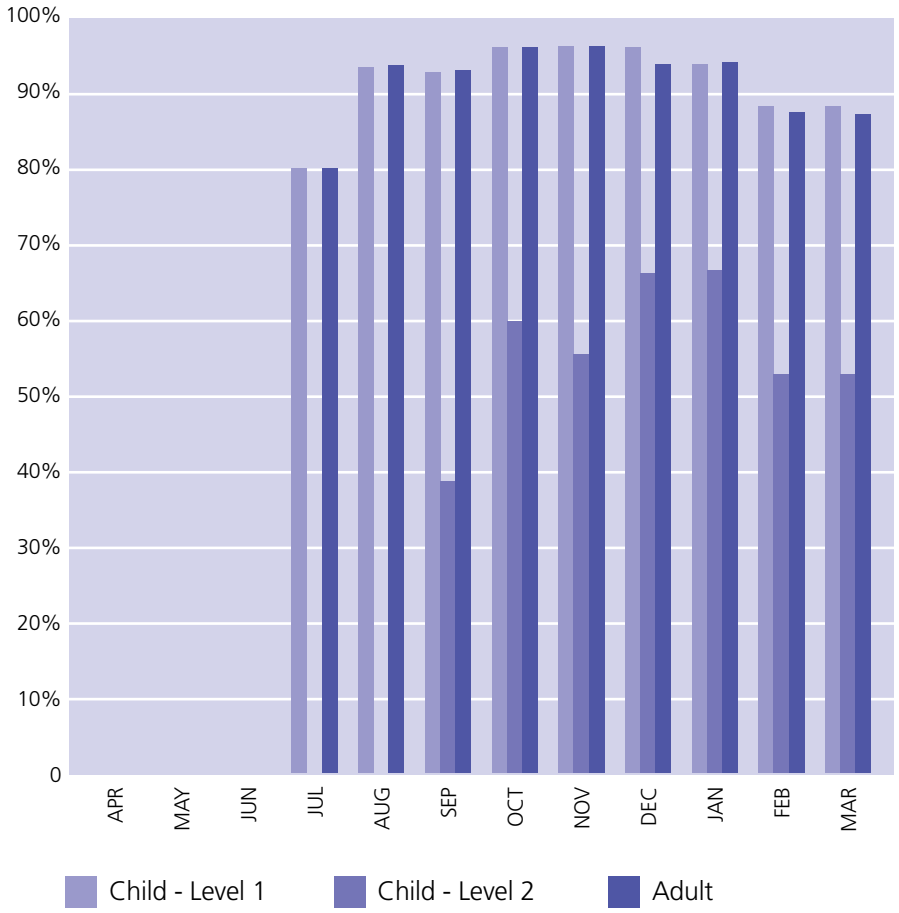
Referrals	2009-10	**2010-11**
CHILDREN		
Referrals	783	**1408**
ADULTS		
Referrals	610	**1061**

We achieved this increase through the significant effort we have put into our staff training programme.

Safeguarding Children level-one is basic-level training which is required by all YAS staff.

Safeguarding Children level-two is more in-depth training and is required by staff who have direct contact with children and vulnerable adults as part of their jobs.

Percentage of Eligible Workforce Trained



Indicator 8: **Vehicle Cleaning and Hand Hygiene**

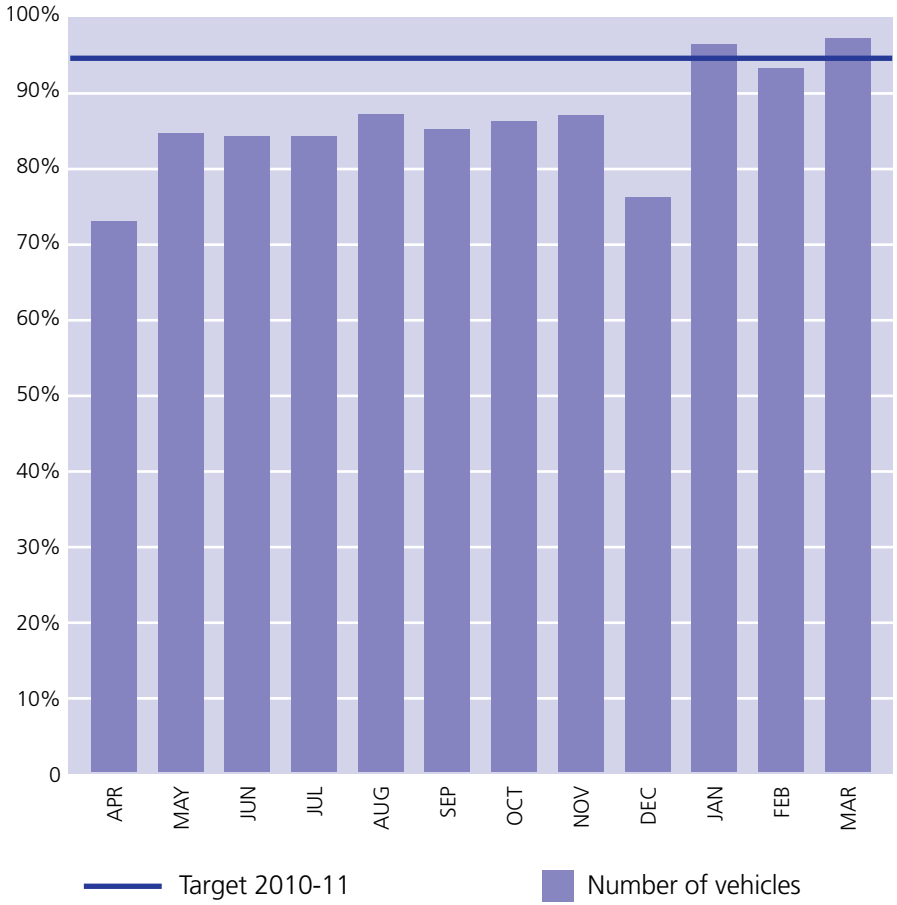
Infection prevention and control is one of the basic elements of providing safe patient care. At YAS we monitor two key indicators:

- Compliance with vehicle deep-cleaning schedules.
- Compliance of staff with hand hygiene procedures.

Vehicle Deep-cleaning

We set ourselves very tight targets for vehicle deep-cleans. In 2010-11 we aimed for 95% of ambulance vehicles to receive a deep-clean once every 28 days. This was a challenging target to achieve as high demand for our services meant that vehicles were only off the road for relatively short periods. During the year we have recruited additional cleaners and developed our processes to ensure standards are consistently met. We will build on our experience in 2010-11 and the lessons we have learned to try to ensure that we meet our targets for the whole of 2011-12.

Percentage of Vehicles Cleaned within Specified Time Period

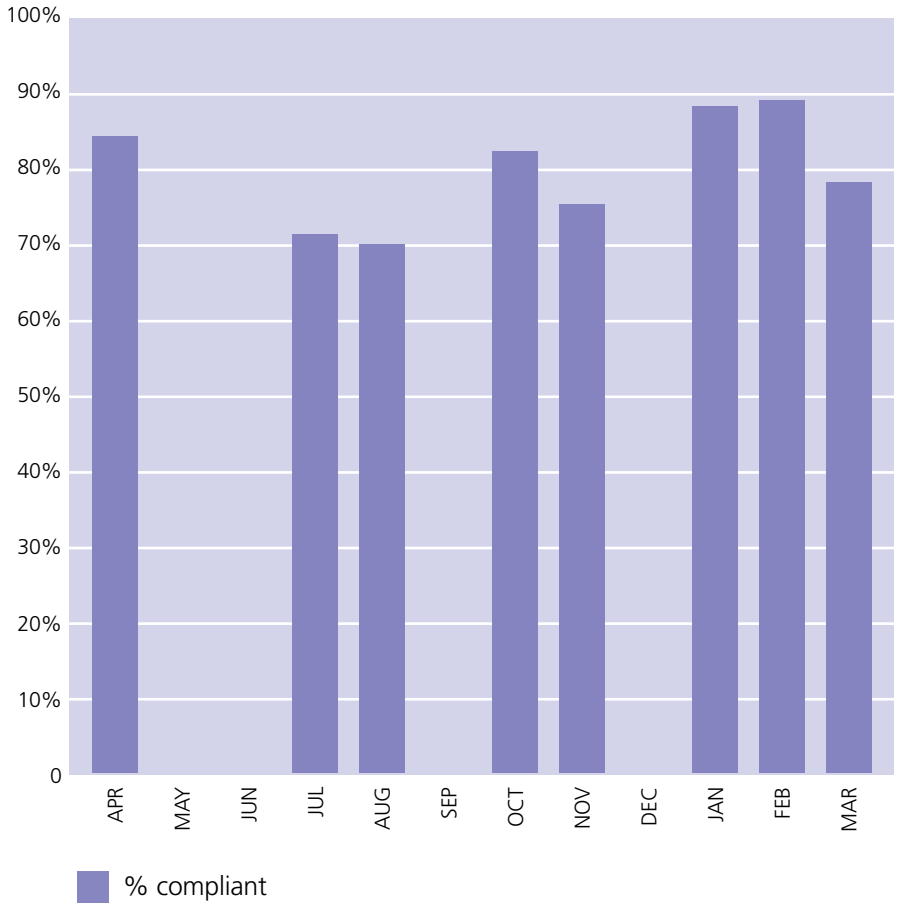


Hand Hygiene Audits

We carried out eight audits on how well our staff were complying with rules on hand hygiene.

Our work this year to improve our infection prevention and control includes the introduction of our Trust 'Bare Below the Elbows' policy and an ongoing programme of awareness-raising activities and staff training. From October 2010 hand hygiene audits have been completed every month with the exception of December 2010 when the process was suspended due to the adverse weather.

Percentage Compliance Hand Hygiene



Indicator 9: **Measuring Patient Experience**

Unlike in hospital trusts, there is no standard national survey of the experience of ambulance service patients. However, we know that it is vital that the Board has a clear picture of what it feels like to be a patient using our services.

In 2010-11:

- **We set up a Patient Experience Group to look at feedback from patients. The Group's role includes developing new ways to obtain feedback to get a balanced view from A&E and PTS patients and recognising the diversity of our communities. The group shares the learning from patient feedback with staff and managers so they can improve services for the future.**
- **Our Trust Board has started to use patient stories at its public meetings. This includes anonymised case studies and video footage of patients talking about their experiences. By putting the voices and experiences of real patients into our Board room it helps Board members maintain their focus on high quality patient care at all times.**
- **We launched a Dignity and Respect Campaign with our staff based around a six-point Dignity Code:**

  1. *Remembering that many care activities can leave people feeling vulnerable (physically, emotionally or psychologically).*
  2. *Demonstrating respectful verbal and non-verbal communication.*
  3. *Having zero tolerance for all forms of abuse.*
  4. *Supporting people with the same respect you would want for yourself or a member of your family.*
  5. *Respecting people's right to privacy.*
  6. *Treating everyone as being of worth, in a way that is respectful of them as valued individuals.*

We received feedback from patients via the following routes:

- 439 patients were asked to complete a **questionnaire** about their experience of the diabetes care pathway. 125 patients sent back their questionnaires although not all patients answered all the questions. Out of 125 patients who responded to the survey, 114 said that they were very satisfied with the care provided by the ambulance staff. Six patients said they were fairly satisfied, one patient was not sure and four did not answer the question.
- We made **comments cards** available to all PTS users. 96 cards were returned over the year. 78% of service users rated the helpfulness and friendliness of our staff as excellent and 16% rated it as good. However some patients also told us they sometimes had to wait too long for their transport home. 51% rated their waiting time as good, 20% said it was satisfactory and 26% said it was poor.
- We telephoned a **sample of PTS patients** directly to ask them to tell us about their experience of our service. We called 125 patients and 46 gave us their feedback. 100% of patients said they were either satisfied or very satisfied with the attitude and professionalism of our staff. However 41% also said they had to wait longer than two hours for their return journeys after their appointments.
- We commissioned patient experience research to look at the **experiences of renal patients** using our PTS.

Statements from Local Involvement Networks, Overview and Scrutiny Committees and Primary Care Trusts

The regulations of the Health Act 2009 require us to send copies of our Quality Accounts to our LINks, OSCs and lead commissioning PCT for comment prior to publication. The regulations state that we must allow a consultation period of 30 working days. We must publish the statements at the end of the Quality Accounts.

We have received the statements which are published in full.

We have listened to all the views and issues put forward to us, some of which have been addressed. Others will be used as basis for further discussion and engagement and to help us further improve our services over the year ahead.

Yorkshire-wide Ambulance Local Involvement Network Group

It has been proposed that the Yorkshire-wide Ambulance LINk Group facilitates a joint statement for publication. Three LINks chose to submit a joint response. These are: Sheffield LINk, East Riding of Yorkshire LINk and North Yorkshire LINk, and the following is their joint view:

Very few trusts map quality to individual services provided and where they do, usually the quality of only one or a few services or specialties are reviewed. This is not surprising, given the wide range of services provided by this Trust, and the need to keep Quality Accounts to a readable length and format for a lay audience. However, this does highlight a key tension in Quality Accounts, between comprehensiveness of comment on the range of services provided on the one hand, and the length and complexity of the documents on the other. YAS has responsibility for many services and LINks have been able to visit and comment on how these are organised. Specialist services for neonates have been discussed. LINks have focused on working with YAS on: the interface between YAS and the Police for people with mental health problems, emergency preparedness, and A&E. Members undertook a comprehensive tour of the A&E communications centre and it was a real pleasure to experience the dedication and professionalism of those staff working in sometimes very traumatic circumstances. Changes to service delivery is something LINks will very closely monitor as they are introduced, via direct liaison with YAS officers and through attending public board meetings where it is possible to discuss openly at senior level with YAS managers.

The key function of Quality Accounts is to provide the lay person with understandable information by way of a dialogue; we are pleased to note this year your Quality Accounts addresses this well; we feel you have listened to the commentary of last year and taken it on board.

In the Review of Quality Performance, the way indicator one is presented does not give in lay person's language a way of comparison of year-on-year performance, benchmarked against other similar size ambulance trusts and nationally. Additional information needs including.

LINk recommend: The use of a 'traffic-light' system, where performance is rated red (poor), amber (adequate or not particularly good) or green (good) and to use this consistently to indicate your performance. This is a way of providing a considerable amount of information with a clear indication of the level of performance at a glance. Traffic light indicators are widely used internally in trusts therefore why not in the Quality Accounts.

An example of development of performance measuring is the new process for Patient Transport Service (PTS):

Patients come first and foremost and because of this we have been able to develop a Patients Charter outlining the expectations of those using PTS, and this document is now being honed before being placed into circulation. However PTS booking* has proved to be a frustrating experience for many, and LINks highlighted the fact that many callers abandoned their attempts to arrange this service. Now a measurable indicator has been established in order to iron out previous difficulties. Much work remains to be done to ensure that a robust and user-friendly transport facility operates and the public needs assurances that they can expect a reliable service.

Yorkshire-wide Ambulance Local Involvement Network Group (continued)

Actual patient feedback on their experiences gives a bleak picture as to how the system is currently functioning. Failure of the communications centre to answer calls over an extended period of time, poorly constructed routes, too few drivers, patients left without any idea of if their transport will arrive, all amount to a poor perception of service, which could easily be improved.

Staff feedback: the views of staff are an important marker of an organisation's managerial competence, workforce well-being and hence its ability to deliver high quality care. Staff views should be shown in the Quality Accounts which in part you have; however the reporting indicates the majority of your staff engagement is at management level. The annual CQC national surveys of NHS staff provide a readily available source of data on the views of NHS staff. Your results in this survey indicated that frontline staff are not feeling engaged fully with the business of the Trust. Quality Accounts are supposed to have a balance of both positive and negative; this would have been a good area to demonstrate this with a statement of how you are going to address this area.

The public are interested in how many complaints there have been, how they were resolved and at what stage; this could have been included in the section on Measuring Patient Experience (page 74).

We are pleased to note the intention of the Trust to produce an "easy read" version of the Quality Accounts. We would however emphasise that the full report be written in clear English.

We are also pleased to note your innovative ways of gaining customer feedback - not an easy task for your service with all your customers basically on the move while you are providing your services to them. LINks have, over the last year, been able to give much constructive criticism as well as useful ideas to assist with core processes.

We are supportive of the Trust's priorities for the coming year, and we would like to thank YAS for its open approach to working with LINks. Openness and transparency is very important for any large public body, and YAS needs to ensure that it is always able to respond to public concerns; we therefore look forward to the continuation of the positive working relationship between YAS and the Yorkshire-wide LINks group.

LINks recently held a very successful showcase event where many senior managers from YAS gave their support and LINks were reassured to learn that the input of LINKs into YAS processes are valued, and this interface must be allowed to continue to facilitate a successful transition to Healthwatch.

Explanatory note:

**YAS is commissioned by NHS North Yorkshire and York and NHS East Riding of Yorkshire to provide a PTS booking service direct to patients. In other areas the booking is made on behalf of the patient by their healthcare provider.*

Sheffield Health and Community Care Scrutiny Committee

Sheffield's Health and Community Care Scrutiny Committee would like to begin by thanking all of the staff at YAS for the hard work they have put in over the past year and the resulting improvements in performance and quality.

We are pleased to see that YAS listened to our feedback from last year, and has produced the Quality Accounts in a way that makes a very complex service easier to understand.

We were pleased to have an opportunity to engage with YAS early in the Quality Accounts process, enabling us to monitor progress on last year's priorities and contribute to the consultation on which quality priorities should be included this time. We were glad to hear that YAS included staff, partners, patients and public as part of the process.

We are pleased to see a focus on clinical outcome measures this year, and the commitment to measure and improve patient experience. We recognise that measuring the experience of ambulance service users poses significant challenges, due to the transient nature of the patient group, and praise the innovative ways that YAS has used to increase patient feedback this year. In future we'd like to see quotes from patient feedback used to illustrate the Quality Accounts.

We look forward to monitoring progress on the quality priorities over the coming year.

Wakefield Social Care and Health Overview and Scrutiny Committee

Wakefield Social Care and Health Overview and Scrutiny Committee considered YAS's Quality Accounts at its meeting held on the 21 April 2011 and noted the following points:

- The Committee welcomes proposals to measure outcomes of clinical care in addition to response time.
- The Committee welcomes the emphasis on improving Patient Transport Service (PTS) performance.
- During the Committee's inquiry into dementia services, members noted the commitment to research as a driver for improving the quality of care and patient experience and considered the research article "A Pilot Study of the Impact of NHS Patient Transportation on Older People with Dementia". The importance of staff trained in person-centred care for people with dementia was supported by this study. The research concluded that escorts appear to improve the experience of patients with dementia during journeys to and from clinics.
- The Committee noted the good engagement with partners (including O&S Committees) to provide input on the content of the Quality Accounts. On the basis of this the Committee is satisfied that YAS priorities match those of the public and they have demonstrated that they have involved patients and the public in the production of the Quality Accounts.
- The Committee welcomes the intention to produce a summary version in an easy-to-read style which will set out the key points.

Statement from NHS Bradford and Airedale (YAS lead commissioners) on behalf of all associate commissioners

NHS Bradford and Airedale, as lead commissioner, has reviewed the Quality Accounts for 2010-11, ensuring all associate commissioner comments regarding content and presentation have been incorporated. Associate commissioners include:

NHS Barnsley

NHS Kirklees

NHS Calderdale

NHS Hull

NHS Doncaster

NHS Rotherham

NHS East Riding

NHS Sheffield

NHS Leeds

NHS Wakefield District

NHS North Yorkshire and York

Overall, this is a well-presented report demonstrating that YAS is committed to providing high quality care for service-users.

NHS Bradford and Airedale acknowledges the improvements cited within the document, in particular the following which demonstrate the commitment to improving the quality of care for service-users:

- The committed work on safeguarding where YAS has worked very closely with NHS Bradford and Airedale safeguarding leads and has successfully met the requirements of the CQUIN scheme indicator supporting this work.
- The positive work in the introduction of a number of alternative care pathways including diabetes, falls and chronic obstructive pulmonary disease, which continues into 2011-12 in order to assure safe and effective use of the pathways and to monitor patient outcomes for those utilising these alternative pathways of treatment.

YAS has clearly demonstrated its participation in national clinical audits and confidential enquiries and demonstrate local audit which shows the organisation has a commitment to improving practice through review and action.

YAS has reviewed the priorities for improvement that were set out in the 2009-10 Quality Accounts document for achievement in 2010-11. They have provided clear evidence that the majority have been achieved and highlight continued areas for improvement. The two areas identified as not fully achieved are:

- That patient report forms (PRFs) for all emergency patients would be fully completed: the current position is not stated despite the declaration of partial achievement.

Statement from NHS Bradford and Airedale (YAS lead commissioners) on behalf of all associate commissioners (continued)

- That no serious incidents would identify inadequate clinical assessment as a root cause: it has been noted that there have been two serious incidents where clinical assessment was cited as a root cause. Going forward, improvement in the area will be supported through the CQUIN scheme for 2011-12.

Associate commissioner comments include:

- There is concern regarding the streamlining of how the frequent callers are managed across the region, and parity across the district would be appreciated. This issue is being addressed via the 2011-12 CQUIN scheme.
- With regards to service-user feedback, the report would be more constructive if it contained how improvements were made as a direct result of the audits. This issue is also being addressed via the 2011-12 CQUIN scheme.
- It was noted that there is no mention of NICE (National Institute for Health and Clinical Excellence) guidance throughout the document, although assurance has been received through the Clinical Review Group that YAS is compliant with all guidance which is relevant to it.
- More information on patient transport waiting times would have been preferable, given that over a quarter of patients rated this as poor. The report should assure commissioners how this is being addressed. It is noted that improvement in PTS waiting times is one of the priorities identified by the Trust for action in 2011-12.

The required statements of assurance have been provided, demonstrating achievement against essential standards.

NHS Bradford and Airedale supports the future priority areas identified for 2011-12 and agree with their relevance to and representation of services. It is noted that they are linked to this year's CQUIN goals and therefore are agreed areas for improvement by all commissioners and YAS.

NHS Bradford and Airedale commend the work of YAS over the last year and support its continued commitment to quality improvement.

Simon Morritt, Chief Executive, NHS Bradford and Airedale, on behalf of all associate commissioners.

North Yorkshire Scrutiny of Health Committee

The North Yorkshire Scrutiny of Health Committee (SoHC) recognises that YAS is only required to seek the views of the overview and scrutiny (OSC) for the area in which the Trust's head office is located, ie the Wakefield OSC. The North Yorkshire SoHC therefore commends YAS for the way in which it has shared its Quality Accounts with all OSCs in its catchment area. The Trust clearly welcomes patient and public involvement and is entering into the spirit intended for Quality Accounts.

Over the last year YAS has engaged with the SoHC on pathways for stroke and trauma patients in the Hambleton and Richmondshire area as well as on ambulance response times in that area generally. We therefore welcome the continued emphasis in the Quality Accounts towards improving patient pathways and response times. The improved response times in rural areas such as Hambleton and Richmondshire are particularly welcomed.

A recent report by scrutiny members at Richmondshire District Council highlighted potential to improve the Patient Transport Service. Measures in the Quality Accounts to improve this service demonstrate the Trust is prepared to listen and act accordingly.

As we mentioned in our comments on last year's Quality Accounts we do feel that YAS should explore whether or not there is potential to improve operational links with the air ambulance services serving North Yorkshire.

In summary, from our experience with the Trust over the last year and what have we learned from the briefings on this year's Quality Accounts we are confident that the Trust has strong commitment to improving the quality of care and there is a commitment to sharing information on that work.

Finally on behalf of the Committee I would just like to thank and commend the staff and senior mangers from YAS on how they have engaged with the Committee. We look forward to working with them in the future.

County Councillor, Jim Clark, Chairman, North Yorkshire Scrutiny of Health Committee.

Calderdale Local Involvement Network

We would like to thank the Trust for the opportunity to comment on the many areas of improvement described in the Quality Accounts, especially around the Quality Governance Framework.

Calderdale LINk welcomes the fact that during the past year YAS has engaged staff and stakeholders in discussions about service quality. Importantly, engagement has taken place with patients and the public of which Calderdale LINk has been a part.

Regarding Performance Against Priorities for Improvement 2010-11, pages 53-55.

Indicator 1: Ambulance Response.

The significant progress in improving response times for patients requiring emergency ambulance attention is welcomed, whilst recognising that there is still improvement to be made especially in relation to emergencies in rural areas. This includes building relationships with other emergency services.

Indicator 5: Complaints, Concerns, Comments and Compliments.

Calderdale LINk welcomes the knowledge that YAS is concerned to resolve problems with patient complaints about waiting times relating to patient transport, including injuries whilst being transported and patient mistaken diagnosis. It has developed a new system in its 999 communications centres and additionally has developed new training and assessment to refresh staff skills.

Indicator 7: Referrals to Services for Safeguarding Vulnerable Adults and Children.

The good practice of YAS is recognised in that it is leading the way in developing best practice for safeguarding in ambulance services and in sharing knowledge and experience between trusts.

In general Calderdale LINk is satisfied with this Quality Accounts and the Trust's priorities for 2011-12, especially around providing a high quality service.

Calderdale LINk sees the need for continued patient and public involvement to be a priority in the coming year as set against a continually challenging environment for health and social care services.
YAS, in its priorities, would appear to be recognising this need.

East Riding of Yorkshire NHS Overview and Scrutiny Committee

The East Riding of Yorkshire NHS Overview and Scrutiny Committee welcomes this opportunity to comment on YAS's Quality Accounts.

YAS attended one NHS Committee meeting in 2010-11 providing the Committee with an update on service provision.

The accounts clearly lay out the challenges that faced YAS last year and the steps taken to address these issues. It is obvious that the bad winter caused a number of problems for the service but that the YAS did all it could to continue to provide a good service to members of the public.

Although YAS is now achieving an overall figure of responding to 73.5% of Category A incidents within eight minutes, the Committee notes with concern that the response times for the East Riding Of Yorkshire Council are the second worst (behind North Yorkshire and York) and fall below that figure at 68.2%. Worryingly, East Riding of Yorkshire also come last for the Category A 19-minute response times and Category B response times. It is understood that such a largely rural area as the East Riding will create problems for the service, but it is vital that the service continues to work towards increasing this figure to enable response times to fall in line with the urban areas. Rapid responders have helped to address this issue and the Committee would urge the service to continue to invest and expand in this service to help rural areas.

The Committee welcomes the fact that the priorities for next year will cover 'Working with Partners to Ensure Appropriate Care and Management of Frequent Callers'. It had become clear from discussions with YAS that there continued to be a lack of information within the public arena and some health services over the role of YAS and when they should be brought in.

The Committee was therefore aware of the pressures placed on YAS due to people not knowing who to call with particular health-related queries or problems. By prioritising this area of work, together with developing patient pathways, there appears to be a great deal of potential in helping people navigate the system and better use of NHS resources being achieved. Hopefully, work in this priority area will mean that patients receive care from the appropriate care provider in a timely manner, thus ensuring that YAS resources can be targeted towards those who genuinely need their help.

The Committee is pleased to see that YAS will continue to monitor the patient transport service (PTS), particularly due to the high numbers of concerns and complaints received by YAS last year. It is vital that patients have the ability to access health services in a timely manner without unnecessarily long waits before and after appointments.

It would have been useful if YAS had included information on benchmarking, which would have enabled the Committee to establish how well YAS was faring in comparison to others in the country.

There appears to be very little information in the accounts about the views of staff or the results of staff surveys. The views of staff are an important marker of an organisation's workforce well-being and managerial competence and hence an organisation's ability to deliver high quality care. The Committee would like to see more coverage of this in future Quality Accounts.

The Committee noted that the accounts make no reference to equality issues, which was found surprising in consideration of the fact that YAS, like all organisations, is expected to comply with equality legislation. It suggests that YAS may like to explore this area in more detail in the future.

Financial Summary 2010-11

Contents

Operating and Financial Review

Strategy Development

In line with our planned corporate review, in October 2010 following the significant changes outlined in the White Paper 'Equity and Excellence: Liberating the NHS', the YAS Board acknowledged that the context in which we operate and the expectations of our service users had changed significantly since we first described our vision in 2007.

We have used the themes emerging to restate our vision, refresh our purpose and ensure we are well-placed to capitalise on the new opportunities of the changing NHS landscape.

Significant work has been undertaken to update the 2010-15 five-year Integrated Business Plan and this will continue during 2011-12. Our Annual Business Plan for 2011-12 has been agreed and provides a strong framework for assessing achievements against our strategic goals and aims. We have worked closely with the Department of Health and Strategic Health Authority to agree a timetable in relation to our ambitions to achieve NHS Foundation Trust status in 2012.

Service Performance

During 2010-11 we can report significant progress and improvements in terms of our achievements against our business objectives which have positively improved patient outcomes, care, experiences of patients and staff and organisational efficiency.

Rating	Criteria	Number of objectives
RED	Failure to achieve which has an impact on contractual, regulatory, legislative or national standards	1
AMBER	Partial achievement of the agreed objective	0
GREEN	Objective fully achieved	22

The impact of the severe weather during December and January reduced our year-end performance to below 75% for Category A calls reached in eight minutes, despite strong performance delivery between April and November 2010. The target for reaching 95% of Category A calls in 19 minutes was successfully delivered.

YAS performance improved by almost three percentage points year on year in relation to the Category A eight minute standard.

Looking forward to 2011-12 we:

- **have developed a comprehensive Performance Improvement Plan which will ensure that we consistently achieve national standards against both response times and Clinical Quality Indicators**
- **are building on the financial stability of our Patient Transport Service (PTS) by focusing on patient experience and service quality**
- **are implementing our service development ambitions around providing a 111 service for non-urgent callers, enhancing our role in healthcare resilience and looking to transform our delivery of frontline services.**

Financial Performance

Income and Expenditure

We have maintained appropriate control of our expenditure through 2010-11 which enabled us to deliver a small operating surplus of £237,000 or 0.12% of income. This was against the balanced budget that the Board approved in March 2010.

PTS has fully delivered its required cost improvement savings in 2010-11 which has enabled it to recover its financial position and deliver a balanced service line. All other service lines are also in balance.

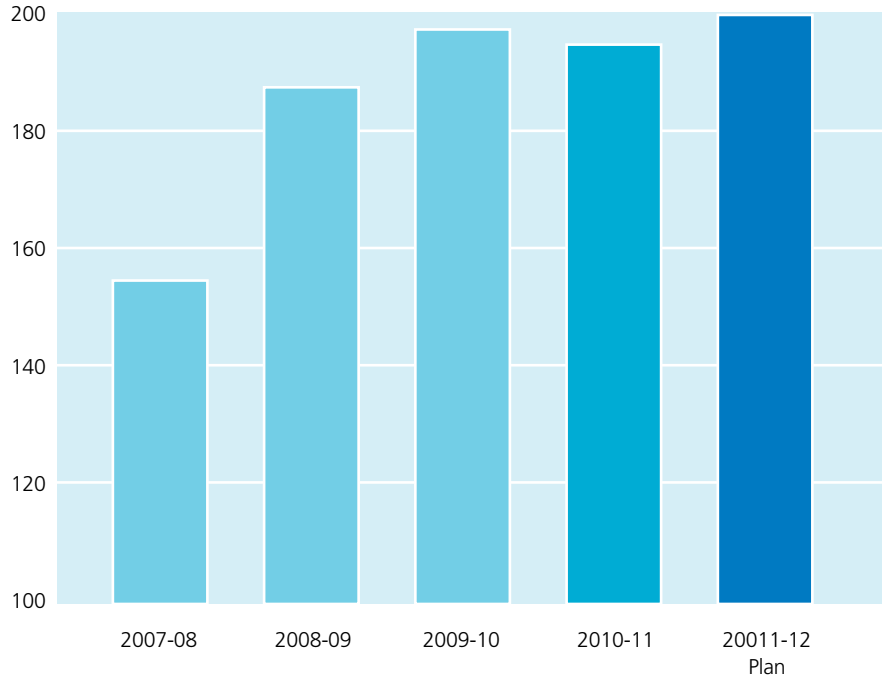
During the year the District Valuer completed a valuation of the recently-built York and Hull ambulance stations and this valuation resulted in impairment in the value from cost which has been charged to the income and expenditure account giving rise to a technical deficit of £1,881,000. The position reported on the statement of comprehensive income is a deficit of £1,644,000 which is the net of the £1,881,000 technical deficit and the £237,000 operating surplus. The £1,881,000 impairment is excluded from the Department of Health's measurement of the breakeven duty.

We are planning to deliver a small surplus of £415,000 on the income and expenditure position in 2011-12 which represents investment from the Strategic Health Authority for purchasing vehicles and equipment to enhance our resilience service.

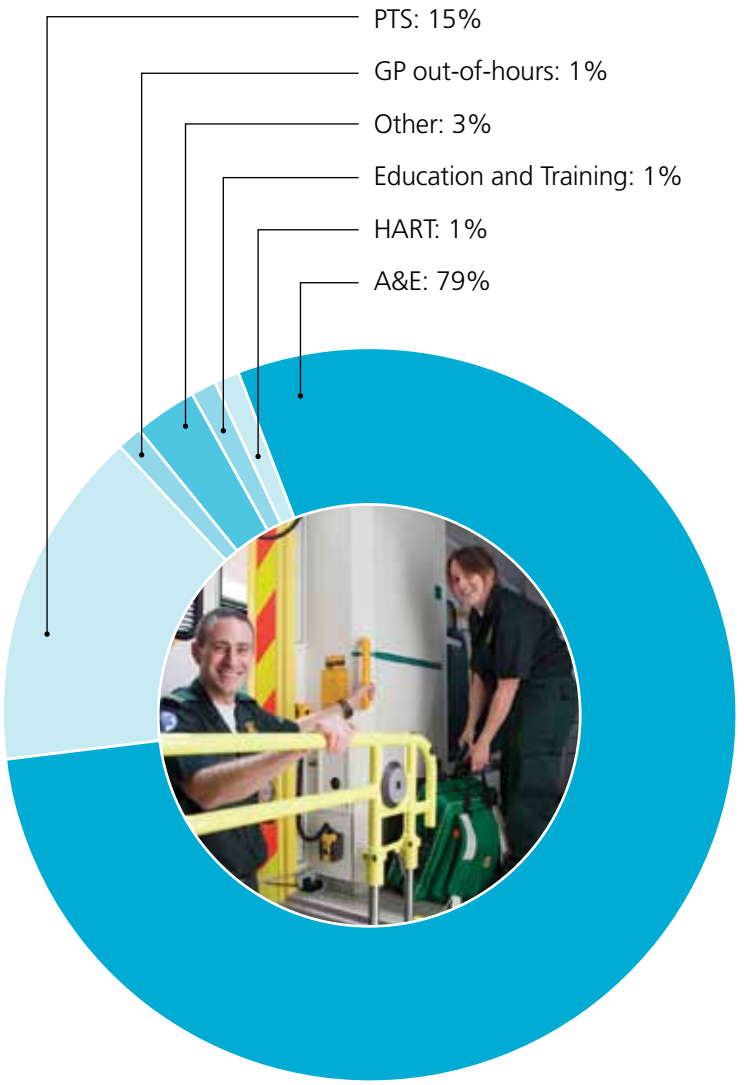
Income

We recognised income of just over £195,228,000 in 2010-11. This is 1% lower than the income received in 2009-10 due to the £6,200,000 of non-recurring income received in 2009-10 through the A&E contract. The breakdown of 2010-11 income can be seen in the diagrams below and on the right. Total income in 2011-12 is projected to be £199,609,000.

Total Income By Financial Year (£000,000)



Total Income By Type

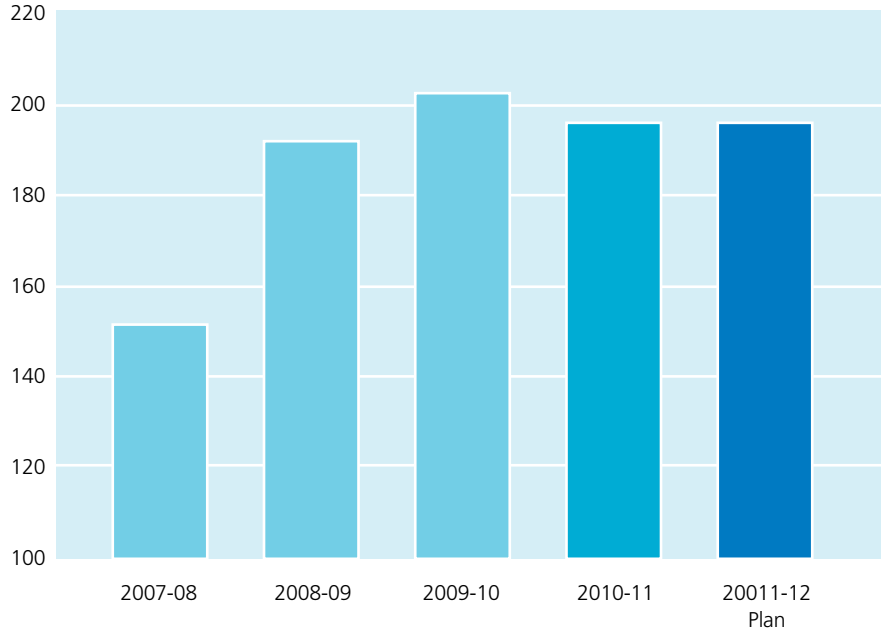


Expenditure

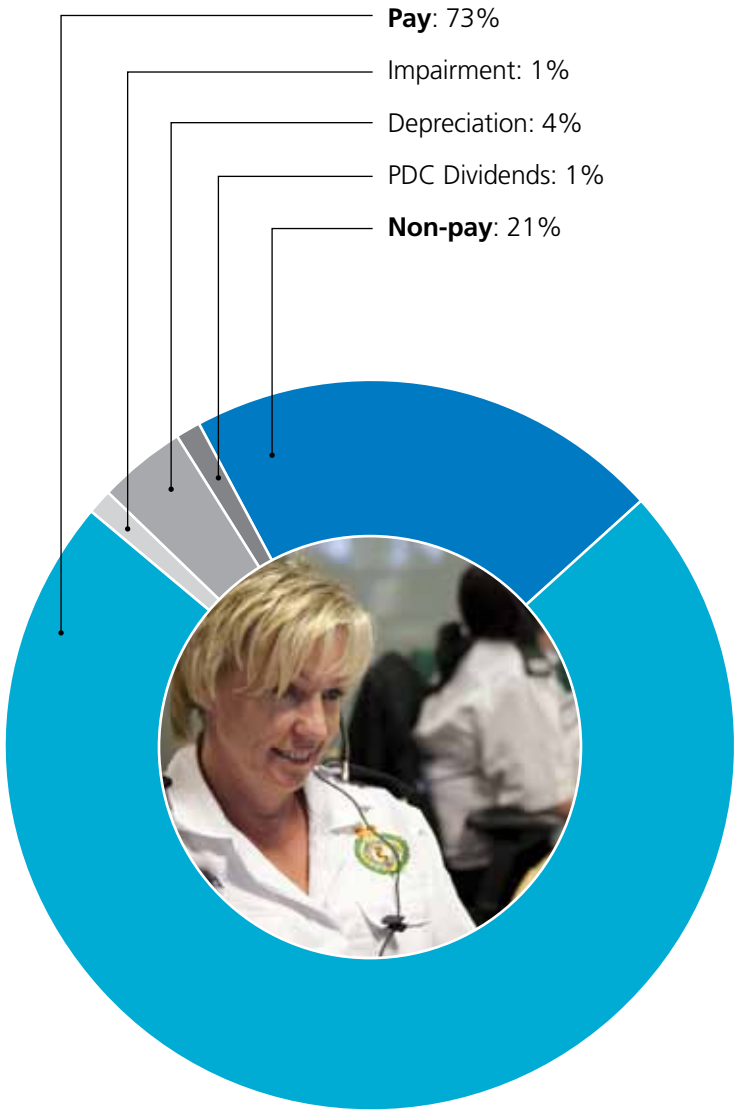
We spent £196,979,000 on revenue items in 2010-11. This is 2.6% lower than the expenditure in the previous year. The breakdown of the spending can be seen in the diagrams below and on the right.

Expenditure is expected to rise in 2011-12 through inflation and cost pressures totalling 5% but is offset by a cost improvement programme. This will ensure that expenditure remains in line with income.

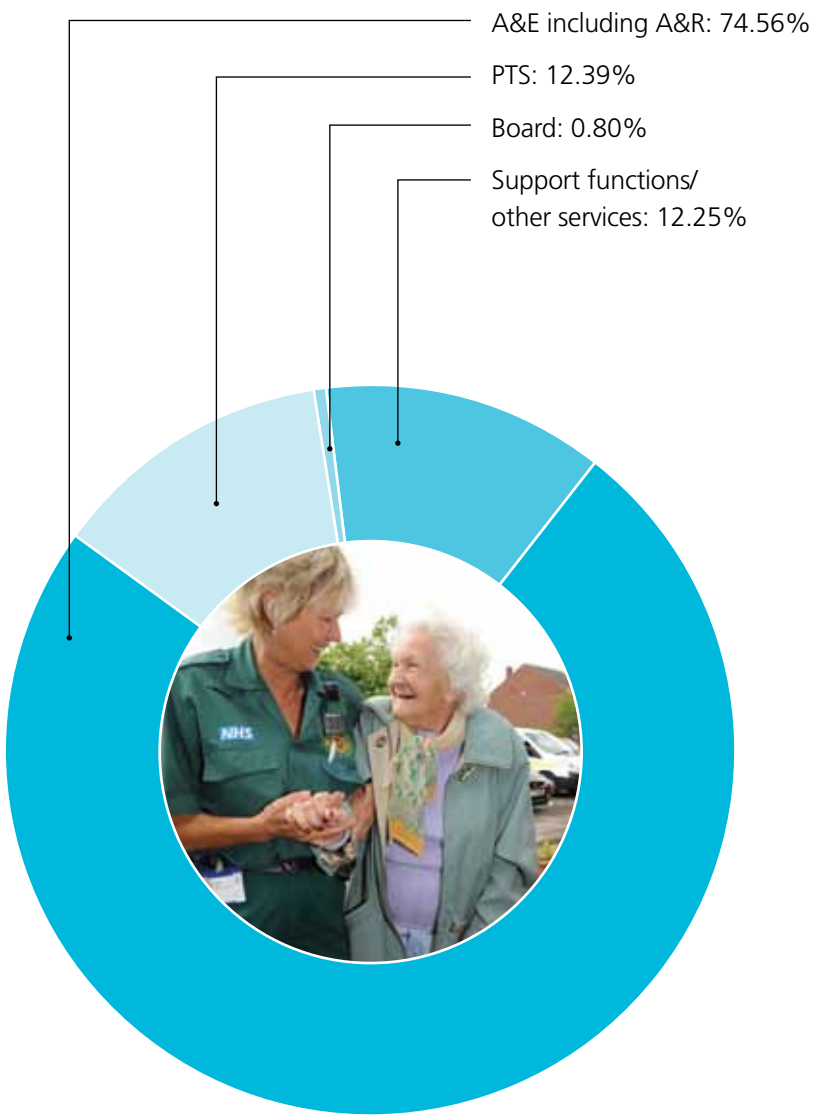
Total Expenditure By Financial Year (£000,000)



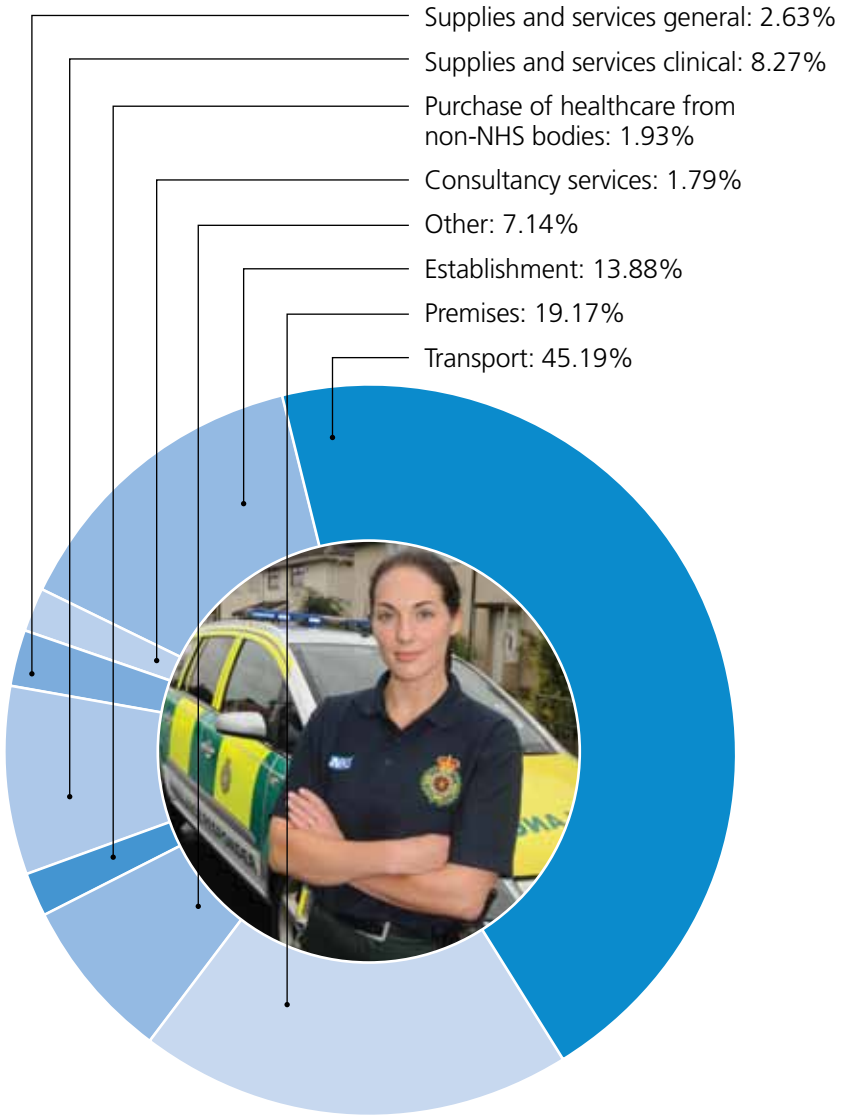
Total Expenditure By Type



Pay By Expenditure Type



Non-pay By Expenditure Type



Cash Releasing Efficiency Savings

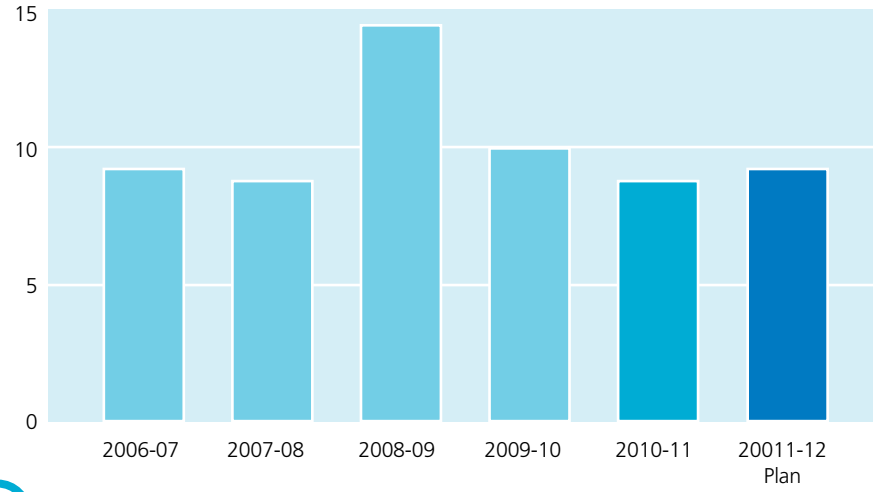
We planned to achieve £15,600,000 savings in the year equating to 8.1% of the recurrent baseline which included some demanding targets against which we had a contingency of £2,500,000. We actually delivered £12,000,000 savings in the year which equates to 6%. The difference was due to the non-achievement of part of the A&E cost improvement plan and delays in achieving the carbon reduction target.

Looking forward to 2011-12 we have plans in place to deliver a further £9,700,000 savings which equates to 5% of the recurrent baseline.

Capital Expenditure

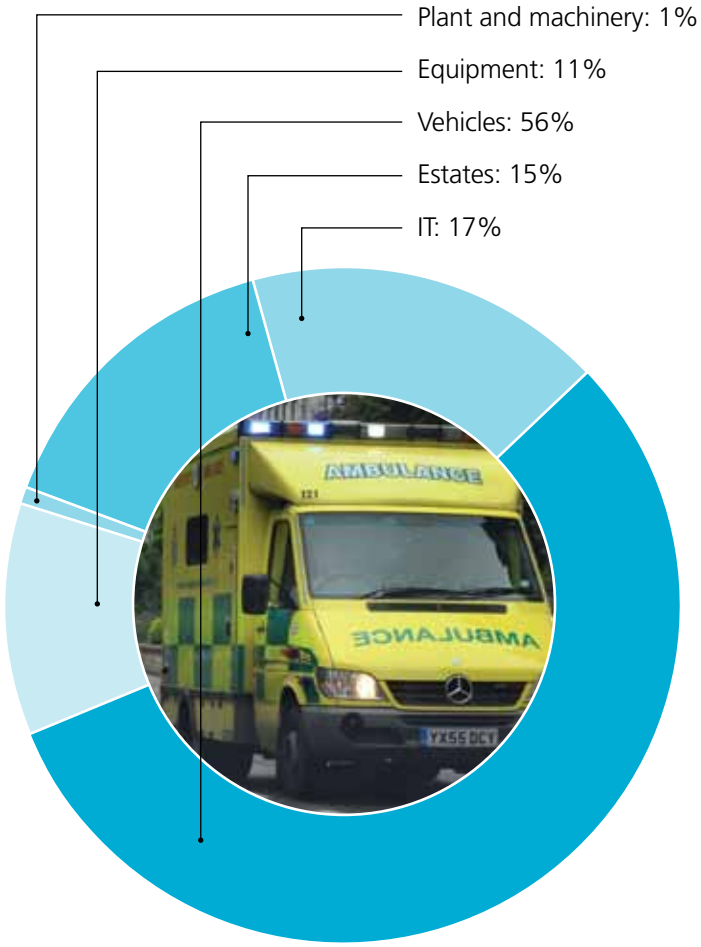
We spent £8,710,000 on capital expenditure in 2010-11. This was a reduction on the previous year which had included the station refurbishment programme. The programme was planned in accordance with the underlying depreciation of the Trust, and any planned disposals. The Capital Resource Limit was set as £8,768,000 and was delivered with an undershoot of £58,000.

Capital Expenditure By Financial Year (£000,000)



The individual programmes within the overall programme were set in 2010-11 using the underlying depreciation generated from that activity. This allowed investment in each of the areas to be maintained and ensured the longer term sustainability of the function areas. Below is the relative split of the overall programme.

Capital Expenditure By Type



Looking forward in 2011-12 we are planning to spend £9,014,000 which is in accordance with the underlying depreciation of the Trust. The component Estates, Fleet and Information, Management and Technology sub-programmes have been allocated funding in line with their respective depreciation in order to sustain the activities undertaken.

Cash/External Financing Limit (EFL)

The EFL is a limit set by the Department of Health on the Trust's cash expenditure. The EFL in 2010-11 was set at -£113,000. The External Financing Requirement is the difference between the opening and closing cash balance (£3,357,000 and £3,611,000 respectively) and was therefore £254,000. As a result the Trust undershot its EFL by £367,000 and therefore achieved this target.

Capital Cost Absorption Rate

The Capital Cost Absorption duty measures the return the Department of Health makes on its investment in the Trust and is set at 3.5% of the actual relevant net assets. The relevant assets at the start of the period were £64,877,000 and £63,328,000 at the end giving an average of £64,103,000. The public dividend capital reflected in the accounts was £2,243,000 which equates to 3.5% of the net relevant assets, thereby achieving the target.

Better Payment Practice Code (BPPC)

The performance of the Trust against the BPPC has improved. Payment of invoices within 30 days has increased by 10% to 75% for non-NHS creditors and by 3% to 65% for NHS. The requirement for order numbers on invoices, the interfacing with the Fleetman system and efforts around on hold items have contributed to this improvement. The implementation of the document management system will improve this further in 2011-12.

Impact of the Economic Downturn

In line with reported plans, YAS forecasts to make considerable savings in order to comply with Department of Health objectives, whilst improving the quality of patient care through efficiencies in the delivery of our services.

Our five-year financial plan has accounted for the potential impact of these economic factors in NHS finances going forward.

Statement on Internal Control

1. Scope of responsibility

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

I am supported in my role as Accountable Officer by a clearly defined management structure as set out in our Risk Management and Assurance Strategy and associated Risk Escalation and Reporting Procedure. These documents detail the processes and monitoring arrangements for managing risk. The strategy describes the strategic and operational risks faced by the Trust and places a specific emphasis on information risk which is regarded as inherent in all Trust activities.

The Trust meets with the Yorkshire and the Humber Strategic Health Authority and our lead commissioner, NHS Bradford and Airedale, on a regular basis to ensure that both the national and local targets are met and risk is mitigated to tolerable levels. The Trust works with its partners through membership of clinical networks across Yorkshire, contractual arrangements with other NHS providers, membership of resilience forums and active liaison with local scrutiny committees and local involvement networks (LINks).

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and
- 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 Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust takes a holistic approach to risk, embracing both strategic and operational risks, and taking into account the importance of including all sections of the organisation in the risk management process. The organisation's risk management committee structure aims to ensure the delivery of this coordinated and holistic approach to the management of risk throughout the Trust.

The Trust Board has overall accountability for the risk management framework, systems and processes and routinely receives reports on the highest principal risks and associated actions from the Trust's Board Assurance Framework (BAF). The Trust appointed a new Chairman in 2010 and new Chief Executive Officer and Non-executive Director in 2011. The agenda setting and function of the Trust Board have been reviewed over the last year to ensure that the level of Non-executive Director challenge at meetings is appropriate to the level of discussion, and is evidenced in the minutes of Trust Board meetings.

The Trust Board has been underpinned during 2010-11 by three key Trust Board sub-committees:

- The Audit Committee – see Review of Effectiveness on page 96;
- The Business Delivery Committee (BDC); and
- The Integrated Governance Committee (IGC).

The BDC is responsible for managing risks relating to operational performance, finance and workforce, as well as monitoring and reviewing these elements of the BAF. The committee is responsible for overseeing the performance management of the Trust's operating systems and procedures and is routinely provided with information in relation to the Accident and Emergency, Patient Transport and Access and Response services, and on progress in relation to operational service improvement plans. The committee assists in the delivery of operational success and value for money by reviewing information on financial performance and on the broad range of human resource and workforce development issues.

The IGC supports the Trust Board in developing an integrated approach to governance. The committee provides the Trust Board with assurances that a comprehensive risk register process is maintained and that the established relationship between the Corporate Risk Register and BAF is functioning effectively. The committee monitors the effectiveness of the BAF in relation to the Trust's clinical and non-clinical risks together with the measures and controls employed to manage these risks. The IGC is routinely provided with risk management information and assurance from the:

- Risk and Assurance Committee
- Strategic Health and Safety Committee
- Infection Prevention and Control Committee
- Information Governance Committee
- Clinical Governance Committee.

As Chief Executive Officer (CEO), I lead on the maintenance of an effective risk management system within the Trust, for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance. Leadership is also provided by the directors and managers at all levels in the managerial hierarchy, who ensure that risk management is implemented within their areas of responsibility.

The Director of Standards and Compliance has lead responsibility for managing the development and implementation of risk management (excluding financial risk management) and integrated governance.

The Director routinely provides the Trust Board and other executive groups with expert advice and reports on risk management and assurance. The Director ensures that they have access to regular and appropriate risk management information, advice, support and training where required.

The Director of Finance has lead responsibility for financial risk management. The Director advises the Trust Board, the Audit Committee and the IGC on an ongoing basis, about risks associated with the Trust's financial procedures, and the financial elements (capital and revenue) of its activities, through the integrated governance framework.

The Medical Director has lead responsibility for clinical risk management and patient safety, ensuring that all clinical procedural documents are maintained and current. The Director advises the Trust Board, the Clinical Governance Committee, and the other executive committees as appropriate, on risks associated with the Trust's clinical procedures and practices.

External consultants have been commissioned to provide the Trust Board with risk management education in the context of their roles and responsibilities. The Trust has developed and delivered a range of risk management training programmes and other education and development initiatives to all grades of management and staff, where applicable. The Trust utilises the Knowledge and Skills Framework (KSF) which prescribes that risk management forms part of the core competences for managers.

The Standards and Compliance Directorate has developed monitoring arrangements to ensure that, in addition to learning lessons from adverse events, a proactive approach is also taken to learn from examples of good practice.

4. The risk and control framework

The Risk Management and Assurance Strategy and supporting Risk Escalation and Reporting Procedure defines the process which specifies the way risk (or change in risk) is identified, evaluated and controlled. The Trust's risk management process adheres to the guidance provided by the Australia/New Zealand (ASNZS: 4360) Risk Management Standards, the NHS Litigation Authority Risk Management Standards for Ambulance Trusts and the National Patient Safety Agency (NPSA).

The organisation's major risks are separately identified: those that have been managed in year and also those that will be managed in the future. The Trust identifies risk to its Annual Business Plan and five-year Integrated Business Plan and aims to prioritise and manage the principal risks that may impact on the achievement of the Trust's strategic objectives and implementation plans.

Major risks that have been managed this year include the risk of failing to achieve the national ambulance response time targets and the potential adverse impact on clinical outcomes. This risk is identified as significant internal control issue, which is later detailed in section 5.

The Trust has undertaken a further major upgrade to its Computer Aided Dispatch (CAD) system and has successfully mitigated a major risk of failing to introduce the necessary improvements required to deliver a consistent and efficient response service.

The challenge of achieving the national ambulance response time targets for Category A (immediately life-threatening) calls, will continue to pose a major risk in the future.

The Risk Management and Assurance Strategy, and associated procedural documents, are actively promoted by risk and assurance managers to ensure that risk management is embedded through all sections of the Trust.

The process and acceptance of responsibility for local risk assessment are progressed by direct involvement of risk and assurance managers in meetings with individuals and groups across the Trust, and up to and including the Trust Board.

Reference is made, within the Risk Management and Assurance Strategy, to the Information Governance Policy which describes in detail the arrangements within the Trust for managing and controlling risks to data security. The Senior Information Risk Officer role for the Trust was undertaken by the Director of Information, Communication and Technology, supported by the Trust's Medical Director as the Caldicott Guardian. During the year there has been just one serious untoward incident involving personal data.

A close working relationship between the Risk team and business planning managers has been established to ensure that business planning informs and is informed by risk management. An improved quality impact assessment process ensures that all decisions on efficiency savings and expenditure on new developments are objective, risk based and balanced, taking account of costs and savings, impact on quality and ease of implementation.

In addition to the Risk Management and Assurance Strategy and Corporate Risk Register (CRR), the BAF enables the Board to examine how it is managing risks that are threatening the achievement of strategic objectives. This has been achieved by aligning risks in the CRR to those on the BAF and subjecting both of these documents to comprehensive executive review on a monthly basis. Any significant gaps in controls are identified and routinely managed through the CRR.

The BAF has been designed to comply with the guidance provided in Building an Assurance Framework: A Practical Guide for NHS Boards published by the Department of Health in 2003 as well as subsequent official recommendations.

The BAF and associated action plans are reviewed and updated on a monthly basis, with performance management and exception reports provided for consideration to the IGC, Business Delivery Committee and the Trust Board.

The 2010-11 review of the Trust's system of internal control has identified the following significant control issue:

- *The Trust has made further improvements in service delivery to fully achieve the national response standard targets for both Category A and Category B response times. Severe adverse weather conditions during quarter three impacted considerably on the Trust's capability to meet the response standard targets during this period. The Trust has implemented comprehensive programmes designed to improve performance to achieve these targets, which are actively monitored on a weekly basis by the Executive Team and Trust Board.*

A condition had been placed on the Trust's initial registration with the Care Quality Commission (CQC) in April 2010. Subsequently the Trust implemented a number of successful actions to improve operational performance, which led to the condition being removed in October 2010.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Yorkshire Ambulance Service NHS Trust has a generally sound system of internal controls that support the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

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

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 members' records are accurately updated in accordance with the timescales detailed in the regulations.

The Trust has undertaken a climate change risk assessment and developed an adaption plan, to support its emergency preparedness and civil contingency requirements, as based on UK Climate projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

The Trust is fully compliant with the CQC's essential standards of quality and safety.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The overall opinion of the Head of Internal Audit is that: 'Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently'. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- external audit reports
- Care Quality Commission Essential Standards for Quality and Safety – Provider Compliance Assessments
- the Care Quality Commission registration process
- ongoing self assessment in respect of the Auditors' Local Evaluation
- Internal Audit reports
- NHS Connecting for Health Information Governance Toolkit.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee and IGC. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board seeks assurance that risk management systems and processes are identifying and managing risks to the organisation appropriately through the following:

- At least annually; a review is carried out of the effectiveness of the Trust's system of internal control. The Trust Board ensures that the review covers all material controls, including financial, clinical, operational and compliance controls and risk management systems.
- An annual review of the Risk Management and Assurance Strategy.
- A biennial comprehensive review of the BAF.
- Monthly performance reports outlining achievement against key performance, safety and quality indicators.
- Assurance reports at each meeting, providing information on progress against compliance with National Standards.
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented.

The risk assurance infrastructure closely scrutinises assurances on controls to assess their validity and efficiency. A key element of this work will be to ensure that all procedural documents are subject to monitoring compliance against the detail described within them; that they meet with regulatory requirements; and that they have considered all current legislation and guidance.

The Risk and Assurance Committee carries out a detailed analysis of assurances received to identify any gaps in the assurance mechanisms and to provide an evaluation of the effectiveness of them, reporting findings to the IGC through to the Trust Board.

The Audit Committee provides overview and scrutiny of risk management. The committee independently monitors, reviews and reports to the Trust Board on the processes of governance and, where appropriate, facilitates and supports through its independence, the attainment of effective processes. The Audit Committee concludes upon the adequacy and effective operation of the organisation's overall internal control system. In performing this role, the committee's work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives; the BAF.

The Audit Committee reviews all risk and control related disclosure statements and memoranda (in particular the Statement on Internal Control, declarations of compliance with the Essential Standards of Quality and Safety and the Quality Governance Framework), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board.

The committee independently monitors, reviews and reports to the Board on the processes of governance and, where appropriate, facilitates and supports, through its independence, the attainment of effective processes. In carrying out this work, the committee primarily utilises the work of internal audit, external audit and other assurance functions, but is not limited to these audit functions. It also seeks reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

The Business Delivery Committee is responsible for monitoring achievement against the Trust's strategic objectives relating to operational performance, finance and workforce. This committee has a key role in monitoring performance improvement in emergency ambulance response times and in the Patient Transport Service improvement plan.

The IGC is responsible for monitoring achievement against the Trust's strategic objectives, specifically those relating to risk, compliance, quality and safety. This committee monitors the effectiveness of the BAF in relation to the Trust's clinical and non-clinical risks, together with the measures and controls employed to manage these risks. The IGC also oversees the performance management of the Trust's operating systems and procedures to provide assurance to the Trust Board on governance and compliance.

During 2010-11, the Trust's systems of internal control effectiveness have also been reviewed by fully complying with the requirements to participate in other explicit reviews/assurance mechanisms such as; the use of a BAF process, the CQC Essential Standards for Quality and Safety - Provider Compliance Assessments, the Audit Commission Auditors' Local Evaluation scores and the NHS Litigation Authority Risk Management Standards for Ambulance Trusts.

On final review and closure of the 2010-11 iteration of the BAF, a significant control issue was identified relating to not fully achieving the national response standard targets. In addition, the Head of Internal Audit opinion identified some weaknesses in the design and/or inconsistent application of controls which put the achievement of particular objectives at risk, most notably in relation to overtime management, estate management and information governance.

The Trust has already taken action to deal with the significant control issue and other concerns identified by the Head of Internal Audit.

Following an external review and refinement of the Trust's governance committee arrangements in 2009, a further review of Trust's corporate governance committees has been undertaken in 2010-11, and the Executive Director portfolios and associated management structures are currently being refined. A pivotal group in these revised arrangements will be the Trust Executive Group.

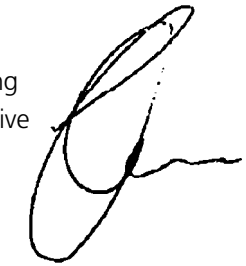
Reporting to the Trust Board, the Trust Executive Group will meet fortnightly and be accountable for the operational management of the Trust and the delivery of objectives set by the Board. It will also be the formal route to support the Chief Executive Officer in effectively discharging his responsibilities as Accountable Officer. One of its primary functions will be the management of organisational governance arrangements, providing an even greater focus on the management of risk.

The Trust is in the process of appointing a Corporate Secretary to take up post in early 2011-12. The Corporate Secretary will play a key role in ensuring the Trust Board, its sub-committees and other executive groups operate effectively within their Terms of Reference with no gaps in governance arrangements.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Yorkshire Ambulance Service NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Date: 7 June 2011

David Whiting
Chief Executive



Remuneration Report

Salary Entitlements of Senior Managers

Name and title	2010-11			2009-10		
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (Rounded to the nearest £000) £000	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (Rounded to the nearest £000) £000
Martyn Pritchard[1] - Chief Executive	25-30	0	1.2	125-130	0	6.2
David Whiting[2] - Chief Executive	20-25	0	0	N/A	N/A	N/A
Simon Worthington - Director of Finance	35-40	0	1.9	100-105	0	5.7
Simon Worthington[3] - Acting Chief Executive	80-85	0	3.8	N/A	N/A	N/A
Rosie Johnson[4] - Director of OD and HR	N/A	N/A	N/A	40-45	0-5	0
Dr Alison Walker[5] - Medical Director	105-110	0	6.3	80-85	0	0
Keeley Townend - Director of ICT	75-80	5-10	0	75-80	5-10	0
Sarah Fatchett - Director of Operations - PTS	35-40	0	3.3	80-85	0	7.2
Sarah Fatchett[6] - Acting Deputy Chief Executive	45-50	0	3.9	N/A	N/A	N/A
Caroline Wood[7] - Acting Director of Finance	50-55	0	0	N/A	N/A	N/A

1: Held this post until 11 June 2010 2: Appointed 1 February 2011 3: Acting Chief Executive 14 June 2010 - 31 January 2011 4: Left 31 August 2009 5: Notional Benefit in Kind as seconded

6: Acting Deputy Chief Executive 17 July 2010 - 31 January 2011 7: Acting Director of Finance 14 June 2010 - 31 January 2011

Name and title	2010-11			2009-10		
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (Rounded to the nearest £000) £000	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (Rounded to the nearest £000) £000
Jo Pollard[8] - Director of Urgent Care	N/A	N/A	N/A	50-55	0	0
Fiona Barr[9] - Director of Corporate Affairs	N/A	N/A	N/A	25-30	0	0
David Forster[10] - Director of Corporate Affairs	N/A	N/A	N/A	20-25	0	0
David Forster[11] - Director of Policy and Strategy	30-35	0	0	55-60	0	0
Steve Page[12] - Director of Standards and Compliance	75-80	0	3.2	35-40	0	1.6
Wendy Foers[13] - Director of OD and HR	105-110	0	0	75-80	0	0
Keith Prior[14] - Interim Director of Operations - A&E	115-120	0	3.1	15-20	0	0
Dr Nick Varey[15] - Chairman	0-5	0	0	20-25	0	0
Della Cannings[16] - Chairman	15-20	0	0	N/A	N/A	N/A
Roger Holmes - Non-executive Director	5-10	0	0	5-10	0	0
Nancy Murgatroyd[17] - Non-executive Director	0-5	0	0	5-10	0	0
Richard Roxburgh - Non-executive Director	5-10	0	0	5-10	0	0
Nina Wrightson - Non-executive Director	5-10	0	0	5-10	0	0
Paul Osborne[18] - Non-executive Director	5-10	0	0	5-10	0	0
Patricia Drake[19] - Non-executive Director	0-5	0	0	N/A	N/A	N/A

8: Appointed 22 September 2008; Left 15 October 2009 *9: Appointed 14 April 2008; Transferred role 12 July 2009* *10: Appointed 13 July 2009; Resigned 4 October 2009*

11: Appointed 5 October 2009; Resigned 31 August 2010 *12: Appointed 5 October 2009* *13: Appointed 19 August 2009; Resigned 11 February 2011* *14: Appointed 8 February 2010. Notional Benefit in Kind as seconded*

15: Resigned 9 May 2010 *16: Appointed 10 May 2010* *17: Resigned 30 September 2010* *18: Appointed 1 April 2009; Resigned 31 March 2011* *19: Appointed 4 October 2010*

Pension Entitlements of Senior Managers

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Martyn Pritchard[1] Chief Executive	0-(2.5)	0-(2.5)	25-30	85-90	386	434	(46)	0
David Whiting[2] Chief Executive	0-(2.5)	0-(2.5)	35-40	115-120	574	661	(19)	0
Simon Worthington[3] Acting Chief Executive/ Director of Finance	2.5-5.0	12.5-15	30-35	100-105	450	432	(3)	0
Caroline Wood[4] Acting Director of Finance	0-2.5	2.5-5.0	10-15	40-45	163	160	(3)	0
Keeley Townend Director of ICT	0-2.5	0-2.5	10-15	35-40	143	158	(22)	0
Sarah Fatchett Director of Operations - PTS	0-2.5	0-2.5	10-15	40-45	157	173	(25)	0
Steve Page Director of Standards and Compliance	0-2.5	0-2.5	25-30	80-85	436	482	(71)	0

1: Held this post until 11 June 2010 2: Appointed 1 February 2011 3: Acting Chief Executive 14 June 2010 - 31 January 2011 4: Acting Director of Finance 14 June 2010 - 31 January 2011

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a formal sub-committee of the Board.

The Chairman and all the Non-executive Directors have served as members of the committee during the year. It meets regularly to review all aspects of pay and terms of service for directors and senior managers. When considering the pay of senior managers the committee applies the Department of Health annual pay settlement and the guidance on 'Very Senior Managers' Pay'.

From 1 April 2011, the measure by which pensions are increased each year has changed from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI).

Independent Auditor's Report

We have audited the financial statements of Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2011 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1-39. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies. We have also audited the information in the Remuneration Report that is described as having being audited.

This report is made solely to the Board of Directors of Yorkshire Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. Our audit work has been undertaken so that we might state to 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 Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements.

We read all the information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- **give a true and fair view of the state of Yorkshire Ambulance Service NHS Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and**
- **have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.**

Opinion on other matters

In our opinion:

- **the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and**
- **the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.**

Matters on which we report by exception

We have nothing to report in respect to the Statement on Internal Control on which we report to you if, in our opinion the Statement on Internal Control does not reflect compliance with the Department of Health's requirements.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Trust's responsibilities

The Trust is responsible for the putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission. We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, not 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.

Basis of conclusion

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

- **securing financial resilience; and**
- **challenging how it secures economy, efficiency and effectiveness.**

The Audit Commission has determined these two criteria as those 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 2011. 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.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, we are satisfied that, in all significant respects, Yorkshire Ambulance Service NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2011.

Certificate

We certify that we have completed the audit of the accounts of Yorkshire Ambulance Service NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul Thomson (Engagement Lead)

For and on behalf of Deloitte LLP

Appointed Auditor Leeds

7 June 2011

Summary Financial Statements

Statement of comprehensive income for the year ended 31 March 2011

	2010-11 £000	2009-10 £000
REVENUE		
Revenue from patient care activities	**190,298**	191,225
Other operating revenue	**4,930**	6,685
Operating expenses	**(194,613)**	(202,245)
Operating surplus/(deficit)	**615**	(4,335)
FINANCE COSTS:		
Investment revenue	**26**	96
Other gains and losses	**81**	229
Finance costs	**(123)**	(121)
Surplus/(deficit) for the financial year	**599**	(4,131)
Public dividend capital dividends payable	**(2,243)**	(2,308)
Retained surplus/(deficit) for the year	**(1,644)**	(6,439)
OTHER COMPREHENSIVE INCOME		
Impairments and reversals	**-**	(820)
Gains on revaluations	**412**	3,254
Reclassification adjustments: - Transfers from donated and government grant reserves	**(35)**	(110)
Total comprehensive income for the year	**(1,267)**	(4,115)

Reported NHS financial performance position (Adjusted retained surplus/(deficit))

	2010-11 £000
Retained surplus/(deficit) for the year	**(1,644)**
IFRIC 12 ADJUSTMENT	-
Impairments	1,881
Reported NHS financial performance position (Adjusted retained surplus/(deficit))	**237**

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

The Trust has recently built and brought into operation three new stations; Yearsley Bridge in York, Hessle and Burma Drive in Hull. It was prudent to have these assets revalued to their modern equivalent as per IFRS requirements and the accounting policies of the Trust. The subsequent valuations in 2010-11 resulted in the assets being impaired by £552,274, £1,002,369 and £326,277 respectively. The total impairment of £1,880,920 has been fully charged to the Income and Expenditure account. This charge is not considered part of the organisations operating position and therefore is adjusted for, to come to the retained surplus in the year.

Statement of financial position as at 31 March 2011

	31 March 2011 £000	31 March 2010 £000
NON-CURRENT ASSETS		
Property, plant and equipment	**69,317**	70,754
Intangible assets	**177**	26
Trade and other receivables	**2,349**	1,521
Total non-current assets	**71,843**	72,301
CURRENT ASSETS		
Inventories	**1,468**	1,388
Trade and other receivables	**10,267**	9,489
Cash and cash equivalents	**3,611**	3,357
Total current assets	**15,346**	14,234
Total assets	**87,189**	86,535

	31 March 2011 £000	31 March 2010 £000
CURRENT LIABILITIES		
Trade and other payables	**(12,365)**	(10,403)
Provisions	**(2,554)**	(2,236)
Net current assets/(liabilities)	**427**	1,595
Total assets less current liabilities	**72,270**	73,896
NON-CURRENT LIABILITIES		
Trade and other payables	**(180)**	
Provisions	**(5,122)**	(5,661)
Total assets employed	**66,968**	68,235
Financed by taxpayers' equity:		
Public dividend capital	**74,094**	74,094
Retained earnings	**(11,365)**	(9,767)
Revaluation reserve	**4,194**	3,828
Donated asset reserve	**45**	80
Total taxpayers' equity	**66,968**	68,235

The enclosed financial statements were approved by the Board on 7 June 2011 and signed on its behalf by:

Signed:  David Whiting, Chief Executive

Date: 7 June 2011

Statement of changes in taxpayers' equity for the year ended 31 March 2011

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Total
	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010-11 **Balance at 31 March 2010**	74,094	(9,767)	3,828	80	68,235
Retained surplus/(deficit) for the year	-	(1,644)	-	-	(1,644)
Transfers between reserves	-	46	(46)	-	-
Net gain on revaluation of property, plant, equipment	-	-	412	-	412
Reclassification adjustments: - transfers from donated asset/government grant reserve	-	-	-	(35)	(35)
Balance at 31 March 2011	**74,094**	**(11,365)**	**4,194**	**45**	**66,968**

Statement of cash flows for the year ended 31 March 2011

	2010-11 £000	2009-10 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**615**	(4,335)
Depreciation and amortisation	**8,527**	8,669
Impairments and reversals	**1,881**	6,957
Transfer from donated asset reserve	**(35)**	(110)
Dividends paid	**(2,190)**	(2,360)
(Increase) in inventories	**(80)**	(326)
(Increase)/decrease in trade and other receivables	**(1,658)**	2,477
Increase/(decrease) in trade and other payables	**2,558**	(3,759)
Increase/(decrease) in other current liabilities	**-**	(2)
Increase/(decrease) in provisions	**(344)**	265
Net cash inflow/(outflow) from operating activities	**9,274**	7,476

	2010-11 £000	2009-10 £000
Cash flows from investing activities		
Interest received	**25**	96
(Payments) for property, plant and equipment	**(9,003)**	(9,893)
Proceeds from disposal of plant, property and equipment	**152**	611
(Payments) for intangible assets	**(194)**	(28)
Net cash (outflow) from investing activities	**(9,020)**	(9,214)
Net cash inflow/(outflow) before financing	**254**	(1,738)
Cash flows from financing activities		
Public dividend capital received	**-**	93
Net cash inflow from financing	**-**	93
Net increase/(decrease) in cash and cash equivalents	**254**	(1,645)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**3,357**	5,002
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**3,611**	3,357

Management Costs

	2010-11 £000	2009-10 £000
Management costs	**11,197**	11,773
Income	**195,228**	197,910

Management costs are defined as those on the Department of Health website at:

www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4007923

Glossary of Terms

Term/Abbreviation	Definition/Explanation
Access and Response (A&R)	The department which handles all our emergency and urgent calls and deploys the most appropriate response.
Accident and Emergency (A&E) Service	A responsive service for patients in an emergency situation with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.
Advanced Medical Priority Dispatch System (AMPDS)	An international system that prioritises 999 calls using information about the patient as supplied by the caller.
Ambulance Service Cardiovascular Quality Initiative (ASQUI)	The initiative aims to improve the delivery of pre-hospital (ambulance service) care for cardiovascular disease to improve services for people with heart attack and stroke.
Assistant Practitioner (AP)	They work on ambulances to assist paramedics/emergency medical technicians in providing the care, treatment and safe transport of emergency and non-emergency patients in a clinically safe and professional environment.
Automated External Defibrillator (AED)	A portable device used to restart a heart that has stopped.
Bare Below the Elbows	An NHS dress code to help with infection prevention and control.
Better Payment Practice Code (BPPC)	The BPPC was established to promote a better payment culture within the UK and urges all organisations to adopt a responsible attitude to paying on time. The target is to pay all invoices within 30 days of receipt.
Board Assurance Framework (BAF)	Provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their strategic objectives.

Term/Abbreviation	Definition/Explanation
British Association for Immediate Care (BASICS)	A group of doctors who provide support to ambulance crews at serious road traffic collisions and other trauma incidents across the region.
Business Delivery Committee (BDC)	The BDC is responsible for managing risks relating to operational performance, finance and workforce, as well as monitoring and reviewing these elements of the Board Assurance Framework.
Caldicott Guardian	A senior member of staff appointed to protect patient information.
Call Connect	A way of measuring ambulance response times introduced on 1 April 2008.
Capital Cost Absorption Rate	The process whereby the cost of capital is taken account of fully (absorbed) in an organisation's costs.
Capital programme	Details the capital investment plans for the Trust.
Capital Resource Limit (CRL)	CRLs are set by the Department of Health and are a measure of capital expenditure less disposal of assets, grants and donations.
Cardio-pulmonary Resuscitation (CPR)	A procedure used to help resuscitate a patient when their heart stops beating and breathing stops.
Care Quality Commission (CQC)	An independent regulator responsible for monitoring and performance measuring NHS organisations.
Category A Call	An immediate life-threatening situation requiring emergency assistance eg cardiac arrest, choking, uncontrolled haemorrhage etc. The objective is to provide immediate aid to apply life-saving skills supported by paramedic intervention.

Term/Abbreviation	Definition/Explanation
Category B Call	A serious condition which is not immediately life-threatening eg controlled haemorrhage, overdose/ conscious etc. The objective is to provide paramedic intervention as soon as possible.
Centre for Maternal And Child Enquiries (CMACE)	Aims to improve the health of mothers, babies and children by carrying out confidential enquiries and related work on a nationwide basis.
Chief Executive Officer (CEO)	Highest-ranking officer in an organisation.
Clinical Hub	A team of clinical advisors based within the 999 communications centres providing support for patients with non life-threatening conditions.
Clinical Pathways	The standardisation of care practices to reduce variability and improve outcomes for patients.
Clinical Performance Indicators (CPIs)	Method of assessing how well the ambulance trust is doing in relation to specific patient presentations.
Clinical Quality Indicators (CQIs)	Measure the overall quality of patient care and end-results. These are now referred to as ambulance quality indicators.
Clinical Team Educator (CTE)	Undertakes operational frontline duties and facilitates the development of clinical staff and helps them to practice safely and effectively by carrying out regular assessment and revalidations.
Clinical Team Leader (CTL)	Works on the frontline as part of the operational management team to achieve departmental objectives and key performance indicators.
Commissioners	Ensure that services they fund can meet the needs of the patient.
Commissioning for Quality and Innovation (CQUIN)	A payment framework which makes a proportion of providers' income conditional upon the achievement of quality and innovation targets.

Term/Abbreviation	Definition/Explanation
Community First Responders (CFRs)	Volunteers in their local communities, who respond from their home addresses or places of work to patients suffering life-threatening emergencies.
Comprehensive Local Research Networks (CLRNs)	Coordinate and facilitate the conduct of clinical research and provide a wide range of support to the local research community.
Computer Aided Dispatch (CAD)	A method of dispatching ambulance resources.
Department of Health (DH)	The government department which provides strategic leadership for public health, the NHS and social care in England.
Development And Validation of Risk-adjusted Outcomes for Systems of Emergency Medical Care (DAVROS)	A research project to identify patient characteristics that predict survival.
Electrocardiograms (ECG)	An interpretation of the electrical activity of the heart. This is done by attaching electrodes onto the patient which record the activity of the different sections of the heart.
Emergency Care Practitioner (ECP)	Emergency Care Practitioners are paramedics who have received additional training in physical assessment, minor illnesses, minor injuries, working with the elderly, paediatric assessment, mental health and pharmacology.
Emergency Department (ED)	A hospital department responsible for assessing and treating patients with serious injuries or illnesses.
Emergency Medical Technician (EMT)	Works as part of an emergency ambulance crew to provide the care, treatment and safe transport for emergency patients.

Term/Abbreviation	Definition/Explanation
Equality and diversity	Equality protects people from being discriminated against on the grounds of their sex, race, disability, etc. Diversity is about respecting individual differences such as race, culture, political views, religious views, gender, age, etc.
External Financing Limit (EFL)	The EFL is a limit set by the Department of Health on the Trust's cash expenditure.
Face, Arm, Speech Test (FAST)	A brief test used to help determine whether someone has suffered a stroke.
Foundation Trusts (FTs)	NHS organisations which operate under a different governance and financial framework.
General Practitioner (GP)	A physician who is not a specialist but treats all illnesses.
Governance	The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and wider community.
Hazardous Area Response Team (HART)	A group of staff who are trained to deliver ambulance services under specific circumstances, such as at height or underground.
Health Overview and Scrutiny Committees (HOSCs)	Local authority-run committees which scrutinise matters relating to local health services and contribute to the development of policy to improve health and reduce health inequalities.
Human Resources (HR)	A function with responsibility for implementing strategies and policies relating to the management of individuals.
Information, Communication and Technology (ICT)	The directorate responsible for the development and maintenance of all ICT systems and processes across Yorkshire Ambulance Service.
Information Governance (IG)	Allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

Term/Abbreviation	Definition/Explanation
Information Management and Technology (IM&T)	This Yorkshire Ambulance Service department consists of the IT Service Desk, Voice Communications team, IT Projects team and Infrastructure, Systems and Development team which deliver all the Trusts IT systems and IT projects.
Institute of Healthcare and Development (IHCD)	A body responsible for the content of some ambulance staff training which is then delivered through ambulance trusts.
Integrated Business Plan (IBP)	Sets out an organisation's vision and its plans to achieve that vision in the future.
Integrated Governance Committee (IGC)	Responsible for monitoring management of the Trust's operating systems and procedures to provide assurance to the Board on governance and compliance.
KA34	A reporting requirement for all ambulance trusts, with a template completed annually and submitted to the Department of Health. The information obtained from the KA34 is analysed by individual ambulance service providers to show volume of service and performance against required standards.
Key Performance Indicator (KPI)	A measure of performance.
Knowledge and Skills Framework (KSF)	A competence framework to support personal development and career progression within the NHS.
Local Involvement Network (LINk)	Made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services.
Mental Capacity Act (MCA)	Designed to protect people who can't make decisions for themselves or lack the mental capacity to do so.
Myocardial Infarction (MI)	Commonly known as a heart attack, an MI is the interruption of blood supply to part of the heart, causing heart cells to die.

Term/Abbreviation	Definition/Explanation
Myocardial Ischemia National Audit Project (MINAP)	A national database gathering information on all patients who have had a heart attack or who have acute coronary syndromes.
National Health Service (NHS)	Provides healthcare for all UK citizens based on their need for healthcare rather than their ability to pay for it. It is funded by taxes.
National Health Service Litigation Authority (NHSLA)	Handles negligence claims and works to improve risk management practices in the NHS.
NHSLA Risk Management Standards for Ambulance Trusts	Ambulance trusts are assessed against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA.
National Infarct Angioplasty Project (NIAP)	An audit of patients referred for an angioplasty surgical procedure.
National Learning Management System (NLMS)	Provides access to a wide range of national and local NHS eLearning courses as well as access to an individual's full training history.
National Patient Safety Agency (NPSA)	A national agency which helps to improve the safety of patient care by working with health organisations.
Non-executive Directors (NEDs)	Oversee the delivery of ambulance services for the local community and help ensure the best use of financial resources to maximise benefits for patients. They also contribute to plans to improve and develop services which meet the area's particular needs.
Organisation Development (OD)	The OD team works with all staff to support YAS in becoming a clinically-focused organisation by developing structures, processes and behaviours.

Term/Abbreviation	Definition/Explanation
Overview and Scrutiny Committee (OSC)	Local authority bodies which provide scrutiny of health provision in their local area.
Paramedic	Senior ambulance service healthcare professionals at an accident or medical emergency. Working alone or with an assistant practitioner or emergency care technician, they assess a patient's condition and provide essential treatment.
Paramedic Practitioner	Paramedic practitioners come from a paramedic background and have additional training in injury assessment and diagnostic abilities.
Patient Report Form (PRF)	A comprehensive record of the care provided to patients.
Patient Transport Service (PTS)	A non-emergency medical transport service, for example, to and from out-patient appointments.
Personal Development Reviews (PDRs)	The PDR process provides a framework for identifying staff development and training needs and agreeing objectives.
Personal Digital Assistants (PDAs)	Small computer units which help to capture more accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.
Primary Care Trust (PCT)	PCTs work with local authorities and other agencies that provide health and social care locally to make sure that your community's health needs are being met.
Primary Percutaneous Coronary Intervention (PPCI)	An emergency procedure used to treat a heart attack.
Private and Events Service	Includes medical cover for football matches, race meetings, concerts, festivals and so on. It also provides ambulance transport for private hospitals, corporations and individuals.
Quality Strategy	Framework for the management of quality within YAS.

Term/Abbreviation	Definition/Explanation
Rapid Response Vehicle (RRV)	A car operated by the ambulance service to respond to medical emergencies either in addition to, or in place of, an ambulance capable of transporting patients.
Safeguarding	Processes and systems for the protection of vulnerable adults, children and young people.
Serious Case Reviews (SCRs)	Establish whether there are any lessons to be learnt about the way in which staff and agencies work together to safeguard vulnerable people.
Serious Untoward Incidents (SUIs)	Something out of the ordinary or unexpected. It is an incident - or a series of incidents - that, if left unattended, may pose a risk to service users or the health and safety of staff, visitors and others.
Stakeholders	All those who may use the service, be affected by or who should be involved in its operation.
Statement on Internal Control	The means by which the Accounting Officer declares his or her approach to, and responsibility for, risk management, internal control and corporate governance. It is also the vehicle for highlighting weaknesses which exist in the internal control system within the organisation. It forms part of the Annual Report and Account.
ST Elevation Myocardial Infarction (STEMI)	A type of heart attack.
Strategic Health Authority (SHA)	SHAs manage the NHS locally and provide an important link between the Department of Health and the NHS.
Yorkshire Air Ambulance (YAA)	An independent charity which provides an airborne response to emergencies in Yorkshire.
Yorkshire Ambulance Service (YAS)	The NHS provider of emergency and non-emergency ambulance services in Yorkshire.
Z-score	Describes how many standard deviations above or below the mean score a trust is positioned. A z-score of -2 or above indicates that a trust is performing within acceptable limits in comparison with other trusts. A score of below -2 indicates underperformance in relation to other trusts.

Yorkshire Ambulance Service NHS

NHS Trust

An Aspirant Foundation Trust

The full accounts for the year ended 31 March 2011 for Yorkshire Ambulance Service NHS Trust, together with further copies of this publication, are available on request.

If you would prefer this document in another format, such as another language, large print, Braille or audio tape, please contact our Corporate Communications department at Trust Headquarters to discuss your requirements.

Contact us:

Yorkshire Ambulance Service NHS Trust

Trust Headquarters

Springhill

Brindley Way

Wakefield 41 Business Park

Wakefield

WF2 0XQ

Tel: 0845 124 1241

Fax: 01924 584233

www.yas.nhs.uk

YAS-11-001-03

Design: **Ptarmigan Design**, Leeds. www.ptarmigan.co.uk

This document is printed on recycled paper.