Yorkshire Ambulance Service NHS
NHS Trust

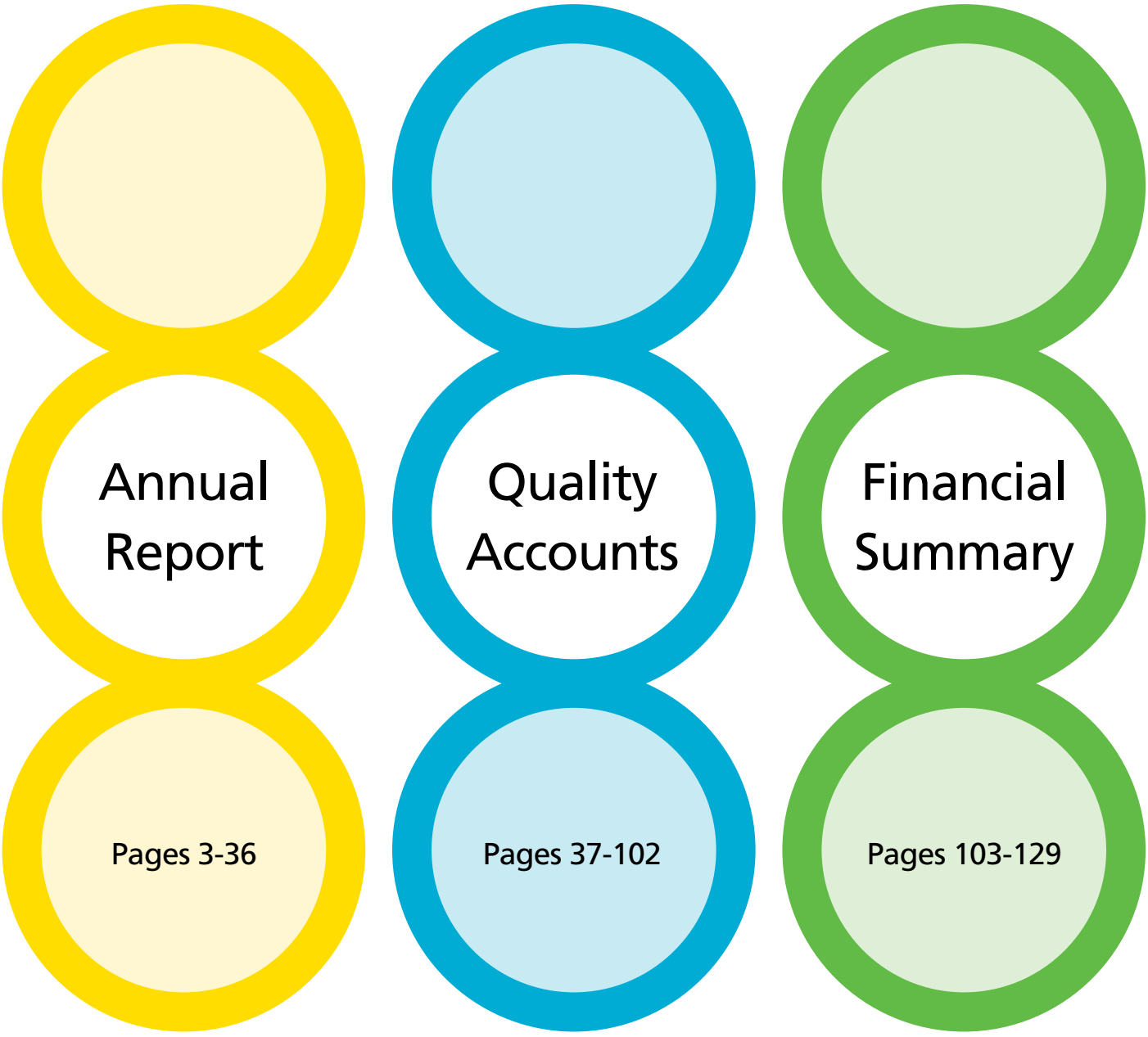
An Aspirant Foundation Trust

2011-12

Annual Report

Quality Accounts

Financial Summary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Annual Report

2011-12

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Our Mission, Vision and Values

Our Mission

Saving lives, caring for you

Our Vision

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

Our 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

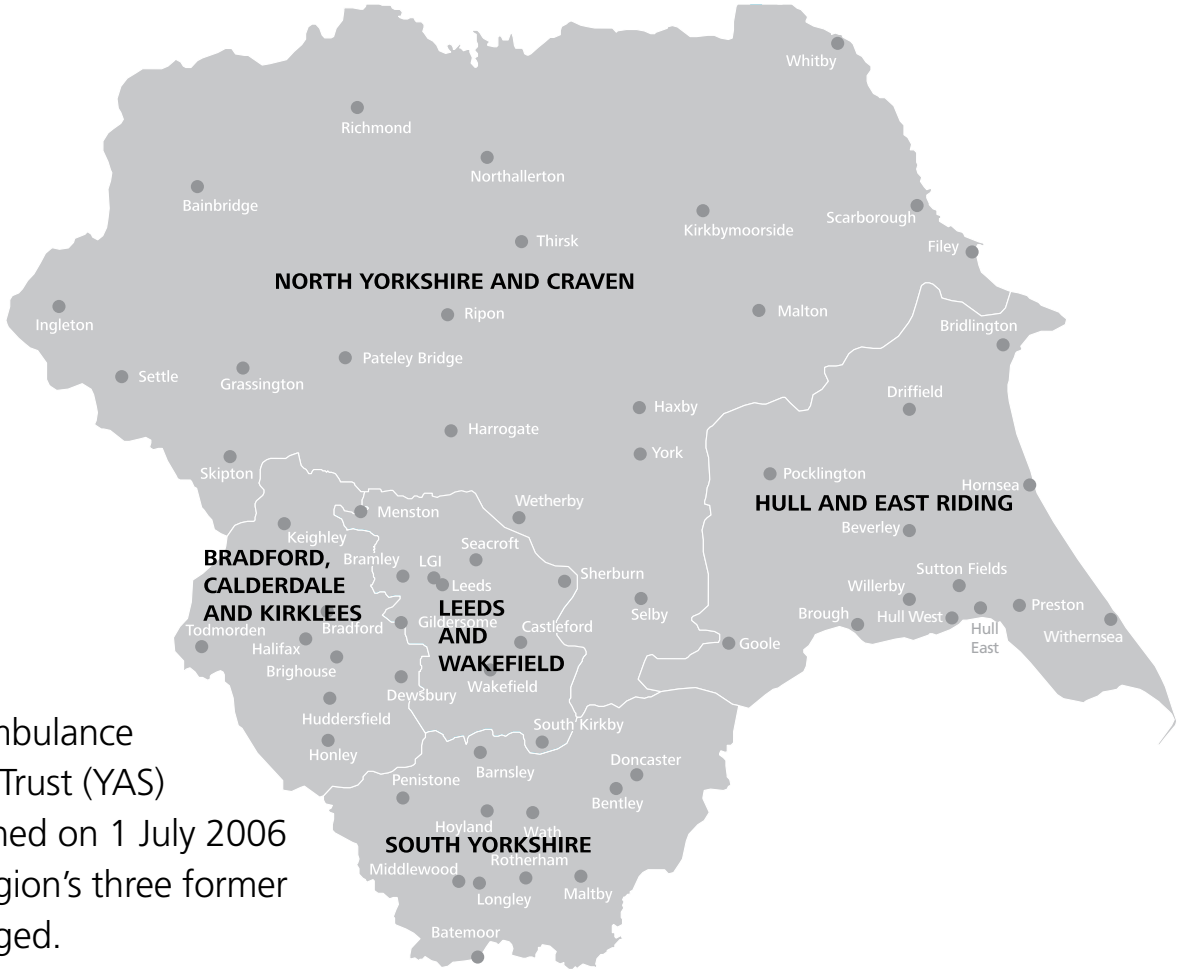
Respect and dignity

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 region's three former services merged.

We operate:

- two emergency operations centres in Wakefield and York where staff receive 999 calls and deploy the most appropriate response to meet patients' needs
- an accident and emergency service in response to 999 calls, including Resilience and Special Services
- a non-emergency patient transport service which takes eligible 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
- a Private and Events service.

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 and the Humber, 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 4,358* staff, who together with over 3,000 volunteers, enable us to provide a 24-hour emergency and healthcare service to more than five million people. The largest proportion of staff, over 87%, are employed within the Operations Directorate which includes A&E, Patient Transport Service (PTS) and the Emergency Operations Centre (EOC).

**4,358 is a headcount figure. It equates to 3,780 full-time equivalents.*

Chairman's Introduction

Welcome to Yorkshire Ambulance Service's 2011-12 Annual Report, Quality Accounts and Financial Summary which are our formal record of activity and developments. We hope they will give you a real understanding of how we have been caring for our patients and outline our future priorities.

2011-12 was another busy year for the Service and we handled over 750,000 urgent and emergency calls, responded to over 631,000 incidents and made just under a million Patient Transport Service (PTS) journeys. We have seen improvements in the quality of care our staff provide for patients and enhanced our Clinical Leadership Framework to ensure that we are training the clinical managers of our future.

Our dedicated staff remain at the heart of our service and we were proud to introduce the ***We Care Awards***, which saw over 100 staff nominated for going the extra mile for patients and who are shining examples of all that is excellent about the Trust. Colleagues celebrated their achievements from 2011-12 at a ceremony held in Leeds in April 2012. Together with the Long Service and Retirement Awards, they form part of the Trust's staff recognition approach.

In July 2011 over 60 members of staff, who between them had contributed over 1,600 years of service, were honoured at a ceremony held in Wetherby.

It was a year of celebration, as a number of frontline staff were recognised both inside and outside of the Trust for their vital contributions to patient care. You can read more about these achievements on pages 11 and 12.

We have also seen real improvements in the quality of care we provide which continues to be recognised by those who use our services. Like all public sector organisations and the wider economy we have financial challenges to overcome and will need to work differently, delivering more with less and ensuring that we can continue to deliver high quality services within a reduced financial envelope. The NHS landscape is also changing, particularly in relation to commissioning arrangements, and we have had early engagement with our future commissioners – the Clinical Commissioning Groups (CCGs).

Towards the end of 2011-12 an important part of our work programme was to participate in the tendering process for the new NHS 111 service, where people will be able to telephone when they need urgent medical help or advice but it is not a life-threatening situation. At the time of writing we await the outcome of the Yorkshire and Humber bid.

Our journey to become a Foundation Trust (FT) is well underway. We held a public consultation from September to December 2011 and received 1,604 responses from members of the public, partner organisations and our staff. This was an excellent response rate and we engaged with more stakeholders in this process than any other ambulance service. We will remain focused on our commitment to becoming Yorkshire Ambulance Service NHS Foundation Trust and recruiting members is a key priority for us in 2012-13.

In June 2011 we welcomed Elaine Bond to the Trust Board as Non-Executive Director and as 2011-12 drew to a close, Nina Wrightson OBE retired as one of our longest-serving Non-Executive Directors. Nina had been with the Trust since its formation in 2006 and prior to this served on the Board of Tees, East and North Yorkshire Ambulance Service. We would like to thank Nina for her valued contribution over many years and the skills and knowledge she brought to the Trust.

The Appointments Commission has appointed Erfana Mahmood as Non-Executive Director and Mary Wareing as Non-Executive Director (Designate) for 2012-13 and three years thereafter. We are delighted to welcome them to the Trust.

I have just touched on some of the highlights of the past year but there is much more to read in the pages ahead and I hope that you enjoy finding out more about Yorkshire Ambulance Service and the tremendous work of our staff.

Della M Cannings QPM
Chairman

Chief Executive's Welcome

I have now been with Yorkshire Ambulance Service for over a year and I am extremely proud of the progress and developments the Trust has made in that time. This is due to the commitment of our staff and their outstanding hard work and dedication in improving patient care and delivering high quality services.

I am delighted to report that the Trust achieved the Red 8-minute response target of 75% to patients with life-threatening conditions at the end of 2011-12. We finished the year at 75.72%, which is two percentage points better than last year and clearly reflects the efforts of so many people across the Trust. This is an achievement that we are proud of and, more importantly, it shows that patient care is improving and we are reaching our most seriously ill and injured patients quicker than ever before. We will continue to build on this success and our focus going forward will be on our clinical priorities and in maintaining both the quality and safety of services. I want to acknowledge and thank all of our people for their continued support, dedication and excellent teamwork.

We have worked with a range of health, emergency service, local authority and voluntary sector partners during the year on a number of projects and we are looking to build on this work during 2012-13. The support and constructive challenge we have received from our commissioners has helped to shape our services and to maintain a clear focus on quality. We have begun to engage with our new commissioners, the Clinical Commissioning Groups (CCGs), and I am looking forward to the opportunities this will bring to collaborate on service change which will meet the needs of local communities.

"I want to acknowledge and thank all of our people for their continued support, dedication and excellent teamwork."

A suite of Ambulance Quality Indicators (AQIs) were introduced in April 2011 for ambulance services in England to measure the quality of outcomes from the care we provide to patients. The 11 AQIs are ambulance specific and provide a balance between the speed of response and clinical outcomes for patients. They are a vital indicator of how well we respond to patients' needs and how we maintain and improve standards of care, and these are benchmarked monthly with all other ambulance services in England. The AQI dashboard provides us with an insight into where we need to focus our efforts to further improve our services. The AQI information is available on our website: www.yas.nhs.uk

In the increasingly competitive Patient Transport Service (PTS) market, which saw the loss of the South Yorkshire renal transport contract in 2011-12, there is a significant amount of service improvement work being undertaken by our management team. We have also embarked on an ambitious Trust-wide service transformation programme to provide a more patient-focused, efficient and flexible service that better meets our customers' needs.

We are also continuing with some exciting clinical developments relating to major trauma, which is part of a national initiative to improve clinical outcomes for patients suffering from such injuries. The roll-out of the Major Trauma Triage Tool has begun, helping our clinical staff to quickly identify those patients who require specialist care. In 2011 we also invested in a range of clinical equipment and drugs to ensure our clinicians can provide the highest standards of trauma care. It is a very significant step forward and we believe this will contribute to saving over 200 more lives each year.

Following consultation and engagement with staff, we have introduced the new roles of clinical supervisor and clinical development manager as part of a strengthened Clinical Leadership Framework. This will help to further improve clinical standards, the quality of clinical practice, provide clinical support and leadership to our staff and, importantly, will improve outcomes for patients.

We have been developing our five-year Integrated Business Plan setting out our direction for the next five years. It will ensure that we are a stable, efficient organisation with a strong focus on quality and safety and with patients at the centre of our plans. In moving to Foundation Trust status, we are looking for our patients, staff and communities to have a greater say in how we shape services for the future and benefit the communities we serve.

2012-13 presents us with fresh and exciting challenges and opportunities to build upon our achievements and continue to improve services for our patients.

David Whiting
Chief Executive

Our Performance in Caring for Patients

It has been a busy year with our clinical staff responding to over 631,000 incidents.

Accident and Emergency (A&E) Operations

Further improvements were made to our emergency response times in 2011-12 and Trust-wide we achieved the Red 8-minute response target of 75% so we are now reaching our most seriously ill and injured patients quicker than we ever have before.

It has been a busy year with our clinical staff responding to over 631,000 incidents across the region which is an increase of almost 2.47% on 2010-11.

In addition to response times, we have seen real improvements in the quality of care we provide and this has been recognised by those who commission our services. The Ambulance Quality Indicators (AQIs), introduced in April 2011, focus on the quality of care we deliver and patients' experiences and are evidence of the improvements we have made.

Developments in the Treatment of Major Trauma

There have been some exciting developments in the clinical management of major trauma patients this year, which are part of a national initiative.

We have led on the new Yorkshire and the Humber major trauma system which allows our ambulance clinicians to convey patients with potentially major life-threatening or multiple injuries directly to hospitals providing specialist care.

Our clinicians have new equipment, medication and processes to follow and this is raising the standard of care for major trauma patients before they reach hospital. It's a very significant step forward and we believe that it will help us to save up to 200 more lives a year and reduce the risk of disability.

From April 2012 we have also introduced a senior paramedic role in our emergency operations centre managing major trauma across the region and linking with other pre-hospital systems and emergency departments. In addition, the development of critical care paramedics is being piloted through two of our paramedic aircrew on the Yorkshire Air Ambulance.

In 2012 we are rolling out a new medicine called tranexamic acid (TXA) which our paramedics will use for patients who have potentially life-threatening bleeding. The pilot roll-out started with our Hazardous Area Response Team (HART) and our aircrew paramedics prior to being circulated more widely across the Trust.

Clinical Leadership Framework

Following consultation and engagement with our staff, the Trust has introduced new roles of clinical supervisor and clinical development manager as part of a strengthened Clinical Leadership Framework. Moving forward, this network of clinical leaders will help to further enhance our clinical practice, improve patient outcomes and deliver greater consistency of staff supervision and leadership. It also provides our clinical staff with clear career progression opportunities as the new clinical supervisors and clinical development managers will provide our potential senior managers and senior clinicians in the future.

Police and Paramedic Schemes

The late-night pairing of a paramedic and a police officer in towns and cities across the region continues to be an effective initiative which helps to ease the pressures placed on the police and ambulance services.

It provides a quick response to people with alcohol-related illnesses and injuries and those calling for police assistance in the city centre night spots during weekend and bank holiday evenings, a time when traditionally 999 calls to both services are high.

The joint approach can have an instant impact because while police are dealing with any anti-social behaviour, crime and disorder the paramedic can safely enter the environment and provide early medical assessment and treatment to those who are injured.

Schemes are up and running in Leeds, Sheffield, Rotherham, Barnsley, Doncaster, Hull, Bradford and York.

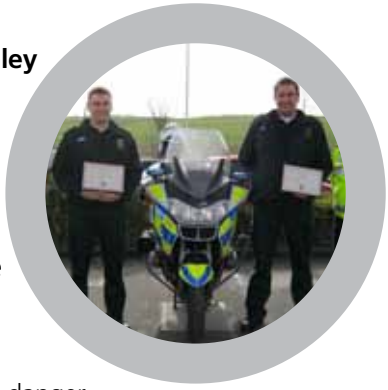
Awards

Our staff are very dedicated and the Trust has been delighted that a number of frontline clinicians have been recognised for their exemplary contributions to patient care during 2011-12. Some of these are highlighted to the right and overleaf:

Paramedic **Michelle Ping** was named Reservist of the Year at *The Sun*-sponsored Military Awards for her bravery in rescuing a wounded soldier while under Taliban fire in Afghanistan.

The Royal Naval Reserve Air Branch Reservist won the title for climbing onto a roof under a hail of bullets to reach Highlander Craig Paterson, 22, who had been shot in the head. Michelle was stationed with the Fourth Battalion Royal Regiment of Scotland - the Highlanders - as part of her tour of duty in Helmand Province, when the incident happened.

Her brave actions have also led to her receiving the top military honour of being Mentioned in Despatches - the oldest form of recognition of gallantry within the UK armed forces.



Brave Paramedic **Pete Cownley** and Emergency Medical Technician **Richard Mitchell** from Rotherham were named as finalists for *ITV Daybreak's* Emergency Services Award as part of the *Daily Mirror's* Pride of Britain Awards in October 2011.

They put themselves in grave danger to save the lives of two patients trapped in a burning car. First on scene at a car crash in Rotherham, our clinicians were faced with a horrific scene where two cars had collided and one had burst into flames. With no regard for their own safety, they raced to the burning, smoke-filled car, where two people were trapped unconscious.

Richard dragged the driver to safety while Pete struggled to free the second occupant through the passenger door. They then administered emergency treatment at the roadside until assistance arrived. The vehicle was completely destroyed by the flames before the fire and rescue service arrived.

Cathryn James, Clinical Pathways Advisor and Emergency Care Practitioner, has won a number of awards for her work to provide a more appropriate response to patients who have used a personal alarm to call for help.

In July 2011, Cathryn received a £5,000 bursary award for the scheme after receiving the NHS Clinical Leaders Network (CLN) - AquA Henderson Quality First Prize Award at the CLN Congress in London. She was also a finalist in the Software and Telehealth category at the seventh annual Medipex NHS Innovation Awards in September 2011.

In September 2011, she was also presented with a Leeds City Council Partnership Award for the joint work she did with the council on the scheme which enables non-clinical monitoring staff at Sheffield's City Wide Care Alarms and Leeds Care Ring to speak to YAS clinical advisors working in the emergency operations centre who then carry out a telephone assessment of the patient. This has helped to reduce the number of inappropriate emergency ambulance responses and ensure the most appropriate care is arranged or advised for the patient.

Most recently, Cathryn received an award at the 2012 Ambulance Leadership Forum (ALF) event, along with ten other colleagues from all trusts, for her exceptional contribution to the ambulance service (as nominated by chief executives).

Head of Emergency Operations (Hull and East Riding) **Mark Inman** (above) and Community Paramedic **Pete Shaw** (below) have each received High Sheriff's Awards for their exceptional services to the community.

Mark was recognised for his commitment to the Life-Cycle initiative over the last ten years, initially as York's first cycling paramedic and now as a manager.

Pete was honoured for his efforts in setting up seven volunteer Community First Responder schemes in the Yorkshire Dales and also for the development of his community paramedic role at Leyburn Medical Practice. As part of the role, which is unique to Leyburn, Pete responds to emergency calls as well as being able to see and treat walk-in minor injury and illness cases at the practice.

A&E Performance

*We received **751,910** urgent and emergency calls in 2011-12, an average of over **2,050** calls a day. We responded to a total of **631,113** incidents of which **252,619** were categorised as immediately life-threatening.*

	Target	2010-11	**2011-12**	Percentage Point Change
Red 8-minute response (previously Category A 8 minute response)	75%	73.72%	**75.72%**	+2.00
Red 19-minute response (previously Category A 19 minute response)	95%	97.38%	**97.94%**	+0.56
Green 1 response (previously Category B 19 minute response)	95%	93.69%	**N/A**	N/A

Staff are on hand to deploy the most appropriate response to best meet patients' needs.

Calling for Medical Help - What Happens Behind the Scenes

The first point of contact for anyone needing to use our 999 service is one of the emergency operations centres in Wakefield or York.

Staff are on hand to deploy the most appropriate response to best meet patients' needs and they play a vital role in providing calm reassurance and advice over the telephone to people who are often anxious and distressed.

During 2011-12 there have been a number of developments in our 999 emergency operations centres:

- Further improvements in the time it takes to answer an emergency call and dispatch an ambulance from 107 seconds to 95 seconds.
- New mapping on mobile data terminals which are used to pass details of jobs to ambulance clinicians and record response times.
- We have taken on Airwave digital radio which is a significant improvement on the previous analogue system.
- A dispatch bay reconfiguration in York has balanced out the responsibility for ambulance resources and a similar reconfiguration will also take place in Wakefield.
- Ongoing recruitment and training of staff.
- We have continued to deliver the GP Out-of-Hours service for primary care trusts (PCTs) in Hull, East Riding, North Yorkshire and Gateshead.

YAS is prepared with the knowledge, skills and equipment to deal with such events should they arise.

Emergency Planning

The last twelve months have seen many developments within the Resilience and Special Services department, formerly known as Emergency Preparedness.

As well as the continuation of work to provide advice and support to teams throughout the Trust on issues that may potentially impact on local communities, plans and systems have been refined and work has been carried out to acquire new equipment and deliver additional training.

Despite the winter period being milder than that of previous years, the Trust still encountered challenges as a result of adverse weather (eg snow in March) and seasonal ill health. We had sound plans in place, incorporating learning from previous years, which meant that we were well prepared for all eventualities.

In light of incidents both within and outside the UK, such as the Cumbrian shootings and bombings/ shootings in Norway, the Resilience and Special Services department has continued to ensure that YAS is aware of the threats and risks posed and is prepared with the knowledge, skills and equipment to deal with such events should they arise.

Building on the growing knowledge and experience we have within the team we have embarked on a programme of reviewing our current plans and guidance to streamline both so that they are more accessible and user friendly. We are also looking to refresh the information we provide to colleagues and invest in the education of the Resilience and Special Services department by a Certificate in Resilience Management in partnership with Leeds University.

Training for all staff and managers across the Trust remains a priority to ensure we are ready for a major incident. It has been a real challenge to balance training needs against daily operational demands, but we have devised innovative ways of delivering training through e-learning programs, including a module on 'Managing Incidents with Multiple Casualties'.

We have invested in the education of managers and specialist resources to ensure we can work closely with our emergency service and healthcare partners in the event of a mass casualty situation. We have staff trained in the appropriate use of personal protective equipment (PPE) for such events. We have also developed and are currently rolling out a bespoke course, in partnership with South Yorkshire Police, which delivers training to ensure that our commanders are competent in making effective decisions based on sound intelligence and judgement. We remain committed to working alongside our partners and being actively involved in multi-agency table-top and practical training exercises, several of which have been successfully completed in 2011-12.

Other projects that are ongoing include the development of a pre-hospital/mobile hospital teams capability and an Advanced Casualty Clearing Station to hold seriously injured casualties near to a scene whilst the wider health community can mobilise an effective response to deal with a large influx of casualties.

We have also been involved in supporting the 2012 Olympic Games by providing pre-planned aid in London and the torch relay journey through our region.

Patient Transport Service

Our Patient Transport Service (PTS) is the second largest ambulance provider of non-emergency transport in the UK. We provide transport for people who are unable to use public or other transport due to 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.

In the increasingly competitive PTS market, which saw the loss of the South Yorkshire renal transport contract in 2011, there is a significant amount of work to be done in transforming the service to ensure we are more patient-focused.

Against this backdrop, it was a busy year for PTS where we undertook 962,499 journeys and have been working hard to embed the four major contracts we have with our primary care trust (PCT) commissioners - which focus on the experience of patients and delivering a high-quality, credible service.

Last year, we faced a number of challenges and, even though we experienced a milder winter than 2010-11, we made it a priority to ensure that our renal and oncology patients' treatment was not interrupted during cold snaps or the Christmas period. PTS provides valuable resilience and good patient care and has the ability to provide patients and hospitals with the reassurance that we will do everything we can to ensure patients get urgent treatment, whatever conditions we are faced with.

PTS Performance:

*We made **962,499** journeys transporting patients to and from hospital and treatment centre appointments.*

We were named Employer of the Year in the NHS Yorkshire and the Humber Apprenticeship Awards 2011.

During 2011-12 there were a number of significant changes and improvements made in PTS:

- We were named Employer of the Year in the NHS Yorkshire and the Humber Apprenticeship Awards 2011.
- So far, 66 apprentices have completed the Apprenticeship Programme with the Trust and a further 22 apprentices are due to complete their training by August and November 2012. Twelve new operational apprentices started their training in February 2012 and ten new apprentices started in communications in April 2012.
- We employed 33 new PTS staff and 41 apprentices in 2011-12 and we have 758 PTS staff in total (WTE).
- The introduction of voice-call recording for quality purposes has enabled our PTS communications centre teams to provide valuable feedback to our call handling teams and improve callers' experiences.
- Expanding the use of touch-screen technology to allow call handling and dispatch operators to function more quickly and effectively has benefitted service-users and patients.
- We have reviewed our volunteer services to ensure they are fit for purpose, streamlining working practices across PTS to ensure consistency in all areas.
- We have introduced eligibility screening for patients in North and East Yorkshire.
- We appointed Heads of Department to strengthen the PTS management team and ensure that we have the capacity to deliver an effective service.

Following discussions with our commissioners, staff and patients, the Trust Executive Group arranged for external consultants to work with the YAS team to support the service transformation programme which is focused on improving our PTS to make it work more efficiently and effectively.

Plans for 2012-13 include:

- upgrading our Personal Digital Assistant (PDA) units to ensure we continue to capture accurate patient journey-time data
- looking to increase the number of volunteers supporting PTS by embarking on a recruitment campaign in spring 2012
- working with volunteer organisations and community groups who provide patient transport
- undertaking a pilot scheme of PTS volunteers working in hospitals to assist PTS patients
- continuing to support and develop our PTS Apprenticeship Programme and act as ambassadors for apprenticeships promoting them in other ambulance services and businesses across England
- developing access to our services by increasing the number of service-users booking transport online.

PTS will continue to focus on improving service quality in 2012-13 and ensure we use our resources wisely. We aim to consider making further cost efficiencies whilst providing a high quality service for patients.

We will 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 colleagues in A&E operations.

We are aware that there are still concerns around patient delays that need to be eliminated and we are working hard with our teams to do this. It is really important that we reduce waiting times for patients after difficult treatments and our own staff are only too aware of the impact this has on patients and we are all determined to make improvements.

Our Fleet and Equipment

We have continued to invest in our fleet and equipment to ensure we can provide the best clinical care and efficient and comfortable transport for all our patients, whatever their needs.

During 2011-12, the Trust purchased:

- 29 new emergency ambulances fully kitted with medical equipment
- 10 specialist 4x4 ambulances for use in rural locations across our region including medical equipment
- 106 rapid response vehicles
- 16 PTS single wheelchair vehicles
- 11 PTS stretcher vehicles
- 15 defibrillators
- 117 suction units.

The team also continued to maintain vehicles and equipment throughout the Trust.

During 2012-13 we will be developing a single specification vehicle conversion ambulance for YAS which will help to deliver both financial and environmental savings.

The people who make up YAS are vital to the delivery of high quality care, good patient experiences and improved health outcomes. The way in which our staff and volunteers are led, managed and developed is extremely important to us and to the standard of care that we provide.

Our Staff

The people who make up YAS are vital to the delivery of high quality care, good patient experiences and improved health outcomes. The way in which our staff and volunteers are led, managed and developed is extremely important to us and to the standard of care that we provide.

During the last 12 months, we have taken significant steps to refocus and reframe our approach to people management and development, as set out in our new Workforce Strategy *YAS People*. This new strategy ensures that we will continue to recruit, retain, develop, engage, reward and recognise the right people, with the right skills, in the right roles, at the right time to deliver the YAS vision, mission and values. In particular, *YAS People* will ensure that we are an organisation that has staff who are:

- **well led, well managed and well developed**
- **sustainably high performing, patient focused, adaptable and flexible**
- **able to adopt and deliver an ethos of 'right first time, every time'**
- **well educated, skilled and trained to provide safe, high quality, clinically effective and patient-focused care**
- **reflective of the communities the Trust serves and celebrate the benefits that difference can make to creating healthy teams**
- **self-aware, innovative and creative**
- **professional at all times**
- **ambassadors in the community and at work and are respected for their individual and collective contributions.**

Our work underpinning the *YAS People* strategy has meant that, during the last year, we have continued to invest significantly in the development of our people through the delivery of a broad range of statutory and mandatory training, access to continuous professional development (CPD) opportunities and through the roll-out of skills-based training, such as our new trauma equipment. We have also continued to partner closely with a range of universities, including Sheffield Hallam, Teesside and Bradford.

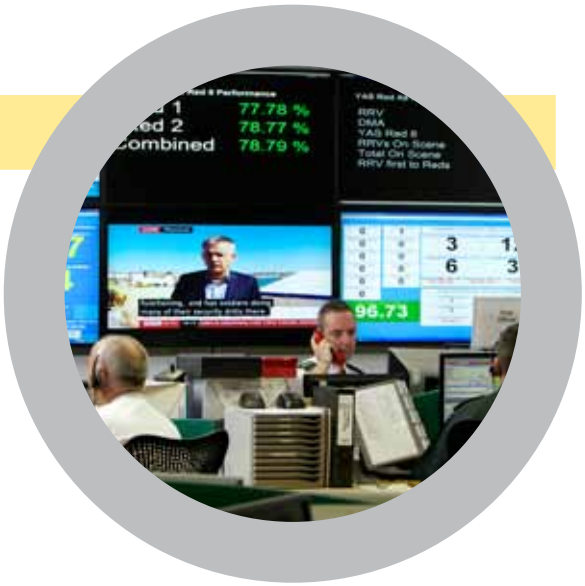
Our work to improve equality of opportunity and celebrate the diversity of our workforce and the communities that we serve, has significantly improved with the publication of our first Single Equality Scheme and the establishment of a number of staff support networks for people within our workforce from minority groups. We remain a 'two tick' employer, accredited by Job Centre Plus, for our approach to guaranteeing interviews for people with disabilities who meet the essential requirements for our roles. We have also continued to attract and recruit staff into a range of roles during the last year and our work to support young people into employment achieved notable success when our approach to apprenticeships achieved the Employer of the Year Award in the NHS Yorkshire and the Humber Apprenticeship Awards 2011.

Managing attendance and ensuring our people are properly supported and productive remains a key challenge and priority for us, which we continue to proactively address in partnership with our recognised trade unions and occupational health providers. We were especially proud that our approach to managing health and wellbeing in the workplace led to the Trust being a shortlisted finalist for the Chartered Institute of Personnel and Development (CIPD) People Management Awards in 2011.

Following the progress made during the last year, we recognise that we have a firm foundation from which to further develop our people to deliver even higher standards of service to the public.

Recruitment

During 2011-12, the Trust recruited 247 new members of staff. Of these 175 joined the Operations Directorate – 20 in the Emergency Operations Centre (EOC), 78 in the Patient Transport Service (PTS) and the remaining 77 within our A&E service.



Long Service Awards

A Long Service and Retirement Awards ceremony was held in July 2011 to recognise the dedication and commitment of 60 members of staff who had collectively contributed over 1,600 years of service between them.

Individuals who had reached their 20, 30 and 40 years of service, as well as those who had retired after a long career with the ambulance service, were honoured at the event at Wetherby Racecourse. The event also honoured staff who received the Long Service and Good Conduct Queen's Medal for 20 years' exemplary frontline emergency service.

The Queen's Representative, Deputy Lieutenant of West Yorkshire Stanley M. Hardy Esq., presented the awards alongside our Chief Executive David Whiting and Vice Chairman Pat Drake.

We Care Awards

This year saw the first ever YAS *We Care Staff Awards*, which were held in April 2012 to mark the achievements of our staff during 2011-12 and recognise those who go the extra mile for patients and colleagues.

There were eight award categories that staff could nominate their colleagues for, including two special awards; 'Team of the Year' Award and 'Trust Board Choice' Award.

Over 100 staff were nominated for the various awards and were honoured at the ceremony which took place in Leeds.

Sickness Absence

The table below shows the overall sickness absence figures for each month of 2011-12 in comparison with 2010-11.

During the past year our employee Health and Wellbeing Programme has continued to develop. An internal staff intranet portal was established providing staff with information on benefits, discounts and health and wellbeing advice. Staff have been encouraged to develop health and wellbeing groups at a local level, with examples of good practice being identified expertly within our emergency operations centres.

A review of our progress against the Stress Management Action Plan produced in 2010 showed that considerable work had taken place to address issues raised by staff through the stress audit and focus groups. This review, and analysis of the Staff Survey data from 2011, will now inform our forward-looking action plan as we continue to manage and improve the wellbeing of our staff.

	2010-11	**2011-12**	+/-
April	5.50%	**5.27%**	-0.23%
May	5.31%	**4.94%**	-0.37%
June	5.15%	**4.98%**	-0.17%
July	5.36%	**5.54%**	+0.18%
August	5.76%	**5.49%**	-0.27%
September	5.44%	**5.45%**	+0.01%
October	5.61%	**5.62%**	+0.01%
November	5.93%	**6.57%**	+0.64%
December	6.85%	**6.55%**	-0.30%
January	6.84%	**6.29%**	-0.55%
February	5.67%	**6.33%**	+0.66%
March	5.30%	**6.40%**	+1.10%

Workplace health and the wellbeing of our staff is a high priority for the Trust, as is our need to reduce levels of sickness absence to improve our productivity and the quality of service we provide to the public. To ensure that we actively reduce levels of sickness absence in the coming year, the Trust will:

- target interventions by both line managers and HR professionals to those areas where sickness absence is the highest
- target training for line managers to ensure that they manage sickness issues fairly but robustly and hold them to account for the performance of their teams in this respect
- tender for consistent occupational health service provision which is focused upon supporting the Trust as an employer and provides active interventions to enable the earlier return to work for staff who have been absent due to illness
- provide a 24/7 employee assistance programme to enable staff to access professional support, such as counselling, when they need it.

It is a formal requirement* that public bodies report sickness absence data and this is reported on a calendar year basis (January - December 2011) from a number of sources**. NHS national sickness absence figures for 2011 show that the Trust had 3,800 full-time equivalent staff in post, which equated to 855,000 available hours. The days lost to sickness were 49,065 which gives a sickness percentage of 5.7% and an average sickness per employee of 12.9 days.

** Treasury Financial Reporting Manual (FReM)*

*** the NHS Information Centre sickness absence publications and iView workforce staff in post, sourced from the electronic staff record (ESR) data warehouse.*

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 behaviour, whether physical or verbal, and we encourage staff to report such incidents so the appropriate action can be taken.

Our staff were subjected to 320 recorded incidents involving physical and verbal abuse between 1 April 2011 and 31 March 2012, compared to 290 during the previous year. This increase may be attributable to increased awareness amongst staff and the encouragement they receive to report incidents.

During 2011-12 there were 17 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.

Listening to Staff

YAS believes in engaging with and involving its staff. Information is shared with staff through various methods of communication, including filming key messages and making them available to staff via the intranet. We recognise the importance of staff being able to express their views, raise concerns, offer ideas for improvement and engage in decisions which affect them. Our weekly *Operational Update* communication includes an interactive Q&A section for staff, enabling them to find answers to questions beyond their immediate line manager or department.

Senior executives and managers actively participate in our 'Listening Watch' programme, which involves visiting various locations to speak to staff, listen to their issues and concerns and capture ideas for improvements. At a local level, we operate a 'Station Surgery' initiative which allows staff to meet with their locality managers on a regular basis. We also operate fleet open days to give staff the opportunity to be involved in decisions around our investment in vehicles.

However, we are not complacent and we have future plans to expand these initiatives even further with the launch of our 'Bright Ideas' suggestion scheme in 2012-13.

YAS participates in the annual NHS Staff Survey to gather the views and opinions of staff about a range of issues affecting their working lives. In 2011-12 the response rate was 55% compared with 57% in 2010.

When comparing our scores to the national average for other ambulance trusts the highest ranking scores are listed below:

- 5% fewer respondents said that they had witnessed potentially harmful errors, near misses or incidents in the month prior to the survey.
- 5% fewer respondents reported experiencing harassment, bullying or abuse from other staff in the previous 12 months.
- 5% more respondents reported receiving job-relevant training, learning or development in the previous 12 months.
- 9% more respondents, who had attended an appraisal in the previous 12 months, said they had received personal development plans.

Our lowest ranking scores compared to other ambulance trusts are listed below:

- 8% fewer respondents reported being able to contribute towards improvements at work.
- On a scale of one to five, respondents rated support from immediate managers at three, 0.21 lower than the national average.
- 4% fewer respondents reported using flexible-working options.
- 4% fewer respondents reported good communication between senior management and staff.

These findings will now help to shape our activity over the coming months, with the aim of continuing to improve the work experience of our staff.

YAS provides a range of occupational health services for our workforce in order to promote and maintain the physical, mental and social wellbeing of our staff.

Supporting Staff

YAS provides a range of occupational health services for our workforce in order to promote and maintain the physical, mental and social wellbeing of our staff. A new service introduced this year is 24/7 access to an employee assistance programme.

The Trust also provides training for staff and managers in areas such as stress management and works in partnership with managers to advise upon staff absence and return-to-work support for staff.

Additionally, the Employee Health and Wellbeing programme provides advice and resources to support staff, both in their personal and working lives. Tangible benefits are offered through the programme such as discounts on gym membership and car breakdown cover. This programme achieved a finalist place in the Health and Wellbeing category of the Chartered Institute of Personnel and Development (CIPD) People Management Awards in October 2011.

YAS is committed to providing all staff with annual personal development reviews in order to identify where further development and support is required, and to ensure they have the skills, knowledge and resources to meet the challenges faced in their roles.

Equality and Diversity

To ensure the Trust continues to meet its duties arising from equalities legislation (Equality Act 2010) and creates an organisation that embraces the benefits of diversity, a number of actions have been completed including:

- Publishing a Single Equality Scheme, which has led to:
  - a nominated executive lead for equality on the YAS Board
  - a new Equality Impact Assessment tool to ensure YAS does not discriminate against minority groups
  - 138 PTS staff and 21 student paramedics receiving equality, diversity, dignity and respect training
  - retaining the 'two tick' disability symbol, which is awarded by Job Centre Plus to employers who are positive about employing people with disabilities
  - the formation of staff support networks for minority groups within our workforce.
- Publishing equality information, which includes:
  - staff data
  - patient data
  - our equality objectives for the next four years.

YAS is using the NHS Equality Delivery System as a tool to effectively meet the requirements of the Equality Act 2010. This system will assist YAS to continually make improvements in delivering care services and fair employment to all sections of the community.

Training and Education

Leadership and Management Development

The Trust is continuing to develop leaders and managers, with 20 of our leaders and future leaders having completed management courses and 34 others starting the programmes this year. Approximately 100 team leaders and managers will have completed an Introduction to Coaching course and a course to provide a consistent development programme to support over 160 clinical supervisors as they lead their teams in improving patient care. Looking forward, these programmes will continue to help leaders and managers as they and their staff improve the Service.

Apprenticeships at YAS

YAS has been named Employer of the Year in the NHS Yorkshire and the Humber Apprenticeship Awards 2011.

The award is in recognition of our commitment to developing a wide range of apprenticeships where individuals receive full basic training, on-the-job mentorship, learn job-specific skills and gain a range of qualifications from within an Apprenticeship Programme.

NHS Yorkshire and the Humber ran the award scheme which aims to recognise NHS organisations/employers who have embraced the use of apprenticeships within their organisation. Awards were presented at a ceremony in September 2011 in Leeds.

Many of the apprentices work in the Road Operations and Communications divisions of PTS, which offers great prospects for a future career with the ambulance service. The Apprenticeship Programme achievement rate within YAS is 90% compared to the national average of 63%.

The Apprenticeship Programme achievement rate within YAS is 90% compared to the national average of 63%

Learning Technologies

YAS continues to develop and modernise the provision of education and training by converting traditional tutor-led classroom training into flexible modular online e-learning via 'YAS 247', the Trust's virtual learning environment. One of the first courses to be produced was on Stroke/Transient Ischaemic Attack (TIA) which includes a series of video podcasts, links to key documents, examples of patient experience videos, stroke pathway information, patient report form (PRF) completion and an online evaluation.

Staff are encouraged to undertake a full range of online learning and a total of 1,293 e-learning modules have been completed on the National Learning Management System this year. A total of 232 staff have also undertaken basic IT training to support their use of online learning.

Community and Commercial Education

The YAS Community and Commercial Education team is expanding both its portfolio of training provision and range of clients throughout the private and public sector. It is set to increase turnover for the third consecutive year, despite a very challenging commercial environment.

Their portfolio is largely made up of small and medium sized enterprises, however this year the team has also successfully led a consortium of NHS Ambulance Service Commercial Training providers to secure the consortia's first national contract for first aid training.

Profits made by the team are re-invested directly into public education and community engagement activities.

Public Education and Community Engagement

Innovative public education materials have been funded and developed by the Community and Commercial Education team to support school and community visits that teach young people about:

- appropriate use of 999 emergency services
- how to act in the event of an emergency
- the provision and importance of high-quality chest compressions in cardiac arrest
- safety and security
- health and fitness.

At the end of 2011-12 the team and other staff from across the Trust will have delivered educational programmes to over 50 schools in the region.

In 2012-13 the team and other staff from across the Trust will play a leading role in the development of the Trust's Public Education and Community Engagement Strategy that will foster and enhance links with the communities we serve.

Partnership Working

We continue to work very closely with a number of partners, including other emergency services, NHS trusts and volunteers, and very much appreciate their support.

Community Resilience

The Community Resilience department identifies potential Community First Responder (CFR) locations and volunteers to assist patients who suffer life-threatening illness such as stroke, heart attacks, breathing difficulties and cardiac arrest. CFRs provide care until the arrival of an ambulance response and attend local emergency calls to patients who may have collapsed or have other potentially life-threatening conditions.

The department engages with other stakeholders and partner organisations such as the British Heart Foundation (BHF), mountain rescue services, HM Coastguard, lifeguards, Cave Rescue and Humber Rescue to assist in local community resilience where YAS may have challenges in reaching and retrieving patients in remote areas and difficult terrain.

By the end of December 2011 we had 3,961 volunteer CFRs across Yorkshire who belong to 391 CFR, co-responder and static-site schemes (a static site is defined as a place with high footfall but doesn't move, eg a railway station, airport, bus station or shopping centre). This increased the number of volunteers in 2011 by 605 and the number of active schemes by 54.

The community-based volunteers have attended over 8,840 incidents during 2011, an increase of 2,800 on last year. Their quick response means they are on hand in the vital first few minutes of an emergency to provide life-saving treatment.

Partnership working arrangements have continued with mountain rescue services, HM Coastguard on the east coast and many police custody suites which now have access to an automated external defibrillator (AED). The East Riding of Yorkshire saw a significant increase in recruitment in the latter part of last year with an additional 52 volunteers supporting areas such as Withernsea, Hedon and Hornsea.

Educational Links - British Heart Foundation

The Community Resilience department has links to its communities through its BHF-funded Community Resuscitation Development Officer (CRDO). This has enabled a total of 1,373 certified students, covering a diverse group of individuals such as drug or alcohol-related students, individuals with learning needs, disabilities and autism, to learn basic life support (BLS) skills. Furthermore, our relationship with Heartstart (through our BHF partner) has seen significant additional training and education in BLS.

BASICS Doctors

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

Yorkshire 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 two YAA helicopters are based at Leeds Bradford International Airport and Topcliffe, North Yorkshire.

Frequent Callers' Project

The Trust's Frequent Callers' Project has now been running for three years and works in partnership with all 12 PCTs in the Yorkshire and Humber area.

The project identifies frequent callers to the emergency ambulance service who require help but not necessarily assistance from our A&E crews. We work closely with PCTs to identify issues with frequent callers and take steps to put alternative pathways in place. This means that the callers are able to gain access to more appropriate services which, for some, will be a personal care package or assistance from a community-based team.

A review of the results for 2011-12 indicates that the project has reduced the call volume expected from frequent callers by 41% across the Trust and helped to reduce the burden on the 999 system.

Our Estate

The Estates team is responsible for the maintenance and repairs of a vast number of electrical, mechanical items and buildings across the Trust's 62 ambulance stations, 11 fleet care vehicle workshops, 19 PTS patient reception centres (PRCs), 32 five-star standby sites, four training facilities, the Hazardous Area Response Team (HART) base, Resilience Operational Support Unit (OSU) and 6 support/administration facilities.

As well as responding to maintenance/repair requests, the Estates team is responsible for installation works and also for carrying out the Trust's Estates Capital Plan.

There has been further capital expenditure on large-scale projects that have helped to significantly reduce the Trust's energy bills and also improve the working environment for staff. These included:

- a full refurbishment of Halifax Ambulance Station which took place in 2011 and consisted of fully replacing the station roof, the heating system and all the lighting, installing a new fire alarm system, replacing the tarmac driveway, full decoration throughout including the garage, replacing fuel tanks and installing perimeter fencing
- replacement of roofs at Longley and Rotherham ambulance stations.

Other successful projects completed during the year included:

- installation of a new fire alarm system at Leeds and Thirsk ambulance stations
- installation of additional internal/external vehicle charging points at various ambulance stations.

In 2011-12 the Estates team has continued to reduce the Trust's energy bills and also make site-working environments better by including them in its plans.

This included the following:

- Installation of a new heating system at Harrogate and Brighouse ambulance stations.
- Refurbishment of Bradford Ambulance Station, including the creation of a 'make ready' area where ambulances are prepared by trained ancillary staff for crews at the start of each shift. This includes re-fuelling and replenishing consumables.
- Refurbishment of Leeds Ambulance Station's offices and garage.
- Installation of new fuel tanks and pumps at various ambulance stations in West Yorkshire.

Due to the delay in the sale of Bramham Ambulance Station, a decision was made to demolish the building to prevent vandalism, make the site safe and assist with security which took place in May 2011.

Other successful projects completed during the year include:

- installation of two 'launch pads' at Menston and Huddersfield ambulance stations for ambulance crews to park their emergency vehicles to enable them to respond more quickly to 999 calls
- installation of a new fire alarm system at the York Emergency Operations Centre (EOC).

Looking forward, the Estates team's capital expenditure for 2012-13 includes the following:

- Various upgrades at Bridlington, Driffield, Harrogate, Hoyland, Leeds, Settle and Whitby ambulance stations.
- Replacement of two uninterrupted power supplies (UPS) at Trust Headquarters, Wakefield.
- Completion of the refurbishment of Bradford Ambulance Station that began in 2011-12.
- Completion of our Gold Command Centre at Trust Headquarters, Wakefield.

How We Work

YAS is committed to reducing the carbon footprint of its buildings, fleet and staff whilst not compromising the core work of the emergency service.

Openness and Accountability Statement

The Trust complies with the NHS Code of Practice on Openness 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 Trust Board meeting in public every two months and our Annual General Meeting is held in September each year. These meetings are open to the public with specific time set aside for questions.

We always welcome comments about our service so we can continue to improve and members of the public who have a compliment, concern, complaint or comment should not hesitate to contact us.

Environmental Policy

We aim to ensure that our buildings and all 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 work of our services.

The Trust's Carbon Management Plan, which is consistent with local and national healthcare strategies, sets out our long-term commitment to sustainable reductions of our CO_2 emissions and carbon footprint.

This report is annually updated and the plan identifies CO_2 savings to be made within Estates, IT and Fleet departments. YAS has pledged to reduce its carbon footprint by 30% by 2015 based on the 2007 baseline.

Many of the measures identified to reduce CO_2 emissions will deliver ongoing financial savings from reduced costs associated with utilities, transport and waste. These can be reinvested into YAS to support further carbon reduction measures and make further long-term cost savings as well as maintain a more sustainable ambulance service for the future.

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 2011-12 is estimated to be 17,500 tonnes of CO_2

Year	Total CO_2 Emission (tonnes)	Emissions from building (tonnes)	Emissions from transport (tonnes)	Emissions per employee (tonnes)	% change
2007-08	16,531	5,553	10,856	4.88	0%
2008-09	16,831	4,929	11,745	4.97	2%
2009-10	17,257	5,707	11,345	4.35	4%
2010-11	16,330	5,104	10,961	3.65	-1%

YAS has won many awards in recognition of our carbon reduction work carried out during the year including winner of the People and Environment Achievement Business Awards 2012, EST Fleet Heroes Award for Leadership 2011, Business Green Sustainability Team of the Year 2011 and we were also runners-up of the Emergency Services Awards 2011.

Looking Forward to 2012-13

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This is set out in our policies on sustainable procurement.

YAS Sustainability Report 2011-12

The NHS Sustainable Development Unit (SDU), along with colleagues from the Department of Health, has developed a standard reporting template for NHS organisations which form the basis for their Sustainability Report (SR). This is in line with data requirements in the HM Treasury's Financial Reporting Manual.

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015 and YAS is aiming to reduce its carbon footprint by 32% during this time period.

Reducing the amount of energy used in our organisation contributed to this goal. There is also a financial benefit which comes from reducing our energy bill.

We have incorporated the following points in our SR:

- By reducing our energy costs by 15% in 2011-12, we saved the equivalent of the cost of 192 automated external defibrillators (AEDs).
- We have put plans in place to reduce our carbon emissions and improve our environmental sustainability, and over the next ten years we expect to save £1.3million as a result of these measures.
- In 2011, we recycled 226 tonnes of waste, which is 43% of the total waste we produce. We do not currently generate any energy and renewable energy represents 0.0% of our total energy use. We have not as yet made arrangements to purchase electricity generated from renewable sources.

- The Carbon Reduction Commitment (CRC) Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. As we do not qualify for the scheme, our gross expenditure during 2011-12 was £0.
- During 2011-12 our fuel expenditure was £7.2 million against £6.3 million in 2010-11. Most of the increase is due to increases in international fuel prices and the Trust is continuing to implement ways of reducing fuel use through purchasing more fuel-efficient vehicles and eco-driver training. We have also piloted the use of an electrical vehicle in our PTS.
- The Trust has a Board level lead for sustainability.
- Our staff energy awareness campaign is ongoing throughout 2012-13.
- NHS organisations have a statutory duty to assess the risk posed by climate change and the Trust is considering the potential need to adapt the organisation's activities, buildings and estates in line with this policy. This will pose a challenge to both service delivery and infrastructure in the future.
- Sustainability issues are included in the Trust's analysis of risks facing the organisation. Risk assessments, including the quantification and prioritisation of risk, are an important part of managing complex organisations.
- The Trust has a Sustainable Transport Plan, which considers what steps are needed and are appropriate to reduce or change travel patterns.
- Our expenditure on clinical and non-clinical waste in the last two years was incurred as follows:

	2011-12 (tonnes)	2010-11 (tonnes)
Waste sent to landfill	3406.16	4241.08
Waste recycled/ reused	3636.84	3208.44
Waste incinerated/ energy from waste	0	10.5

By reducing our energy costs by 15% in 2011-12, we saved the equivalent of 192 automated external defibrillators (AEDs).

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.

Since September 2011 the responsibility for reporting events involving the potential loss of personal data to the Information Governance Group and Senior Information Risk Owner has been passed to the Legal Services Manager and Deputy Medical Director (acting on behalf of the Executive Medical Director as Caldicott Guardian).

Summary of personal data-related incidents from September 2011 to the end of March 2012

Category	Nature of Incident	Total
IV	Unauthorised disclosure	One
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	7
I	Loss of inadequate protected electronic equipment, devices or paper documents from secured NHS premises	Nil

Reports relating to the events are analysed to ensure that appropriate measures have been taken to secure any potential losses and organisational learning reported to the Information Governance Group.

The Senior Information Risk Owner for YAS during 2011-12 was Steve Page, our Executive Director of Standards and Compliance.

Corporate Communications

The Corporate Communications team has continued to raise the profile of the ambulance service through the media and trade press and, as part of our ongoing drive to reduce the number of inappropriate 999 calls to the service, has launched various campaigns to encourage appropriate use of the emergency service. At Christmas, traditionally the service's busiest time of year, we launched a campaign entitled '999 for Emergencies Only' which ran alongside an appeal for responsible drinking over the festive period. Overall it received widespread media coverage including broadcasts on radio stations and televised news programmes.

In addition to this, various seasonal public health campaigns ran throughout the year such as our appeal during the summer months for people to be safe around open water when, typically, there is an increase in people requiring ambulance assistance after getting into trouble whilst swimming in lakes, rivers and reservoirs.

The team has continued to produce a wide range of internal bulletins for staff and this year introduced a system to colour code operational and clinical alerts to encourage better understanding amongst staff about the importance of messages.

A new publication, 'YAS Stakeholder eNews', has been developed which is an electronic bulletin for our key stakeholders to keep them up-to-date on Trust developments, achievements, performance and campaigns.

The Trust's name 'Yorkshire Ambulance Service' appeared on media websites, in newspapers and trade press and on radio and television news programmes on 1,674 occasions. 49.97% (911 items) of the overall coverage was analysed as favourable, 28.03% (511 items) neutral and 22% (401 items) negative in tone. Favourable coverage is estimated to have an average PR value of £882,402.

Working alongside the Resilience and Special Services department, communications handling plans have been prepared for major events including as the national day of industrial action which was held in November 2011 and the London 2012 Olympic Games Torch Relay which passed through Yorkshire.

The Trust Board 2011-12

Chairman
Della Cannings QPM

Chief Executive
David Whiting

Deputy Chief Executive and Executive Director of Workforce and Strategy
Stephen Moir

Executive Director of Finance and Performance
Rod Barnes

Executive Director of Standards and Compliance
Steve Page

Executive Medical Director
Dr Alison Walker

Executive Director of Operations
David Williams*
(acting)

**This role was held by Sarah Fatchett from 1 May 2011 until 31 December 2011 when David Williams took over on a temporary basis until the arrival of Paul Birkett-Wendes on 4 June 2012.*

Non-Executive Directors 2011-12

As members of the Trust Board, non-executive directors 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. A non-executive director is accountable to the Secretary of State. They are expected to hold the executives to account, to use their skills and experience to help the Board as it develops health strategies, and ensure the delivery of high quality services to patients. They are lay people drawn from communities served by the Trust.

In addition to their attendance at Trust Board meetings, the non-executive directors chair Tier 1 committees as described on page 36.

The appointment of non-executive directors is made in accordance with the Office of the Commissioner for Public Appointments' (OCPA) Code of Practice. The Appointments Commission is the independent organisation responsible, on behalf of the Secretary of State, for appointing chairs and non-executive directors to NHS organisations, including strategic health authorities, PCTs, ambulance trusts, mental health trusts and hospital trusts. The Appointments Commission ensures that the public appointment process is open, fair and impartial and that appointments are based solely on merit.

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.

Nina occupied this post from 1 July 2006 until 31 March 2012

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.

Richard occupied this post from 1 July 2006 until 31 July 2012

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.

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, Vice Chair of Locala Community Partnerships and Justice of the Peace in Calderdale.

Trust Board - Declaration of Interests

Name	Nature of Interest	Organisation
Della Cannings QPM	Vice Chairman and Director	Association of Ambulance Chief Executives
	Deputy Chairman	National Information Governance Board for Health and Social Care
	Chairman *(up to December 2011)*	Independent Advisory Committee – Army Foundation College (Harrogate)
	Member	Lord Chancellor's Advisory Committee for West Yorkshire (Calderdale and Kirklees Sub Committee)
Roger Holmes	Council Member	St John Ambulance (South and West Yorkshire)
Nina Wrightson *(Occupied this post from 1 July 2006 until 31 March 2012)*	Non-Executive Director	NHS Litigation Authority
Patricia Drake	Director	Innovate and Develop Ltd
	Chair	Artworks Creative Communities
	Vice Chair	Locala Community Partnerships
Elaine Bond	Non-Executive Director	International Greetings PLC

Please note: If a Trust Board member is not listed, there are no interests to disclose

Trust Board and Committee Membership

All Trust Board members and non-executive directors attend the bi-monthly Trust Board meeting held in public and the monthly private Trust Board meeting.

Other Tier 1 committees at the Trust are detailed below:

Committee	Membership
Quality Committee	• Three non-executive directors • Executive Director of Standards and Compliance • Executive Medical Director • Executive Director of Workforce and Strategy • Executive Director of Operations
Audit Committee	• All non-executive directors • Executive Director of Finance • Executive Director of Standards and Compliance
Finance and Investment Committee	• Three non-executive directors • Chief Executive • Executive Director of Finance and Performance
Charitable Funds Committee	• Two non-executive directors • Executive Director of Finance and Performance
Remuneration and Terms of Service Committee	• All non-executive directors • Chairman

Quality Accounts

2011-12

Contents

Statement on Quality from the Chief Executive

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

The progress we have made has once again been acknowledged by the Care Quality Commission (CQC) which agreed in January 2012 that we had met the full requirements for continued registration with them. This means that we are achieving all of the essential standards of quality and safety.

The Trust 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 embed a culture of quality. Demonstrating strong quality governance is essential, as we work towards achieving Foundation Trust (FT) status and our systems and structures continue to be subject to close scrutiny as we progress our application. We welcome this process as it provides us with additional challenges in setting ambitious objectives and supporting innovation.

In 2011-12 we made improvements in important areas of quality including incident reporting, management of serious incidents (SIs), 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 Ambulance Quality Indicators (AQIs). AQI results and achievements are regularly shared with frontline staff in their areas, so they can identify where they can learn from colleagues in other areas.

2012-13 will be a challenging year for all healthcare providers as the healthcare reforms are implemented. We will be exploring and introducing 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 with our partners, our patients and local communities to address concerns, agree local priorities and 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 Yorkshire Ambulance Service (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 these Quality Accounts 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

Our Strategic Goals and Objectives

1. Continuously improving patient care

- **Improve clinical outcomes for key conditions**
  - Reduce mortality for major trauma
  - Improve survival to discharge for cardiac arrest
- **To deliver timely emergency and urgent care in the most appropriate setting**
  - Reduce variability
  - Timely access
  - Partnership working

2. High performing

- **To provide clinically effective services which exceed regulatory and legislative standards**
  - Safe, high quality care
  - Improvement in Ambulance Quality Indicators
  - Improvement in Clinical Performance Indicators
- **To provide services which exceed patient and commissioners' expectations**
  - Improving patient involvement and experience
  - Developing services in partnership

3. Always learning

- **To develop culture, systems and processes to support continuous improvement and innovation**
  - Service transformation
  - New technology
  - Organisational learning
- **To create, attract and retain an enhanced and skilled workforce to meet service needs now and in the future**
  - Leadership development
  - Staff development
  - Staff engagement

4. Value for money and provider of choice

- **To be at the forefront of healthcare resilience and public health improvement**
  - Raising public awareness
  - Coordinating and leading
- **To provide cost effective services that contribute to the objectives of the wider health economy**
  - Sustainable service lines
  - Driving whole system efficiencies

Priorities for Improvement 2012-13

Context

The priorities for improvement have been developed through an engagement exercise both within YAS, and across a wide range of external stakeholders. The process of engagement is detailed further on page 61 and has included LINks, our expert patient and commissioners.

The priorities for improvement have also been aligned to the national agenda through the NHS Operating Framework (Department of Health 2012) and also our locally-agreed priorities with our commissioners through the Commissioning for Quality and Innovation (CQUIN) schemes both within our emergency and patient transport service.

1 Ensure that the response from the ambulance service meets the needs of local populations

Getting to patients with life-threatening conditions as quickly as possible saves lives and is a vital part of achieving the best possible clinical outcome. Throughout 2012-13 this will continue to be one of our highest priorities.

Aims

- Maintain our response times to patients with life-threatening conditions in line with the nationally agreed indicator to reach 75% of these patients within eight minutes.
- Improve patient experience.
- To continue to work with our healthcare partners in maintaining and improving existing and new patient pathways.
- Further develop our Clinical Hub to provide more advice and guidance for ambulance clinicians.

Measures, monitoring and reporting

- Our response times are monitored continuously and are reported to the Trust Board through the monthly Integrated Performance Report (IPR).
- YAS has an established patient experience survey which takes place each month for patients who have used our A&E service. This is analysed and reported monthly to both operational managers and the Trust Board.
- The use of the Clinical Hub is monitored monthly (specifically in relation to alternative care pathways).

2 Ongoing monitoring and improvement of Ambulance Quality Indicators (AQIs)

The AQIs are 11 national quality indicators which help us understand the quality of our service by measuring our performance. Along with the other English ambulance services, we began using these indicators in April 2011, and can now report on the quality of our service for patients suffering from cardiac arrest, ST elevation Myocardial Infarction (STEMI) and stroke and also allows our data to be compared with that of other ambulance services across the country.

The 11 national quality indicators are:

1. Service experience indicator
2. Outcome from ST elevation Myocardial Infarction (STEMI)
3. Outcome from cardiac arrest: return of spontaneous circulation (ROSC)
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 the Emergency Department
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 healthcare professional
11. Red eight-minute response time.

You can view the latest national AQI information which is displayed in the form of a dashboard, on the Department of Health website. It shows how YAS compares to other ambulance services in the country.

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm

There are now two categories of emergency calls; RED (national target) and GREEN (local target)

RED CALLS		GREEN CALLS			
R1	**R2**	**G1**	**G2**	**G3**	**G4**
Minimum 75% of cases	Minimum 75% of cases	Minimum 90% of cases	Minimum 90% of cases		
Response within 8 minutes 19 minute transport standard	Response within 8 minutes 19 minute transport standard	Response within 20 minutes	Response within 30 minutes	Telephone assessment within 20 minutes	Telephone assessment within 60 minutes

The nationally set targets for 2012-13 are for **Red Calls** only.

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 in the right place. To understand how well we do this we will continue to record the clinical outcomes for patients.

Aims

- Improved performance against all the AQIs.
- Provide feedback to staff on a consistent basis to ensure best practice is shared.

Measures, monitoring and reporting

The AQIs (as above) are the measures we use to monitor both performance and quality. They are reported to operational managers and also to the Trust Board on a monthly basis.

3 Improved Patient Transport Service (PTS)

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

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

Aims

- Measure our performance against quality targets and reduce waiting times for all patients.
- Map the timings of individual clinics and use this to plan return journeys that better match when patients are ready to be transferred.
- Improve patient satisfaction for all patients using PTS by postal questionnaires, holding patient/carer and patient representative focus groups.
- Target specific patient groups – renal, oncology, wheelchair users, and patients with learning disabilities.
- Analyse and develop action plans from focus groups and continually monitor and manage changes.
- Understand the different needs of specific patient groups and how they use our service, to refine and improve PTS.
- Deliver the CQUIN schemes agreed with the commissioning consortia.

Commissioning for Quality and Innovation (CQUINs)

The following 2012-13 CQUINs have been agreed with commissioners and will be measured on a monthly basis:

West Yorkshire:

1. Developing a number of initiatives focused on reducing abortive journeys.
2. To obtain and use patient feedback on their experiences from all groups who access PTS.

North Yorkshire:

1. To obtain and use patient feedback on their experiences from all groups who access PTS, with a focus on patients with learning disabilities, to help improve the overall patient experience.

South Yorkshire:

1. To obtain and use patient feedback on their experiences of PTS from seldom-heard groups who access the service in South Yorkshire.
2. Improve the percentage of online PTS bookings made by healthcare professionals.
3. Deliver short-term interventions during quarter one and quarter two to reduce the length of the longest waits for patients, post-appointment, whilst developing long-term sustainable changes to service modelling.

Hull and East Yorkshire:

1. PTS to contact patients within 30 minutes of transport due to arrive at the patient's residence.

The following Key Performance Indicators (KPIs) will also be used to measure quality:

- Patients should be collected in a timely manner following their appointments.
- Patient journey times should be of an acceptable duration.
- Patients should arrive in a timely manner for their appointments.
- Reducing the complaints and service-to-service issues and receiving positive patient feedback.

Measures, monitoring and reporting

- The CQUINs will be reported on both internally to the Trust Senior Management Group and Trust Board, and externally to the commissioning consortia.
- The overall programme is also monitored as part of the work of the newly-established Transformational Programme Group.

4 Implementation of Clinical Leadership Framework

The quality of our clinical leadership is crucial to delivering some of the changes we want to make in the next year. These changes place a greater emphasis on triage, assessment and treatment at home, rather than hospital admission. A significant transformation of clinical services and clinical leadership began during 2011-12 and will continue to be implemented throughout 2012-13. The service requires clinical leaders capable of delivering this transformation and of supporting our frontline clinicians in enhancing their clinical practice to achieve this.

Aims

- Embed the clinical leadership structure through clearly-defined job descriptions and role clarity.
- Increase the number of clinical leaders who have received clinical leadership training and development.
- Deliver bespoke clinical leadership and clinical assessment skills' training.
- Evaluate the impact of implementing the Clinical Leadership Framework.

Measures, monitoring and reporting

- Increase the number of clinical leaders who have received clinical leadership training.
- Increase the quality of patient care through improved clinical decision making and clinical leadership (measure through the clinical AQIs).
- Monitor the completion of mandatory training through monthly reporting to the Clinical Governance Group.
- Development of a dashboard to monitor recruitment, training and implementation of new supervision.
- Dashboard monitored through the Project Group as part of the Trust's Transformational Programme.
- Ongoing monitoring of the impact on quality as part of an agreed return on investment plan.

5 Implementation of the National Trauma Strategy

The National Trauma Strategy identifies the best evidence-based care for patients who sustain major trauma and gives recommendations for healthcare organisations. This includes the use of a Major Trauma Triage Tool to assess patients to ensure those with the most severe injuries are taken to a Major Trauma Centre (MTC) for urgent treatment. This involves the Trust and Yorkshire Air Ambulance (YAA) working with the Major Trauma Network to ensure that the most seriously ill and injured patients are conveyed to the most appropriate place.

Aims

A Trust implementation plan has been developed which will enable us to deliver the following aims:

- Implement a Major Trauma Triage Tool to enable major trauma to be identified.
- Introduce systems which ensure patients suffering major trauma are conveyed to MTCs (bypassing other acute care centres).
- Provide an Enhanced Care team - this means there will be a team of specialists, including trauma-trained paramedics and doctors, in the emergency operations centres (EOCs) who will coordinate a network-wide trauma response (subject to commissioner agreement).
- Support the EOC with an experienced paramedic presence 24 hours a day, seven days a week.
- Enhance trauma training to include the interventions which clinicians can deliver to patients who suffer major trauma.
- Evaluate the impact of the delivery of the trauma plan.

Measures, monitoring and reporting

- Completion of trauma training for all clinicians.
- Audit of the use of the Major Trauma Triage Tool.
- Agree ways to monitor the outcomes of patients who suffer major trauma with provider organisations.
- Progress is monitored via the Trust Executive Group.

6 Improve the Experience and Outcomes for Patients in Rural and Remote Areas

Our service covers the whole of Yorkshire and the Humber which includes isolated moorland and remote areas. The way we deliver our services in these areas needs to adapt and be flexible to the landscape and environment we are working in. Over the next year we want to better understand and deliver a service which will improve the experience and outcomes for patients living in rural and remote areas, by collaborative working across the health economy and community settings.

A CQUIN for 2012-13 has been agreed with a goal to improve the patient experience and outcome for patients in rural areas.

We aim to develop flexible response models to meet the needs of patients residing in rural locations to promote equity with urban locations.

Aims

- Review the current model of care delivery in rural and remote areas.
- Make recommendations for future service delivery to meet the needs of patients in rural and remote areas.
- Development of flexible response models to meet the needs of patients residing in rural locations to promote equity with urban locations.
- The clinical AQIs and stakeholder feedback will be used to monitor the quality of the service within rural areas.
- Patient satisfaction surveys will take place specifically for patients in rural areas.

Measures, monitoring and reporting

- These will be reported to the commissioners on a quarterly basis, and the reports used internally in the Trust to identify future service provision.

7 Improve the Quality of Care and Support for People with Dementia

Dementia is a multi-faceted and complex disease. Since the number of people whose lives are touched by dementia is increasing, it is important that our staff are sensitive and respond to the specific needs and wishes of people with dementia. With this in mind, we have developed a CQUIN with a goal of raising ambulance staff awareness of people with dementia.

Key messages in the *Living well with dementia: A National Dementia Strategy* (Department of Health 2011) includes the need for better education and training for professionals, the need for early diagnosis and helping people live in their own homes longer. Delivery of these objectives will have an impact on ambulance services and they can have a significant role in supporting the national strategy. Ambulance staff come into contact with both people who have been diagnosed with dementia and those who present with another condition but show signs of possible dementia. Staff will therefore need the skills to manage the specific needs of these people in a sensitive way.

Yorkshire Ambulance service will be providing training and awareness to staff in line with the *Common Core Principles for Supporting People with Dementia*, which was published as a workforce development guide by the Department of Health in June 2011.

Aims

To raise staff awareness of the needs of people with dementia, including:

- launching a YAS Dementia Awareness campaign for Dementia Awareness Week (w/c 20 May 2012)
- developing a Dementia Awareness Guide for all staff
- producing a modular Dementia Awareness course on the Trust's virtual learning environment (VLE) to be accessible for all staff
- incorporating Dementia Awareness training into all new operational basic training courses
- recruiting 'Dementia Care' champions to raise awareness of dementia care within the Trust
- incorporating Dementia Awareness into statutory and mandatory training for all staff by April 2013.

Measures, monitoring and reporting

- All relevant staff to be trained in dementia.
- Feedback from staff, carers and patients through YAS Patient Experience Team and staff surveys.
- Progress will be reported to commissioners at each performance meeting through the CQUIN process.

8 Develop a Safety Thermometer Tool Relevant to the Ambulance Service

The NHS Safety Thermometer is a tool designed to help hospitals understand where they can potentially cause harm to patients, for example, when patients develop a pressure sore or thrombosis. This work has been progressed to date within provider organisations, and in-patient providers have a national CQUIN relating to the submission of patient data for a range of indicators within a Safety Thermometer tool.

Currently there is no equivalent national tool for use in ambulance services.

We have agreed a regional CQUIN with our commissioners to develop a Safety Thermometer tool for the ambulance service which can be used to predict potential harm and therefore plan interventions to reduce this. This CQUIN will support the development of a similar tool, with appropriate indicators for use within the ambulance service setting.

Aims

- Understand contributors and levels of harm within an ambulance service.
- Develop a tool which will enable potential harm to be identified.
- Undertake specific activity to reduce levels of harm.
- Ensure learning is shared across the organisation to ensure best practice is embedded.

Measures, monitoring and reporting

- Data collection and analysis will inform the Integrated Performance Report for 2013-14.
- Development, implementation and delivery will be reported to commissioners, through the CQUIN process.

9 Raising Public Awareness to Support Appropriate Use of Ambulance Services

Raising public awareness in relation to the expectations of the public can potentially have a positive effect on the resource we have available to send to people with life-threatening illnesses. Patients and the public can find the current system for accessing health services confusing and do not know when to see their GP, call NHS Direct, or go to a walk-in centre. This quite often means that members of the public will call 999 for patients who, following our assessment, are confirmed not to be suffering from a life-threatening condition. In some cases, an ambulance is not needed at all. Whilst we appreciate that an ambulance is often called at times of vulnerability and fear, we want to work with members of the public to increase the awareness of more appropriate alternatives to 999 when the patient does not have a life-threatening condition.

We have agreed a regional CQUIN this year to raise public awareness and provide vital information to patients and the public to enable them to get the right care, at the right time, and at the right place every time.

This quite often means that members of the public will call 999 for patients who, following our assessment, are confirmed not to be suffering from a life-threatening condition.

Aims

- Analyse any existing public awareness campaigns.
- Identify target audiences for each audience group.
- Develop educational tools and resources.
- Utilise a variety of methods to engage with the public and communicate our key messages.

Measures, monitoring and reporting

- Analysis of feedback from 999, emergency (A&E) and PTS patient surveys.
- Analyse demand information and feedback from stakeholders to evaluate the effectiveness of the methods used.
- Progress will be reported to commissioners at each performance meeting as part of the CQUIN process.

2012-13 Indicators for Quality Improvement

Safety	Effectiveness	Patient Experience
1. Improved clinical decision making and patient assessment/ clinical record-keeping.	1. Implementation of national stroke strategy to deliver more streamlined care and improved clinical outcomes.	1. Patient dignity – ensuring a positive patient perception of YAS care.
2. Safe administration of medicines, with a focus on improvements in administration of pain relief and on reduction in medication-related adverse events.	2. Further improvement in the national Clinical Performance Indicators (CPIs).	2. Effective use of alternative patient pathways for end-of-life care to ensure that all patients receive the most appropriate care.
3. Infection, prevention and control, ensuring continued delivery of a clean, safe environment and clinical care across the Trust.	3. Cardiac arrest survival – delivering a 50% improvement in survival rates through implementation of the Resuscitation Plan.	3. Improvement in patient experience of YAS services; based on patient surveys, active engagement with expert patients, critical friends and other approaches, to gain patient feedback in all aspects of the service.
4. Safeguarding children and vulnerable adults, with a focus on ensuring effective assessment and referral processes and improved partnership working.	4. Effective development and use of patient pathways and development of YAS clinical support systems, to ensure patients get the right care, in the right place, and at the right time.	4. Improvements in the care of patients with learning disabilities, with a focus on awareness raising and on partnership working to ensure that patients with a learning disability receive the most appropriate care.

Statements of Assurance from the Trust 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, which makes our accounts comparable 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 CQC.

Ms Della M Cannings QPM
Chairman

Review of Services 2011-12

During 2011-12 YAS provided five NHS services:

- Accident and Emergency (A&E) response (including Yorkshire-wide community resilience and an Emergency Care Practitioner (ECP) service)
- Patient Transport Service (PTS)
- GP Out-of-hours (OOH) 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.

In addition, YAS supports the wider health community through the provision of:

- a critical care bed-base helpline
- telephone provision for out-of-hours District Nurse service.

Furthermore, YAS provides community and commercial education to schools and public/private sector organisations.

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

The income generated by NHS services reviewed in 2011-12 represents 100% of the total income generated from the provision of NHS services by YAS for 2011-12.

In addition to Board reports and scrutiny at the Clinical Governance Committee, directors and other senior managers 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 and other senior managers the opportunity to hear directly from staff about a wide range of issues and to discuss safety and quality-related issues. After every visit, senior staff record their learning from 'Listening Watch' and a six-monthly report is presented to the Trust Senior Management Group. Key issues are discussed and actions agreed and, wherever possible, feedback is provided to staff on actions taken by the directors and other senior managers as a result of their visits.

"During the last year YAS has provided us with development opportunities including new skills and equipment which have had a direct impact on the delivery of enhanced care to patients and their potential long-term recovery.

The introduction of new major trauma equipment, including the intra-osseous bone drill, arterial tourniquet and trauma dressing pack, has allowed us to provide additional treatment to patients suffering from serious traumatic injury. This has given us the professional self-satisfaction that we are able to give the best possible clinical care available. Not only has this benefited patients, but it has meant that clinical staff feel more valued and have been encouraged to learn, develop and practise their clinically-focused skills."

Andy Pippin, Paramedic and Clinical Development Manager, Hull and East Riding

The YAS Clinical Leadership Framework is a key element in ensuring the delivery of high quality, safe services which deliver the right care to the patient at the right place and at the right time.

Clinical Leadership

The development of the workforce is crucial to the safe and effective delivery of care. Clinical leadership is central to this.

A significant transformation of clinical services and clinical leadership began during 2011-12 and will continue to be implemented throughout 2012-13. These changes place a greater emphasis on triage, assessment and treatment at home, rather than hospital admission. The service requires clinical leaders capable of delivering this transformation and of supporting frontline clinicians in changing their clinical practice to achieve this. In addition, all clinical leaders complete the Bronze Commander Training, which ensures they have the skills to manage more serious and major operational incidents effectively.

The YAS Clinical Leadership Framework is a key element in ensuring the delivery of high quality, safe services which deliver the right care to the patient at the right place and at the right time.

Clinical leadership is not a new concept and the need to optimise leadership potential across the healthcare professions is being embraced by YAS.

YAS has adopted the national Clinical Leadership Competency Framework (CLCF) to increase and expand its leadership capacity. This framework offers a common and consistent approach to leadership development, based on a shared set of professional values and beliefs.

Practitioners are also being supported in their leadership development through a bespoke Clinical Leadership module which has been designed and delivered with the University of Bradford.

During 2011-12, 60 clinical leaders completed the module and the benefits included:

- implementation of clinical leadership skills assessments and development
- identification of service improvements projects.

Our Progress as an Aspirant NHS Foundation Trust (FT)

YAS is in the process of applying for FT status. We are now entering the detailed assurance phase. In addition, we commissioned an external review of our Quality Governance arrangements, which will be reviewed in July 2012.

This year we have also undertaken a significant public consultation exercise.

The Trust received 1,604 formal responses. This figure represents the largest response rate for an NHS ambulance trust foundation trust consultation in the country.

The response rate highlights the Trust's genuine attempt to engage with as many staff and external stakeholders as possible over the 12-week period, to provide them with an opportunity to share their views about future plans and help inform the development of the new organisation.

Further details can be found on our website: http://www.yas.nhs.uk/foundationtrust

NHS 111 - Our Ambition

NHS 111 is a new service being introduced to make it easier for patients to access local NHS healthcare services. Following trials of the new number, residents in some areas of the country are now calling 111 when they need medical help, but it isn't a 999 emergency. It is to be launched nationwide in April 2013.

In Yorkshire and the Humber our NHS commissioners are looking for a single contractual arrangement to provide the new NHS 111 service across the region and urgent care services in West Yorkshire and Craven. The procurement process has started and public and private sector suppliers have submitted bids for the contract.

Our aim is to play a major role in running the new service in this region and we have put together a comprehensive and competitive bid outlining our credentials to do so. We have partnered with Local Care Direct (LCD), an experienced provider of urgent care consultation and treatment to 2.1 million patients across West Yorkshire.

We both know the region well and have extensive experience in call handling, triage and urgent care provision.

Working together, we are confident that our bid to deliver an NHS 111 service which supports local health services across the region and ensures patients needing urgent care in West Yorkshire and Craven will get the right care at the right time in the right place.

Yorkshire Ambulance Service currently handles just under one million urgent, GP out-of-hours and emergency calls each year. We are focused on operating a seamless and cost-effective service for patients in Yorkshire and the Humber, extending the services we currently have available to meet the non-urgent medical needs of local people as well as the emergency service we already provide.

As the provider of the ambulance service in the Yorkshire and Humber region, we recognise the benefit to patients of the emergency 999 and non-emergency 111 services working closely together.

Participation in Clinical Audit

The Yorkshire Ambulance Service NHS Trust (YAS) Board has made the development of quality governance one of its main priorities for 2012-13.

We are committed to delivering effective clinical audits in all the clinical services we provide and see clinical audits as a cornerstone of our arrangements for developing and maintaining high quality patient-centred services. Our Clinical Audit Plan sets out how we will use clinical audits to confirm that current practice compares favourably with evidence of good practice and to ensure that where this is not the case that changes are made that improve the quality of care. The Clinical Audit Plan sets out development objectives for the short, medium and long-term. The short-term objectives focus on:

- compliance with regulatory requirements and national policies
- guidance and best practice including Clinical Performance Indicators (CPIs) and Ambulance Quality Indicators (AQIs)
- improving data quality and reporting systems
- staff education and training.

The results of clinical audits are monitored and reported on via the Clinical Governance Group.

During 2011-12 two national clinical audits and no national confidential enquiries covered NHS services that YAS provides.

During that period YAS participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that YAS was eligible to participate in during 2011-12 are as follows:

1. Myocardial Ischemia National Audit Project (MINAP)/National Infarct Angioplasty Project (NIAP). This is a national database which gathers information on all patients who have had a heart attack or who have coronary syndromes and of patients referred for an angioplasty surgical procedure. The audit produces annual reports *"How the NHS manages heart attacks"* to show the performance of hospitals, ambulance services and cardiac networks in England and Wales against national standards and targets for the care of heart attack patients.
2. National Ambulance Non-conveyance Audit (NANA) pilot and audit. A governmental audit looking at improving the role of ambulance services in delivering alternative care models for patients.

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/NIAP	There is no direct submission of data by YAS. The MINAP/NIAP process requires ambulance trusts to validate data submitted by acute trusts. Where possible, we validate the YAS patient data submitted by the 15 trusts.
NANA	NANA looked at 1,658 (emergency 999) calls over a 24-hour period, with 1,265 calls eligible for audit. 505 Red calls and 760 Green calls resulted in five re-contact incidents within 24 hours.

The national clinical audits and national confidential enquiries that YAS participated in, and for which data collection was completed during 2011-12 are listed below alongside the 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.

National Audit	Cases Required	Submitted
MINAP/ NIAP	Data required submitted to acute trust	100%
NANA	1,658	100%

We will continue to support future national audits and are contributing to the design of these audits. Examples include the Trauma Audit Research Network (TARN) and Stroke Improvement National Audit Programme (SINAP). We have also been involved in discussions with the National Institute for Health and Clinical Excellence (NICE) around dedicated audit tools for ambulance services.

...we see clinical audits as a cornerstone of our arrangements for developing and maintaining high quality patient-centred services.

Learning from Clinical Audit

The reports of two national clinical audits were reviewed by the provider in 2011-12 and YAS intends to take the following actions to improve the quality of healthcare provided:

- Staff education and awareness training.
- Implementation of data exchange processes between YAS and regional acute trusts for the validation of MINAP data.
- Spot audits regularly conducted by Clinical Managers.
- YAS Board awareness raised through Board reporting.
- More focus placed on STEMI as part of CPIs and AQIs.
- Report clinical audit through the Quality Committee as a sub-committee to the Board.

As a service we continually review the information we receive from clinical audit and share the learning within the organisation. This will be further developed with the implementation of the Clinical Leadership Framework.

Ambulance Service Cardiovascular Quality Initiative (ASCQI)

YAS is involved in a national project which has a focus on cardiovascular quality, specifically Acute Myocardial Infarction (STEMI) and stroke. This has been established through the National Ambulance Service Clinical Quality Group and is funded by the Health Foundation.

Currently we have one pilot in progress:

Solo responders in York are using lightweight oxygen and entonox more easily (pain relief) cylinders; this allows them to more easily provide pain relief for patients with chest pain. The lightweight cylinders also address the issues concerning the weight of the equipment clinicians carry. The two-month pilot was completed at the end of February 2012 and the results are being reviewed.

Additionally, in November 2011 we launched a new way of providing education for our clinicians by printing vital information on a key tab. The tabs contain the specific elements of care for patients suffering a stroke or heart attack and serve as a prompt for clinicians to ensure they deliver every important element of care.

We have also continued to develop the information provided on best practice on our learning portal which is available to staff 24 hours a day.

Local Audit

Across YAS we undertake local audits to measure our own clinical practice standards against best practice standards.

The local audits we completed last year included:

- quarterly hand hygiene audit report
- quarterly vehicle cleanliness audit report
- quarterly premises' cleanliness audit report
- quarterly cannulation audit report
- annual benzylpenicillin report
- non-conveyance for under 18s and under 2s (that is, not taking children and young people to a hospital emergency department)
- staff confidence to make referrals to social care
- monthly audits of care provided to cardiac arrest patients
- monthly audits of compliance against the four national CPIs
- completion of clinical records
- the management of medicines.

The reports of 11 local clinical audits were reviewed by the provider in 2011-12 and YAS intends to take the following actions to improve the quality of healthcare provided:

- Letter to all operational staff highlighting the importance of CPI documentation and where improvements can be made, specifically in the care of patients with asthma and cardiac arrest.
- Develop monthly updates for all clinical staff within Clinical Business Units (CBUs).
- Asthma posters on all stations relating to the importance of peak flow measurement for patients with asthma prior to treatment and CPI monthly results posted at stations with feedback comments.
- Develop web-based resources which show each of the CPI subjects, providing links to e-learning, research and case studies.
- Ensure alternative care pathways are linked with CPIs and are available on the internet.

During 2011-12, as a result of clinical audit, YAS has:

- increased compliance with appropriate wearing of hand jewellery
- increased compliance with carrying alcohol gel bottles
- increased compliance with correct use of gloves
- increased reporting of damage to vehicle upholstery
- increased the number of vehicles displaying deep-cleaning schedules
- decreased inappropriate storage of clean linen and consumables
- increased the general overall cleanliness of stations
- increased the display of audit results
- developed guidance on documentation completion in poster form and displayed it on all stations
- revised and implemented packs to enable, wherever possible, sterile cannnulation (a needle to administer drugs or fluid to a patient)
- reinforced drugs' regimes for children and adults
- reviewed and updated the YAS Non-conveyance Policy, Procedure and Process
- further developed and delivered CPR training to staff; this is then regularly monitored and recorded.
- changed its safeguarding procedure to streamline and strengthen governance processes, this has led to a significant increase in the number of referrals of vulnerable adults and children, that clinicians make to Social Care teams.

Compliance with National Guidelines and Patient Safety Alerts

NICE Guidance and NICE Quality Standards

All NICE Guidance and NICE Quality Standards are systematically reviewed for their relevance to YAS practices and processes. For each applicable guidance and quality standard an action plan is produced, implemented and monitored through Clinical Governance reporting systems.

Patient Safety Alerts

In 2011-12, the National Patient Safety Agency issued three Patient Safety Alerts, which may have been relevant to YAS. They covered:

- harm from flushing of naso gastric tubes before confirmation of placement
- minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors
- keeping newborn babies with a family history of Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD) safe in the first hours and days of life.

A review of these alerts determined that none were applicable to YAS, therefore all were closed as 'no action required'.

Participation in Research

Research

YAS is committed to the development of research and innovation as a driver for improving the quality of care and patient experience.

We demonstrate this commitment through our active participation in clinical research as a means through which the quality of care we provide can be improved, and contribute to wider health improvement.

YAS works with the National Institute for Health Research Comprehensive Clinical Research Network to ensure we support research activity in a way that promotes the national ambition to double the number of patients participating in research.

During 2011-12 YAS took part in eight research studies approved by an ethics committee:

1. Best Interests Decision Study

Four of our staff were interviewed to find out how the Mental Capacity Act (MCA) and its guidance are being used to protect and empower those patients who are judged to lack capacity. This study was led by the University of Bristol and is now complete. A summary of the findings can be found at:

http://www.applied-social-research.brad.ac.uk/publications/

There are no immediate recommendations for ambulance service staff.

2. High Quality Care for All Quality and Safety in the NHS

349 staff completed a survey to evaluate the extent to which cultural and behavioural changes are occurring in the NHS in response to recent drives to increase quality and safety in healthcare. The project is particularly focused on generating sustainable lessons about how to improve quality and safety in the NHS. This study is led by Aston University and is still active.

3. The Ambulance Service Cardiovascular Quality Initiative (ASCQI)

407 staff completed a survey to explore the extent and variation in the use of quality improvement tools in ambulance services for the second phase of this study. This study is led by East Midlands Ambulance Service (EMAS) and data is currently being analysed.

4. ATLANTIC – Drug Trial

Two patients have taken part in a commercially-sponsored multi-national randomised controlled trial to test whether the use of an antiplatelet drug in ambulances, compared to on arrival in angioplasty departments, improves outcomes for patients having primary percutaneous angioplasty following a heart attack. This study is currently open in ten countries, with 24 patients recruited across the UK.

5. Developing Outcome Measures for Pre-hospital Care

This study aims to develop methods for measuring processes and outcomes of pre-hospital care. It uses literature reviews and consensus methods to create a dataset to routinely link pre-hospital, hospital and mortality data; developing methods to measure proposed indicators, and exploring the practical use of the developed models. This study is a five-year programme of work led by EMAS and the University of Sheffield, which began in December 2011.

6. Decision Making and Safety in Emergency Care Transitions

This study is designed to find out what is currently known about safety in pre-hospital emergency care, and what are the key influences on safe decisions made by emergency care staff directly involved in the care and transition of patients. This study is a fifteen-month programme of work led by the University of Sheffield, which formally began in May 2012. YAS is a co-applicant and has been working closely with the study team from the early development of the study through the funding bid and setting up the project.

7. Exploring the Feasibility and Practicalities of Research in the Pre-hospital Setting

A staff survey to identify the barriers to undertaking pre-hospital research and to identify potential solutions. This survey is being carried out by a student at the University of Sheffield and is still active.

8. CURE-RAPID (Developing the Community Urgent Response Environment for Rapid Response Vehicles)

This is a phased study looking at the possible future design of equipment-carrying systems using focus groups and observations of staff using equipment with actor casualties. YAS is carrying out this study in partnership with Loughborough University. Data is currently being analysed, and the findings are expected to inform future purchasing decisions and improve staff wellbeing.

The number of patients receiving NHS services provided or sub-contracted by YAS in 2011-12 who were recruited during that period to participate in research approved by a research ethics committee was two, plus 760 staff.

In 2011-12 we also:

- supported three ambulance clinicians who were awarded bursaries to study research at masters level
- nurtured our 20 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 CLRN
- South Yorkshire CLRN
- North East Yorkshire and North Lincolnshire CLRN
- University of Sheffield School of Health and Related Research
- University of Loughborough.

Publications

Snaith B, Hardy M, Walker A. Emergency ultrasound in the pre-hospital setting: the impact of environment on examination outcomes. Emergency Medicine Journal March 2011, 10.1136

Taylor J. Putting Safety First, Newsletter, College of Paramedics, September 2011

Mark J, Walker A, Davey C. A mannequin study comparing suitability of the i-gel™ with a laryngeal mask airway device. Vol 3 No 8 • Journal of Paramedic Practice. August 2011

Darnell G, Mason S, Snooks H. Elderly falls: a national survey of UK ambulance services Online First doi 10.1136/emermed-2011-200419

Innovation

During 2011-12 YAS has been recognised nationally for the work which has been led by Cathryn James, Clinical Pathways Advisor and Emergency Care Practioner. Cathryn won the NHS Clinical Leaders Network award for her project to improve telecare alarm services for patients using YAS services and was also a finalist in the Medipex Software and Telehealth awards.

Goals Agreed with Commissioners

A proportion of YAS's income in 2011-12 was conditional on achieving quality improvement and innovation goals agreed between YAS and any person or body we entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

We achieved the majority of our A&E CQUIN goals for 2011-12 which included:

- increasing access to clinical advice for clinicians at the frontline of the service
- improving clinical assessment skills through education and enhancing clinical leadership
- increasing referrals to alternative care pathways
- working collaboratively to reduce the number of frequent callers
- Board-level agreement to introduce electronic patient report forms (ePRFs)
- capturing the patient experience.

The 2011-12 PTS CQUINs were commissioned by consortia and were as follows:

South Yorkshire

- Reduction in the number of abortive journeys.
- Achieving aspirational targets for selected agreed regional KPIs:
  - patients arriving no more than 60 minutes prior to their appointment time - minimum 90%
  - patients departing within 60 minutes of being booked ready - 90% or more
  - patients spending no more than 60 minutes on the vehicle within a 10 mile radius - 90% or more.

East Yorkshire

- Repeat of 2010-11 survey to be undertaken in January or February 2012, with results to be reported no later than 31 March 2012.

West Yorkshire

- Reduction in the number of abortive journeys.
- Setting of stretch targets on two of the agreed KPIs:
  - 70% of patients to arrive up to 60 minutes before the appointment time
  - 95% of patients to be no more than one hour on the vehicle.

North Yorkshire - no CQUIN scheme in place.

The PTS CQUINs for 2011-12 were not fully achieved by YAS, therefore we have assembled a transformational team to address issues and develop more focused service improvement plans for each PCT contract.

The 2012-13 A&E and PTS CQUINs are closely aligned to the priorities for improvement in these Quality Accounts. They are:

A&E

- Improving outcomes and experience for patients in rural and remote areas.
- Reduce conveyance to emergency departments.
- Improving patient safety by understanding the levels of harm in the ambulance service.
- Improving the assessment of patients with dementia through education.
- Increasing public awareness of the role of the ambulance service.

PTS

West Yorkshire

- Developing a number of initiatives focused on reducing abortive journeys.
- To obtain and use patient feedback on their experiences of PTS from all groups who access the service.

North Yorkshire

- To obtain and use patient feedback on their experiences of the service from all groups who access the PTS service, with a focus on patients with learning disabilities, to improve the overall patient experience.

South Yorkshire

- To obtain and use patient feedback on their experiences of PTS from seldom-heard groups who access the service in South Yorkshire.
- Improve the percentage of online PTS bookings made by healthcare professionals.
- Deliver short-term interventions during Quarter 1 and Quarter 2 to reduce the length of the longest waits for patients post appointment whilst developing long-term sustainable changes to service modeling.

Hull and East Yorkshire

- PTS to contact patients within 30 minutes of transport due to arrive at the patient's residence.

Emergency Care Practitioner (ECP)

- To compare outcomes in a specified group of patients accessing healthcare, from specified nursing and residential settings, to inform commissioners to improve pathways of care, the comparator group being patients accessing healthcare via the GP OOH service in Sheffield.

Further details of the agreed goals for 2011-12 and the following 12-month period 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 its current registration status is fully compliant.

The CQC has not taken enforcement action against YAS during 2011-12.

YAS has not participated in any special reviews or investigations by the CQC during the reporting period.

National Health Service Litigation Authority (NHSLA)

YAS is currently compliant to the NHSLA standards to level 1. YAS is committed to achieving level 2 status and will be assessed in October 2012.

Data Quality

The YAS Information Governance Assessment Report overall score for 2011-12 was 66% (level 2) and was graded as satisfactory (Green).

The Information Governance (IG) Toolkit is a performance tool produced by the Department of Health (DH). It draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance.

The effectiveness of all organisations is improved by access to good information. YAS uses good quality information as a driver of performance for the clinical teams and to help ensure the best possible care for our patients. Accurate information assists us in sound planning for the management of the Trust as well as assisting us in decision making for the delivery and location of care for our patients.

The Trust makes it a high priority to maintain effective, secure data management systems. This means that both we and our partners can have confidence that the information we use to measure the quality of our services is reliable, timely, relevant and accurate.

Ultimately, high quality information results in better and safer patient care and minimises clinical risk for our patients.

In 2011-12 YAS took the following actions to maintain and improve our data quality:

- We utilised our Information Asset Owners (IAOs) to drive the data quality agenda within their respective departments, including advocating the use of formal data quality assurance procedures.
- We continued with the data quality training workshops to ensure that managers and staff in key data-processing roles understand their responsibilities and had the necessary skills.
- Our Management Information team developed weekly data quality reports to help managers monitor and improve reporting and data quality in their teams.
- Our managers are responsible for our 'KA34' performance report to the Department of Health and work together to ensure that any changes to our information technology are assessed for their impact on reporting systems.
- Auditors carried out checks on our data quality systems.

YAS will be taking the following actions to improve data quality:

- We will work with internal auditors to assess the Trust's overall approach to data quality and develop an improvement plan.
- We will continue to develop data quality reports for managers to help them monitor and improve data quality in their teams.
- We will develop key performance measures to drive improvement in data quality and monitor progress.
- The IAOs will be expected to take ownership of, and seek to improve, the quality of information within their department and provide evidence of the same.
- We will continue to raise awareness of data quality amongst all staff through the IAO one-to-one process and help to embed best practice throughout the Trust.

Our attainment against the NHS IG Toolkit assessment provides an overall measure of the quality of our data systems, standards and processes. The Trust is on target this year to achieve strong level 2 compliance (within a range from 0 to 3) for all 35 requirements. This is equivalent to satisfactory compliance.

We are in the process of introducing a new data management system which will enable us to work more efficiently and joined up in terms of risk and assurance data capture. It will provide staff with a seamless data input/output process for monitoring compliance, risk management recording and reporting. The new system will minimise risk and improve productivity.

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

- YAS did not submit records during 2011-12 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 2011-12 by the Audit Commission.

How we select our Priorities for Improvement and Key Quality Indicators

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

- We provide weekly *Operational Updates* for all staff, which include clinical, operational and general information.
- Our Chief Executive sends a weekly email bulletin to all managers which includes priorities for the organisation and updates them about service quality and performance.
- We undertake the annual NHS staff survey asking staff to be open and honest in their responses. From the feedback we develop and implement an action plan for the coming year.
- Managers attend workshops focusing on key priorities. This allows them to share best practice and lessons learned.

Engagement with Patients and the Public

We regularly ask for patient feedback through:

- PTS comment cards
- A&E surveys, PTS surveys – which can be completed online or via hard copy
- surveys based around quality and patient experience
- our Critical Friends Network. We welcome their feedback on what they think is important and what they want from the ambulance service.

Engagement with Partners

- Members of the Trust Board attend the quarterly Yorkshire Air Ambulance (YAA) Board meeting to ensure collaborative working and share best practice.
- We hold a quarterly Clinical Review Group attended by the YAS Executive Medical Director, Executive Director of Standards and Compliance (Nurse Director) and PCT commissioners to review quality and performance against CQUINs.
- We continue to work closely with the Yorkshire-wide LINk Ambulance Group encouraging all LINks to participate in events and feedback on any issues.

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.

These findings will help to shape our activity over the coming year, with the aim of continuing to improve the work experience of our staff.

Further details are published in our Annual Report available on our website:

http://www.yas.nhs.uk/Publications

"I feel that there is nothing I can complain about. At 91 years of age I have always been treated with respect and dignity and I was very grateful to welcome members of the Ambulance Service. I would like to say a big thank you to them all."

Mrs C. Moore, Sheffield

Patient Engagement

YAS has appointed an expert patient who works closely with us acting as an advocate for patients. Expert patients have a key role in building our relationship with our patient network. They are a member of the clinical governance management and quality assurance structure, and are therefore able to advice on policy development and service provision. Our expert patient enables us to get a realistic perspective of patient experience, and provides us with access to service-users and other stakeholders, through their wide network of service-users and other stakeholders.

Around 40 members from LINks across the region attended a day-long event in Wakefield on 24 February 2012 organised by the Trust. It was set up to provide an opportunity for representatives within our organisation to meet with LINk members to discuss the services provided to people in the region. They were able to meet with a wide range of staff, including the Trust Board and frontline staff from both the emergency service and the non-emergency patient PTS.

From the results of engagement we learned that while some of the indicators we had chosen in 2010-11 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.

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.

In our 2011-12 Quality Accounts we set ourselves eight priorities for improvement. We chose these priorities based on our 2011-12 Business Plan, the Clinical Quality Strategy and the CQUIN targets we agreed with our commissioners.

We detail a summary of our performance against each of our 2011-12 priorities in the following pages.

Context

When looking at the information presented in this section, it is important to remember the number of patients who use our services each year.
In 2011-12:

We received 751,910 **urgent and emergency calls**

We responded to a total of 631,113 **incidents** of which 252,619 **were immediately life-threatening**

We made 962,499 **journeys** transporting patients to and from their planned hospital appointments.

Performance Against 2011-12 Priorities for Improvement

Recording Performance Monitoring and Recording against Clinical Outcome Measures – 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 2011-12 we continued to ensure that improving our response times was YAS's highest priority.

Aim

Maintain our response times to patients with life-threatening (Category A - now Red 1 and Red 2) conditions in line with the nationally-agreed indicator to reach 75% of patients within eight minutes.

How did we do?

During 2011-12 several operational improvements were introduced that had a positive effect on our services to emergency patients. Our ambulance response times for 2011-12 measured against national targets were significantly improved and the year-end figure for Red response times was 7.5%.

Category R1 and R2 calls

PCT	8 minute %	19 minute %
North Yorkshire and York PCT	71.3%	94.9%
East Riding of Yorkshire PCT	69.9%	94.5%
Hull PCT	90.7%	99.8%
Bradford and Airedale PCT	74.1%	98.2%
Calderdale PCT	78.8%	97.9%
Kirklees PCT	74.8%	98.2%
Wakefield District PCT	76.9%	98.7%
Leeds PCT	75.7%	98.8%
Barnsley PCT	75.9%	99.2%
Doncaster PCT	74.6%	98.6%
Rotherham PCT	75.4%	99.0%
Sheffield PCT	78.0%	99.2%
Yorkshire Ambulance Service	**75.7%**	**97.9%**

Developing Patient Pathways

There are a significant number of people who contact YAS as an emergency service. However, once there has been a robust assessment of the call, it is sometimes confirmed that a 999 ambulance response is not appropriate. In order to ensure we serve our duty to care for all patients who call our services we have, along with our healthcare partners, developed referral systems to ensure patients are appropriately transferred onto alternative care pathways. This may allow a patient to stay at home and a hospital admission may not be necessary.

YAS has also established and implemented a pathway development framework that is now used to inform the development of all new pathways. It details the steps to be taken including identifying a pathway need, implementation, governance, patient outcomes, evaluation and review.

Throughout 2011-12 we have successfully continued to develop these pathways for patients with diabetes, those who fall, and those at the end-of-life.

Aim

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 and the Humber. Having consistent procedures will promote high standards of care 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.

How did we do?

1. We have continued to work with our healthcare partners in developing referral processes and establishing pathways that meet the needs of patients, whether that is to convey them to a hospital or treatment centre or to allow them to remain in their own home with an appropriate care plan in place.
2. We have further developed a number of processes for referring patients to alternative care pathways and, in doing so, have tried to ensure consistency to promote high standards and allow comparisons to be made across the region.
3. We introduced a monitoring process for the care provided to patients referred via the diabetes and end-of-life care pathways throughout the whole patient journey.

The development of care pathways will continue to be important in 2012-13.

"Developing and maintaining robust alternative clinical pathways enables YAS clinicians to provide appropriate high quality care to their patients."

Liz Harris, Clinical Pathways Advisor

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

Some of the people who call our 999 service most frequently require help, but not necessarily the attendance of A&E ambulance clinicians or require transporting to hospital.

Since 2009 we have worked with local 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 individual needs, this reduces the number of times they call 999 for an ambulance, leaving resources free for others who need them. This work continued to be recognised nationally in 2011 when it won the Incident Response Award at the Inaugural Emergency Services Awards 2011 for the work on managing these patients.

Aim

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 previous 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 calling 999 for an emergency ambulance.

How did we do?

1. Monthly reports are sent to each PCT on the top ten individuals (frequent callers) and top ten care homes. Liaison with PCT leads each month provides feedback on patient/ care home action plans.
2. Following reviews by a patient's GP if appropriate, a case conference is organised. Over the last 12 months YAS has contributed to action planning in over 50 case meetings.
3. At present York University, in conjunction with YAS, is piloting a prediction tool which will analyse past cases to identify early warning indicators for potential frequent callers. They will work with healthcare partners to develop procedures for early action so at-risk individuals can get the care they need before resorting to calling 999.

Improving Patient Transport Service (PTS) Performance

Our PTS provides transport for eligible people who are unable to use public or other transport because of their medical condition. These include:

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

Aim

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.
3. In order to reduce waiting times for homeward journeys and improve patients' overall experiences of our service we need to have better knowledge of the timings of individual clinics. Currently, we plan journeys based on an appointment time of one-and-a-half hours for every clinic. In 2011-12 we will:
    - Map the timings of individual clinics and use this to plan return journeys that better match when patients are ready to be transferred.

How did we do?

1. The targets for 60-minute waits are set in the contracts and most areas are achieving this, or close to achieving it. Where this has not been delivered, we have been given the opportunity to work with commissioners to set trajectories for improvement. The priority for us is preventing the extended waits for all patients and, in particular, those patients that have been waiting in excess of two hours. Trajectories for improvement are included in each area's Service Improvement Plans.
2. We have continued to measure performance against all quality targets, however not all of these targets have been achieved and waiting times, in particular, have not shown significant reductions. We have recognised this must be a priority area for focus during 2012-13 and have established a Service Transformation team whose primary objective is to deliver significantly improved PTS. The Service Transformation team is initially focusing on South Yorkshire, Hull and East Yorkshire localities. Working with PCTs and acute trusts, the team has developed service improvement plans to implement the changes.
3. During the last 12 months we have created a 'Site List' document for each of the PTS contract areas. These lists have helped us to confirm specific sites and times of operation. Through discussion with our commissioners we have been able to more easily identify where changes have needed to be made to improve services for patients.

Developing Clinical Leadership and Assessment Skills

In order to continually improve the quality of our care in line with the AQIs 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 referrals to appropriate alternative care pathways.

YAS is investing significantly in the development of clinical leadership through the implementation of the Clinical Leadership Framework.

Aim

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 (PRFs) where all essential fields are complete.

How did we do?

1. The YAS Clinical Leadership Framework has been developed and implementation has begun, ensuring the delivery of high quality, safe services which provide the right care to the patient at the right place and at the right time. YAS has also designed and delivered education programmes in collaboration with Higher Education Institutes to support the implementation of the Clinical Leadership Framework.
2. We continually monitor staff skills and their development and this will continue throughout 2012-13. This includes the completion of a mandatory training schedule as well as other opportunities for learning and development.
3. We have continued to monitor the clinical record-keeping standards and complete a monthly audit of the completeness of clinical records. Table 1 details the monthly results.

Table 1 PRF Completion Results

Patient Report Form (PRF) Data	% of completed forms
April 2011	97.9%
May 2011	98.7%
June 2011	97.2%
July 2011	98.1%
August 2011	98.1%
September 2011	98.7%
October 2011	98.4%
November 2011	97.9%
December 2011	98.3%
January 2012	98.4%
February 2012	99.1%
March 2012	Amendments to process - awaiting outcome

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 job means that they often deliver care in people's 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.

Aim

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 (RRVs) can 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.

How did we do?

1. The Clinical Hub has been developed and provides the following services:

   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. Following this assessment they may 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 in the community.

   Health Desk Advisors (non-clinical staff)

   The Health Desk Advisors process information from crews about appropriate care pathways available to them for their patients. They complete the administrative process and make the referral to the appropriate service which allows the crew to spend more of their time assessing and monitoring patients.

   Hear and Treat

   When members of the public contact us, we currently assess the reason they are calling and, in some instances, determine that the situation is not life-threatening or an emergency, and that the problem can be resolved over the telephone. Clinical advisors or qualified nursing staff within the EOC can offer advice which, where appropriate, enables people to stay at home rather than be taken to hospital. Currently we 'hear and treat' 4.3% of the calls we receive.

How did we do?

2. In 2011-12 we provided all YAS staff with a single phone line into the Clinical Hub called the 'Crew Advice Line'. This enables all our staff to access advice and support when needed. Throughout the year the extent to which clinicians have accessed the 'Crew Advice Line' has increased and is shown in Table 2 below.

	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Acute criteria	3	11.54%	16	22.86%	29	7.44%	26	5.67%
Clinical advice	11	42.31%	9	12.86%	65	16.67%	80	17.74%
Diabetic referral	0	0.00%	5	7.14%	24	6.15%	31	6.87%
Falls referral	0	0.00%	3	4.29%	45	11.54%	46	10.20%
Frequent caller advice	0	0.00%	0	0.00%	2	0.51%	7	1.55%
General pathway information	3	11.54%	14	20.00%	107	27.44%	149	33.04%
STEMI pathway	0	0.00%	1	1.43%	12	3.08%	10	2.22%
Stroke pathway	2	7.69%	3	4.29%	15	3.85%	8	1.77%
Safeguarding	3	11.54%	6	8.57%	24	6.15%	30	6.65%
Toxbase	2	7.69%	5	7.14%	13	3.33%	14	3.10%
JRCALC/NICE guidelines	1	3.85%	0	0.00%	2	0.51%	11	2.44%
YAS policy advice	1	3.85%	8	11.43%	35	8.97%	38	8.43%
Other	0	0.00%	0	0.00%	17	4.36%	1	0.22%
Total	**26**	**100.00%**	**70**	**100.00%**	**390**	**100.00%**	**451**	**100.00%**

3. In addition, a staff satisfaction survey was conducted in July and August 2011 to understand the staff satisfaction with the advice they received from the 'Crew Advice Line'. A second survey took place in March 2012. Overall staff were highly satisfied with the advice they received.

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.

Aim

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.

How did we do?

1. We have implemented a Service-User Experience Survey for patients who have used our emergency service. This can be completed through a postal survey or electronically. A low response rate to the A&E survey for service-users under 18 years old and carers of under 2-year olds, has led to further work to look at other feedback mechanisms to gain feedback from this age group. This is included in the Patient Experience Workplan for 2012-13.
2. We have also improved the ways we can understand patients' experiences who travel on our PTS vehicles. This is captured through the completion of an annual survey and we have also revised the comments cards to include a question on dignity and respect, together with increased anonymity of feedback and improved readability.

How did we do?

All surveys are written in plain English and are available in large print, alternative formats, Braille or a different language on request.

We display posters in our emergency and PTS vehicles informing patients how they can give feedback. We have also continued to record narrative and filmed patient stories as a further method of gaining patient feedback.

3. The Patient Experience Group has continued to manage the service-user feedback from patients. The group is also in the process of developing new ways to better represent the diversity of our communities.
4. The clearest theme from both the A&E and PTS surveys is that patients appreciate the care provided by YAS staff. To reinforce positive behaviour and raise awareness of the minority of negative comments the results are widely publicised to all staff and patient stories and feedback from the surveys is also used within training.

   During 2012, we are reviewing the services we provide for bariatric patients. This Trust-wide review will enhance the quality of care we can provide for bariatric patients giving consideration to:

   - equipment and associated training
   - privacy and dignity
   - working collaboratively with the other stakeholders
   - risk assessment procedures.

   This review has included the contribution of a service-user for which we are very grateful.

How did we do?

5. Throughout the year we have continued to measure the experience of our patients and we are committed to capturing patient stories as part of our work to understand our patients' experience. Over the last year we have developed a library of patient stories, including filmed and written formats. The patient stories are an integral part of our Trust Board meetings, and are also used in inducting and training our staff. We have a robust process to engage patients in patient stories which includes obtaining consent.

Response Rates to Postal Survey

Postal Survey	Q1	Q2				Q3				Q4			
	May (pilot)	July	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total
Postal surveys sent	570	570	570	570	1,710	570	570	570	1,170	570	570	570	1,710
Postal surveys returned	123	134	165	181	480	191	143	142	476	167	171	155	493
% response rate	21.6%	28.1%				27.8%				28.8%			

Response Rates to Online Survey

Online Survey	Q1	Q2	Q3	Q4
Surveys completed	221	145	138	96

The results show that for the majority of 999 callers, the ambulance service was the first service they contacted. This is a clear trend from the online results (61%). From the postal results the figure has decreased to 47% in Q4 (from 54% in Q3). Around 21% of callers had first contacted either their own doctor or the GP out-of-hours service (GPOOH).

Between 92% (online results) and 84% (postal results) of callers considered the call answer time as good or excellent.

Satisfaction with ambulance response times is generally higher for the postal survey results (70.5% online compared with 94% postal).

The results (both quantitative and narrative) clearly show a high level of satisfaction with the care provided by YAS clinicians. The quantitative average is between 85% (online results) and 96% (postal results) satisfaction.

There is also a high level of satisfaction regarding how the patient was transferred to the ambulance. The percentages of respondents stating they were satisfied ranged from 92% (online results) to 96% (postal results).

Overall, respondents were satisfied with the care provided by the ambulance service and the dignity and respect shown to them by YAS staff (between 72% online and 95% postal).

Diversity is a cross-cutting theme amongst all of our patient feedback and our aim is to provide a positive experience for all our patients.

Patient Story One:

Mrs S is a bariatric patient who lives alone on the first floor of her two-storey house. Mrs S is unable to stand for long periods however she does occasionally go out.

During the past year Mrs S has spent quite a length of time in hospital where, initially, she was advised that it would be challenging for her to return home due to the nature of her accommodation (the toilet was on the first floor). Mrs S did however return home to live on the first floor. She is happy with this decision and feels that being able to stay in her own home has had a positive effect on her emotional wellbeing and her quality of life.

Over the years Mrs S has used both the emergency ambulance service and PTS. We were introduced to Mrs S by our Expert Patient as she was interested in telling us about her experiences and perspectives of the Yorkshire Ambulance Service.

Mrs S referred to an incident when she was still living on the two floors of her house and she fell in her bathroom (trapped between the toilet and the wall). The ambulance clinicians attended and then called the YAS Hazardous Area Response Team (HART) who were able to use specialist equipment to transfer Mrs S downstairs and out to the ambulance.

Mrs S also mentioned other experiences relating to ambulance transport/vehicle equipment as follows:

- Seating in ambulances inadequate for bariatric patients (not wide enough).
- Ambulance unable to accommodate a wheelchair or frame.
- Excessive journey times.

This visit gave us the opportunity to explain that the Yorkshire Ambulance Service is currently reviewing our processes in order to improve the experience and care of bariatric patients. Mrs S has since being involved in the review as a patient advisor.

Mrs S was keen to hear about the filmed patient stories and particularly how powerful they can be when used in staff training. Mrs S subsequently agreed to have her story filmed and this was presented to the attendees of the Trust Board meeting held in public in May 2012. Patient stories are shown at Trust Board meetings held in public and used regularly in both A&E and PTS training.

Mrs S particularly wished to say that the ambulance staff have always been very helpful and treated her with dignity and respect. She has said that she feels her needs are now better understood which will lead to a better patient experience in the future. She will give this positive feedback to her local Disability Forum and offered future linkages in terms of any help or advice around disability which the Forum may be able to offer in the future.

We were very grateful to Mrs S for inviting us into her home and allowing us to gain a greater understanding of her condition and requirements to improve the patient experience for her and bariatric patients in general.

Performance Against 2011-12 Key Quality Indicators

The following section reports on those indicators which we have highlighted in previous Quality Accounts. They may not remain a key priority for the Trust but still remain very important to the quality of the service we provide. It is therefore our intention to report these wider cross-cutting themes within the Quality Accounts as we continue to monitor and improve our performance.

"Over the past five years whenever I have had need of them either for myself or other people the response time has been excellent and the paramedics have been very efficient and reassuring. I would give them 10/10 or even 11/10."

E.S. Scarborough, Whitby and Ryedale Cancer Patient Involvement Group

Indicator 1 Ambulance Response Times

The nationally set target for 2011-12 is as follows:

Category A target has been renamed as RED national target.

In 2011-12 both the nationally-set response targets were achieved.

Trust-wide both Red 1 and Red 2 were exceeded, demonstrating a significant improvement on last year's response times.

Work to improve our response to rural areas continued. North Yorkshire, in particular, has continued to see improvements to response times to life-threatening calls. Delivery of emergency services to a rural area is always a challenge and YAS and the PCT commissioners are working in partnership to develop a range of services to improve response times to rural areas and this remains a priority for improvement for 2012-13.

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 response time targets, on average, over the PCT area.

There is also a local GREEN target that YAS will report on.

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 emergency operations centre by British Telecom and the call being answered by one of our trained call-handlers.

	Time to answer calls (in seconds)												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	AVG YTD
Time to answer calls - Median	00:01	00:01	00:01	00:01	00:01	00:01	00:01	00:01	00:01	00:01	00:01	00:01	00:01
Time to answer calls - 95th percentile	00:35	00:29	00:26	00:29	00:05	00:04	00:20	00:05	00:29	00:05	00:26	00:18	00:19
Time to answer calls - 99th percentile	01:36	00:48	01:05	01:10	01:13	01:09	01:33	01:17	01:40	01:10	01:36	01:33	01:19

Year-on-year the number of emergency calls to YAS has increased and 2011-12 was no exception. The service experienced a significant increase in calls during February 2012 (following the snow and freezing conditions) and early March 2012.

During 2011-12 YAS also:

- made 486,109 emergency patient journeys
- provided region wide access to the specialist care, percutaneous Primary Coronary Intervention (pPCI) for all eligible patients suffering from a ST elevation myocardial Infarction (heart attack)
- transferred 84.6% of eligible patients to a pPCI centre within 150 minutes of 'call for help to balloon inflation'
- transferred 72.6% of patients, who have signs and symptoms of a stroke, to a specialist stroke centre within 60 minutes of calling for help
- provided appropriate care bundle to 95.1% of patients with suspected stroke
- closed 4.7% of calls with telephone advice.

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, in 2011-12 we measured 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 Performance in 2011-12

PTS Inward Arrive on Time	PTS Outward Depart within 60 minutes	PTS Time on Vehicle more than 60 minutes
69.43%	75.44%	14.08%

Patient Story two:

Mrs C is a 62-year old lady suffering from bowel cancer. She had an operation and then needed to attend a series of appointments at the regional oncology hospital prior to commencing a course of chemotherapy she also had pressure sores and needed to travel on a stretcher.

Mrs C's first appointment went without any problems and a second appointment was booked for the following week.

On the day of the second appointment the PTS was unable to provide transport in time for the appointment and it was subsequently cancelled by the hospital. Mrs C was not informed of what had happened.

A further appointment was scheduled for three days later and went ahead as planned. Two weeks later an ambulance arrived to take Mrs C and her husband for another appointment. The ambulance had other patients to collect en route to the hospital and Mrs C was unable to travel due to her being in pain and could not tolerate the longer journey.

Mrs C's son contacted the Patient Relations Department expressing concerns that his mother had missed vital appointments.

The Patient Relations and PTS managers visited Mrs C and her husband, who is her main carer.

Mrs C was understandably very angry and upset about missing her treatment. She expressed concern about her missed appointments and also the attitude of some of the staff who had collected her. However, both Mr and Mrs C were complimentary towards other members of the PTS staff who had attended.

Discussions were held about how best to achieve the next planned appointment and it was agreed that the Patient Relations Manager would ring Mrs C the day before the appointment to advise what time she would be collected so that she could take her pain medication to coincide with the journey.

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.

These CPIs relate to conditions where the care of ambulance clinicians can make a significant difference to patient outcomes for heart attack (STEMI), stroke, low blood sugar (hypoglycaemia) and asthma. For each indicator there are a number of agreed actions that should be completed for every patient with that condition and we audit our Patient Report Forms (PRFs) to identify whether or not these were carried out.

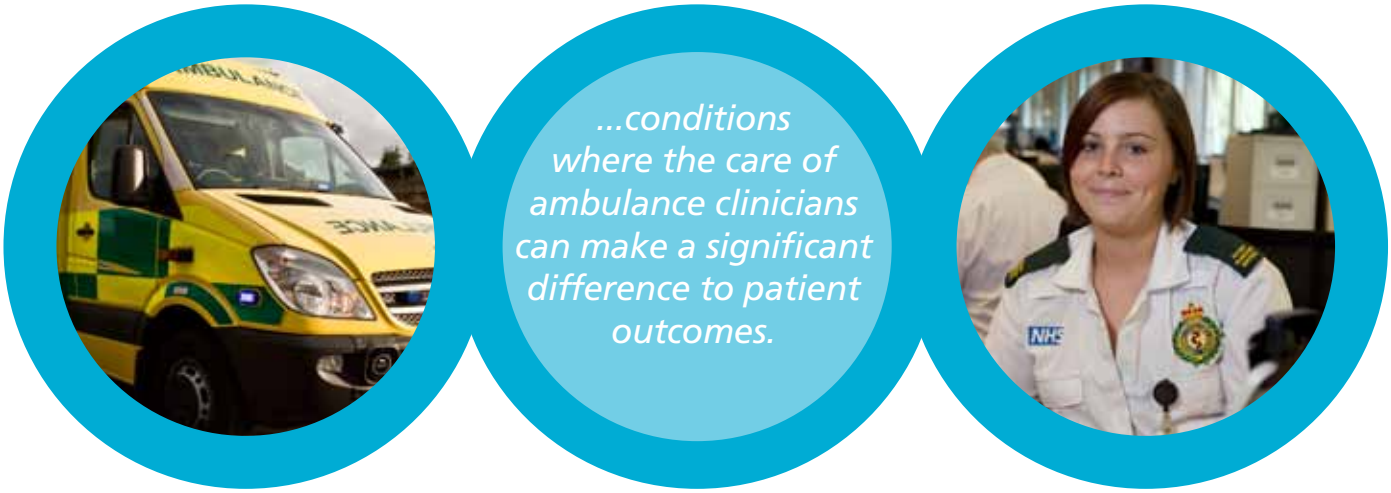
CPI Results 2011-12 - YAS Performance

From Cycle 7 the method for calculating the results has been changed to reflect the way indicators are calculated.

In order to maintain comparisons with the previous cycle, the Cycle 6 results have been recalculated using the new calculation methodology. The table, on the next page, shows Cycle 6 calculated using the original method and Cycles 6 and 7 using the new methodology.

Cycle 7 CPI results demonstrated a global reduction in clinical performance in the immediate management of STEMI and between November 2010 (Cycle 6) and June 2011 (Cycle 7). Subsequently actions were taken with A&E Operations to ensure that the importance of comprehensive clinical management of STEMI was reinforced. Cycle 8 results, from November 2011, have demonstrated a marked improvement.

Similar results were seen for the recognition and immediate management of stroke between January 2011 (Cycle 6) and July 2011 (Cycle 7) with action plans put in place through A&E Operations, monitored by the clinical excellence managers and reported to the Clinical Effectiveness Group. Significant improvement in performance has subsequently been demonstrated in the Cycle 8 results from January 2012.



Performance Against 2011-12 Key Quality Indicators

	Old Calculation Method		New Calculation Method		
	Cycle 6		Cycle 6	Cycle 7	
ST Elevation Myocardial Infarction (STEMI)	Nov 2010 Results %	National Average %	Nov 2010 Results %	June 2011 Results %	National Average %
M1 - Aspirin	98.2	95.2	98.3	94.9	96.5
M2 - GTN	93.8	91.7	94.1	86.0	92.7
M3 - Two Pain Scores recorded	90.2	85.1	90.7	84.1	80.8
M4 - Morphine alone given	67.0	69.3	73.7	71.3	81.3
M5 - Analgesia given	74.5	75.2	79.7	82.2	86.2
M6 - $Sp0_2$ recorded	99.2	97.1	99.2	98.7	97.9
MC - Care Bundle M1, M2, M3 and M5	67.8	59.4	75.4	65.6	66.9
Cardiac Arrest	Dec 2010 Results %	National Average %	Cardiac Arrest is no longer measured as part of the CPIs as this is now measured as part of the AQIs.		
C1 - ROSC on arrival at hospital	14.1	19.7			
C2 - Advanced Life Support provider in attendance	100	98.1			
C3 - Response to cardiac arrest < 4 minutes	15.7	19.0			
PILOT - Care Bundle C2 and C3	15.7	18.5			
Stroke	Jan 2011 Results %	National Average %	Jan 2011 Results %	July 2011 Results %	National Average %
S1 - Face, Arm, Speech Test (FAST) recorded	97.7	95.7	98.0	94.3	95.6
S2 - Blood glucose recorded	97.6	94.0	97.7	96.3	95.6
S3 - Blood pressure recorded	100	98.8	100	99.3	99.6
S4 - Time of onset of stroke recorded	78.7	80.6	82.0	85.3	85.8
SC - Care Bundle S1, S2 and S3	94.9	89.8	95.7	90.7	92.0
Hypoglycaemia	Feb 2011 Results %	National Average %	Feb 2011 Results %	Aug 2011 Results %	National Average %
H1 - Blood Glucose recorded before treatment	99.3	99.2	99.3	97.4	98.8
H2 - Blood Glucose recorded after treatment	100	93.6	100	98.1	97.9
H3 - Treatment for Hypoglycaemia recorded	100	98.4	100	99.6	97.9
H4 - Direct referral made to an appropriate health professional	47.8	30.3	47.8	98.5	64.3
HC - Care Bundle H1, H2 and H3	99.3	92.3	99.3	96.3	95.4
Asthma	Mar 2011 Results %	National Average %	Mar 2011 Results %	Sep 2011 Results %	National Average %
A1 - Respiratory rate recorded	100	97.3	100	99.7	99.1
A2 - PEFR (peak flow) recorded before treatment	59.9	55.7	77.7	84.3	78.3
A3 - $Sp0_2$ recorded before treatment	91.5	94.8	91.5	90.9	92.3
A4 - Beta 2 agonist recorded	99.3	94.0	99.3	93.4	96.6
A5 - Oxygen administered	99.7	93.6	99.7	95.8	96.2
PILOT - Care Bundle A1, A2, A3 and A4	52.8	48.5	72.3	76.7	71.9

Indicator 4 Developing Alternative Care Pathways

We have continued to work with our healthcare partners to develop referral processes and establish pathways that meet the needs of the patient, whether that is to convey them to a hospital or treatment centre or to allow them to remain in their own home with an appropriate care plan put in place. We have further developed a number of processes for referring patients to alternative care pathways and we have established and implemented a pathway development framework that is now used to develop any new pathway. It details the steps to be taken, including identifying a pathway need, implementation, governance, patient outcomes, evaluation and review. We strive to ensure consistency in implementing the care pathways wherever possible to allow comparisons to be made across the region.

Acute Stroke and Cardiac Pathways

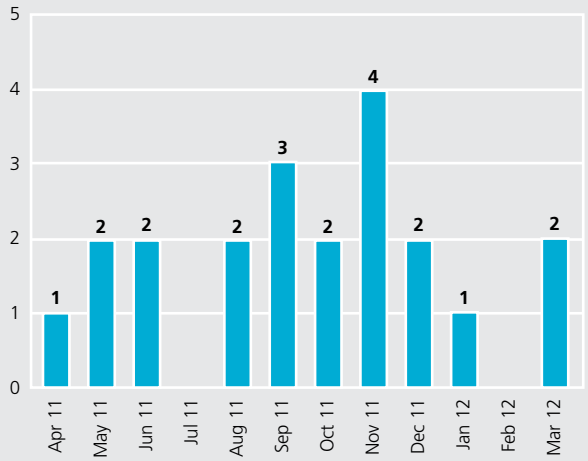
We continue to work with partners to develop pathways for stroke and cardiac care. This year we have improved the referral pathway to all hospitals providing Hyper-Acute stroke care. For our patients who present with symptoms of a stroke, they can be assessed and receive prompt and appropriate care, and where appropriate receive treatment called thrombolysis. Patients suspected of having a heart attack or STEMI, continue to be referred to cardiac centres with over 80% being referred directly by YAS.

Palliative Care/End-Of-Life

Further to the pilot in Leeds we have now rolled out the referral pathway to most areas of YAS. The pathway ensures that wherever possible and where appropriate for the patient that they can remain in their own home and receive the best care possible at the end-of-their-life. The pathway is consistent in that the ambulance clinician can contact the YAS Clinical Hub, and through them, subsequently a community nurse. A discussion can then take place to agree an appropriate care plan for the patient.

Whilst it is acknowledged that the numbers are small it is important to recognise the value of this pathway for patients at the end-of-their-lives. YAS will continue to extend the network of stakeholders, and contribute to the regional strategic leadership on end-of-life in order to increase the quality of care for patients.

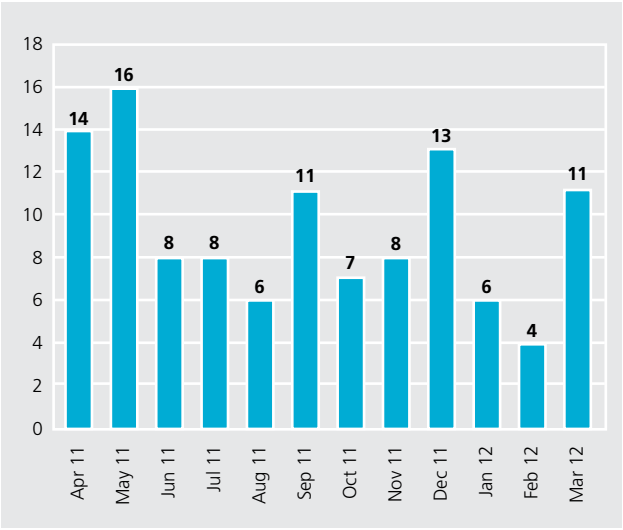
Palliative Care - Number of Referrals



Mental Health

We continue to work with our mental health partners to ensure that patients with acute mental health problems are assessed and cared for in the most appropriate place and avoid the need for emergency department attendances if this is not appropriate. Pathways are now formally agreed in Sheffield, Rotherham, Doncaster and Leeds.

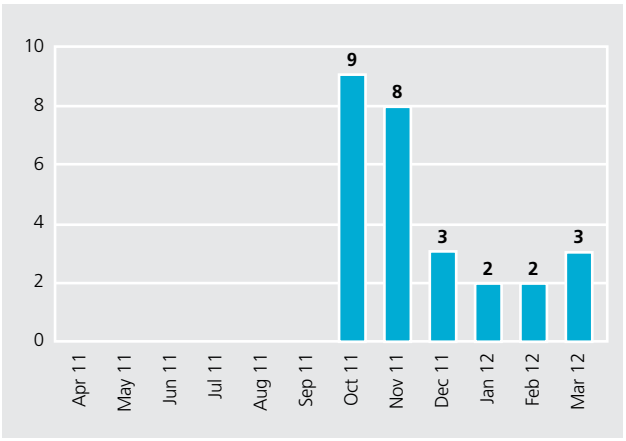
Mental Health - Number of Referrals



Alcohol Pathway

Many adults in the UK are drinking alcohol at levels that may be damaging their health, most without realising it. We have started an innovative pilot in Sheffield where ambulance clinicians can ask a patient some simple questions relating to alcohol and, where appropriate, can then refer the patient onto a specialist alcohol service for further follow up and an invitation to attend an appointment. The Alcohol Service is a team of health and social care professionals who provide a number of services to people who misuse, or have an addiction to alcohol. The aim is to provide packages of care to assist in reducing alcohol intake, or to become abstinent. The YAS Alcohol Services referral pathway began in October 2011 and is available when it is considered the patient may benefit from contact with an alcohol service.

Alcohol Misuse - Number of Referrals



Ambulance clinicians can ask a patient some simple questions relating to alcohol and, where appropriate, can then refer the patient onto a specialist alcohol service.

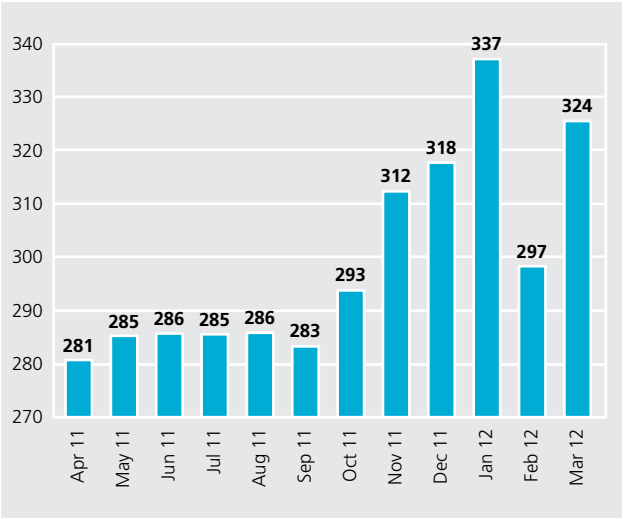
GPs

We have continued to develop referral pathways with our GP partners who work both in and out-of-hours. YAS clinicians are often called to patients who have urgent rather than emergency conditions and therefore may not need attendance or admission to hospital. Direct conversation and clinical discussion with a GP by the attending clinician can ensure an appropriate alternative care pathway for the patient is arranged. This gives the patient and GP the opportunity for home-based care delivered by a variety of clinicians or services in preference to the patient being transported to the emergency department. Use of this referral pathway increases patient choice and potentially improves patient experience and satisfaction. We have started to refer patients to in-hours GPs in the Huddersfield area in a more formal way with the referral going through the YAS Clinical Hub and we are currently having discussions with GP leads across the region to roll out this pathway more widely.

Falls

Across the region we have continued to maintain a consistent referral pathway for patients who have had a fall and are not conveyed to hospital. Referral is from clinician via the Clinical Hub and onto the community services for the patient to receive further follow-up and falls assessment with the aim to reduce further falls and complications such as fractures. The pathway is established in 11 out of the 12 PCT areas.

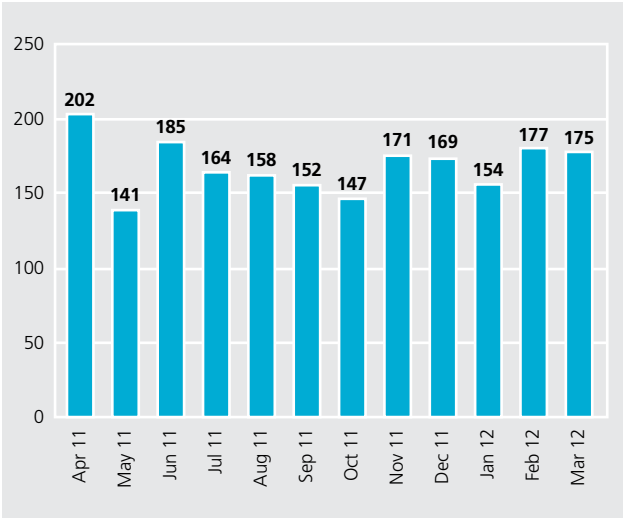
Falls Pathway - Number of Referrals



Hypoglycaemia Pathway

This pathway is YAS-wide and ensures that patients receive a follow-up assessment after we have attended them for an acute hypoglycaemic episode. Appropriate support and education can then be provided to prevent reoccurrence of hypoglycaemia. We are now working with NHS Diabetes and the National Diabetes Information Service to take a closer look at the information we have about patients across the region who have hypoglycaemic episodes and how this can be used to look at ways of reducing these life-threatening events.

Hypoglycaemia Pathway - Number of Referrals



Acute Care Pathways

The change in the healthcare landscape, for instance the reconfiguration of services between hospital sites, has led to a number of hospital sites being bypassed. Pathways for YAS staff have been developed to ensure patients are taken to the right hospital first time. Leeds Teaching Hospitals NHS Trust, Mid Yorkshire Hospitals NHS Trust, and South Tees Hospital NHS Trust all have differing pathways of care in place for medical and trauma patients. The development of the Clinical Hub and the Trust's intranet library of clinical pathways ensure staff are aware of new pathways as they are implemented.

Indicator 5 Complaints, Concerns, Comments and Compliments

Our staff work very hard to get the job right first time but, as in any complex service, mistakes can happen and problems occasionally occur. When people tell us about their experiences we listen, we always strive to put things right and learn for the future.

Gauging the views of our patients and the public about the services we provide is an important aspect of how we shape our future developments.

There are times when the standard of service is perceived to have fallen below what is expected and we view comments and suggestions on how we can improve our services just as importantly as concerns and complaints.

During 2011-12 we continued to ensure that concerns and complaints were dealt with quickly and that each enquirer received a full and detailed response.

In 2011-12 we received 1,569 concerns and 82 formal complaints. Of these 172 (10.42%) were resolved within 24 hours, and a further 1,013 (61.36%) within 25 working days.

The Trust is always pleased to receive compliments about the quality of service provided to patients. In 2011-12 we received a total of 716 appreciations and commendations, complimenting staff for their professionalism and dedication.

Learning lessons from complaints, concerns and comments is very important to us. Every two months we report key issues, themes and trends to our Quality Committee (a sub-committee of the Trust Board) on how we are learning from these to improve our services in the future.

Some of the improvements we made in 2011-12 as a result of issues highlighted through complaints, concerns and compliments were as follows:

- A number of complaints have been received regarding PTS bookings. Patient Relations has been identifying notes which can be added to patient bookings (ie a four-person lift needed, cannot travel in a small ambulance due to sickness). There have been issues regarding whether or not PTS planners are adding these notes which has resulted in patients experiencing repeated problems. PTS managers have now been asked to remind the planners of the importance of adding the notes, which should reduce the number of repeated complaints.
- PTS managers have been reminded to keep patients informed of any updates on their pick-ups. A number of incidents have occurred where YAS has contacted a clinic to advise of a delay, the clinic has subsequently cancelled the appointment, but no-one has informed the patient.
- A number of complaints and concerns were received where members of the public reported feeling intimidated by the driving of ambulance staff. To address this and in addition to the work being led by the YAS accident reduction manager, a reminder was issued to all staff from the Trust's lead driving instructor reminding them about good driving practice and the consequences should individuals be found to have shown undue aggression towards other drivers.

YAS continues to develop its approach to learning lessons. This work includes the following aspects:

- Developing a culture to encourage reporting incidents and reinforcing a positive attitude to investigations with a focus on learning and not blame.
- Investigation skills and Root Cause Analysis training is currently being developed which will be delivered to investigating managers across the Trust to improve investigation processes and findings.
- Identifying new ways of analysing themes and trends from a number of reports.
- Procurement of the new risk management data system from April 2012.

Performance Against 2011-12 Key Quality Indicators

2011-12												
Complaints, Concerns and Comments	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Attitude - negative	20	19	11	16	17	8	18	20	12	26	20	20
Delayed, inappropriate, no response	77	91	100	105	94	72	80	93	89	118	96	89
Patient care	21	25	30	18	21	28	15	24	22	24	37	29
Driving issues	10	5	14	9	7	13	11	8	7	9	12	9
Administrative	13	13	9	13	11	14	10	7	13	14	11	8
Other (procedural issues)	2	4	3	1	6	3	8	3	9	6	2	13
Total (negative)	143	157	167	162	156	138	142	155	152	197	178	168
Compliments	69	78	51	57	24	115	61	62	58	36	52	53

2010-11												
Complaints, Concerns and Comments	Apr	May	Jun	Jul	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	Apr	May	Jun	Jul	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

Patient Story three:

Miss X called the ambulance at 03.00 for her daughter who had acute pain in her back and chest and was also having difficulty breathing. When the ambulance arrived Miss X became concerned that the clinicians did not sufficiently assess her daughter's condition and appeared to make assumptions as to the cause of her pain. Miss X subsequently wrote to YAS with her concerns regarding the assessment of her daughter's condition and the care given by the crew.

Miss X had never called for an ambulance before and was dissatisfied with her experience.

The complaint was handled through the Patient Relations department, and Miss X was visited by the Associate Medical Director and the Patient Relations Coordinator.

An apology was given and the events of the incident were explained and discussed.

A clinical case review was also conducted where the incident was reviewed with the staff involved and their managers. These reviews are aimed at identifying both individual and team areas for learning. The outcomes from this particular meeting were shared with Miss X.

Despite the initial upset caused by this incident the family were pleased to be offered a meeting and also with the outcome of their concerns.

Miss X contacted YAS to express her appreciation of the professionalism and sensitivity YAS showed in handling her complaint.

Gauging the views of our patients and the public about the services we provide is an important aspect of how we shape our future developments.

Indicator 6 Adverse Incidents and Serious Incidents

An incident can be described as:

"An event or circumstance which resulted in unnecessary damage, loss or harm to a patient, staff, visitors or members of the public."

At Yorkshire Ambulance Service we report incidents via the 'Prism' incident reporting system and all incidents are assigned to local managers for an internal investigation. Incidents can vary in severity and in cases where they have resulted in major or catastrophic consequences; these require a higher level and more thorough investigation. These types of incidents are reported as Serious Incidents (SIs) to the Trust's commissioners; NHS Bradford, Airedale and Leeds and a full, comprehensive investigation must be completed and the report submitted within 12 weeks of the incident being reported.

SIs include any event which causes death or serious injury, involves a hazard to the public, causes serious disruption to services, involves fraud, has the potential to cause significant reputational damage to the Trust, plus a number of other types of events.

Incidents

The Trust works continuously to improve our incident reporting system, updating categories to allow more specific reporting which allows us to identify trends more accurately and, in turn, learn lessons from incidents. The table below shows the number of incidents reported across different directorates in 2011-12. The number of 'Other' incidents decreased dramatically after October 2011 which was due to the large amount of work that had taken place to improve the incident categories.

Compared to last year's figures, overall there have been more incidents reported this year. The Trust views this as a positive development. We promote incident reporting throughout the Trust as this enables us to identify key issues, themes and trends and we can then work to rectify these problems before they have the potential to turn into a more serious incident. Figures increased between November 2010 and January 2011 due to the adverse weather conditions. Although we did not experience such adverse conditions in 2011-12, we also worked hard to improve our business continuity and resilience plans so that we were better prepared should the weather deteriorate.

New Incidents Reported 2011-12	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operations – Accident & Emergency	166	235	193	209	172	260	244	378	371	411	355	302
Emergency Operations Centre	64	89	62	55	107	61	41	65	84	216	45	42
Patient Transport Services	51	56	66	52	61	59	54	79	74	90	68	68
Other	172	183	187	156	176	161	223	12	8	14	20	17
Total	**453**	**563**	**508**	**472**	**516**	**541**	**562**	**534**	**537**	**731**	**488**	**429**

November 2011 to January 2012 had the potential to see an increase in incidents due to the busy festive period, but our resilience plans meant we coped better with this during this period this year.

Throughout the year, the incident trends included road traffic collisions, drugs lost, stolen or damaged, Emergency Operations Centre (EOC) control issues, plus others. The Trust employed an Accident Reduction Manager in September 2011 to focus on reducing vehicle accidents.

An improved process was implemented late 2011 regarding the management of controlled drugs and this was rolled out across the Trust to reduce the number of drug-related incidents. The CQC praised YAS in January 2012 for their impressive work on this.

Serious Incidents (SIs)

In 2011-12 we reported 11 SIs in comparison to 19 in 2010-11.

Incident Category	Number of SIs 2011-12
Delayed dispatch/response	5
Road traffic collision	0
Equipment-related	1
Clinical care	1
Inadequate clinical assessment	0
Alleged assault	0
Data protection breach	0
Adverse media attention	1
Workplace safety	0
Medication-related	1
Other	2
Total	**11**

It is the Trust's expectations that as the number of reported incidents increases, the number of SIs will decrease. This should happen as a result of the organisation learning lessons from the less severe incidents and working proactively to correct the issues that are raised. This pattern was correct in 2011-12 with our number of SIs almost halving in comparison to the previous year.

The highest category of SIs remained the same with delayed dispatch/response being the cause of most serious incidents. The Trust has made significant improvements relating to clinical assessment and workplace safety to reduce the number of incidents in those areas.

Action plans from SIs are monitored by the Trust and externally by NHS Bradford, Airedale and Leeds. Actions that have been taken as a result of SIs during this year include the following:

- Improved business continuity plans and processes across the Trust to ensure resilience.
- Improved processes and documentation at key meetings to accurately record decisions made.
- An improved controlled drugs management process.
- Training workshops in the EOC to ensure call handlers and dispatchers continue to refresh their knowledge and skills. This should reduce the number of delayed dispatch incidents.

Indicator 7 — Referrals to Services for Safeguarding Vulnerable Adults and Children

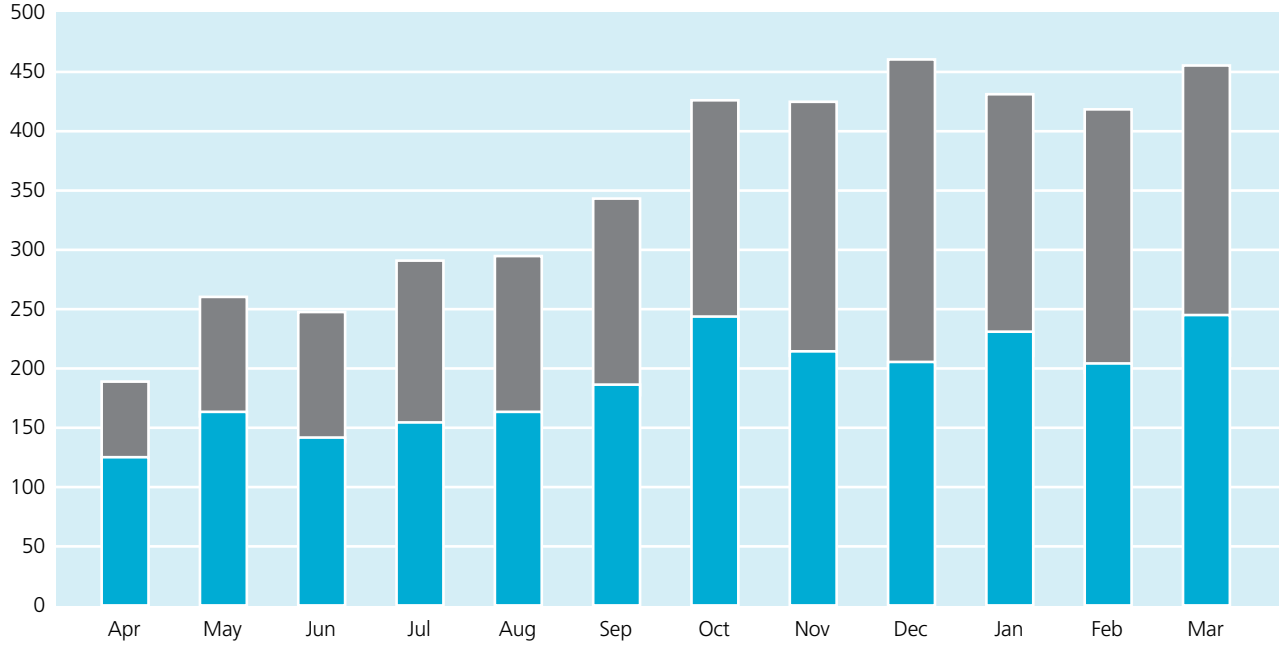
Safeguarding continued to be challenging for the YAS Safeguarding team during 2011-12.

During May 2011, YAS introduced a new referral process following feedback from a staff survey as part of a CQUIN requirement. This resulted in all safeguarding referrals being completed via the Clinical Hub in the YAS EOC. This simplified the process for staff and improved governance and security of the procedure. The change resulted in a significant increase in the number of referrals made to Social Care teams across Yorkshire and the Humber.

Following changes to national guidance, YAS also responded to improving safeguarding children training for relevant staff with the production of a bespoke ambulance Level 2 Safeguarding Children distance-learning workbook. This enabled YAS to improve falling compliance levels for this element of provision, as all relevant staff were requested to complete the resource.

The YAS Safeguarding team continued to work in partnership with organisations across Yorkshire and the Humber involved in the safeguarding of children, young people and adults.

Number of Referrals 2011-12

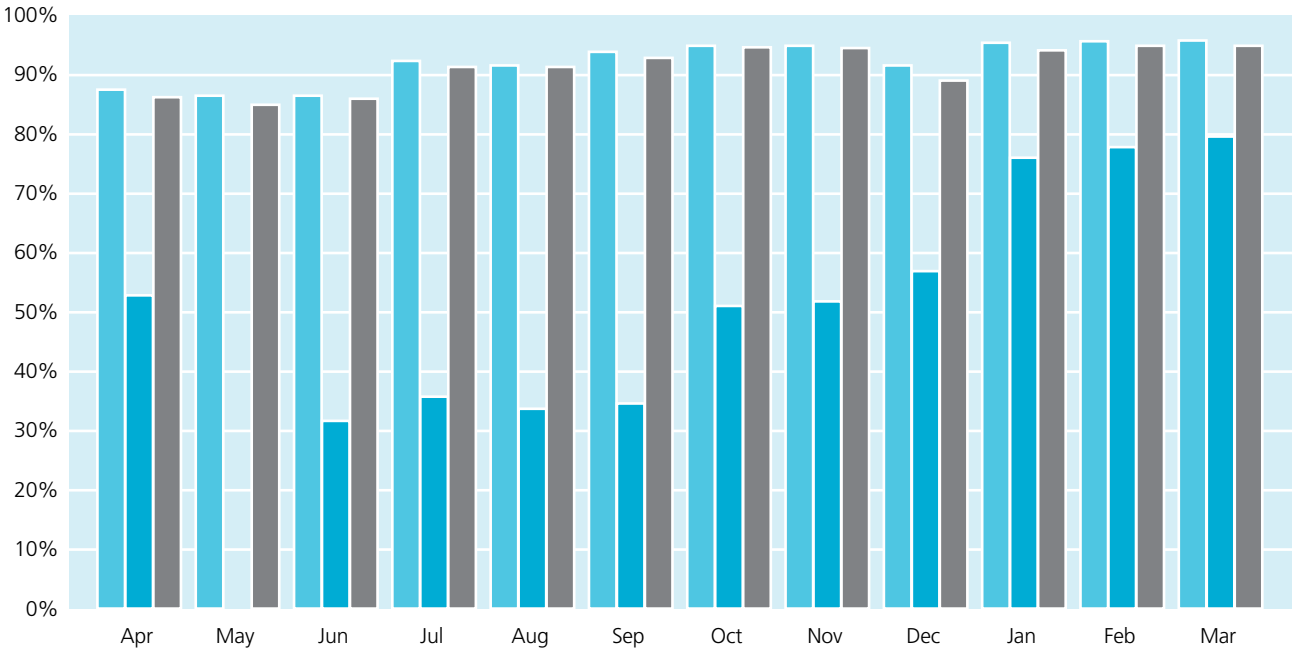


Referrals 2011-12	Total	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Children	1,408	122	162	139	155	162	183	245	215	202	233	202	247
Adults	1,061	64	96	109	137	133	162	180	209	259	197	212	210
Total	**2,469**	**186**	**258**	**248**	**292**	**295**	**345**	**425**	**424**	**461**	**430**	**414**	**457**

Safeguarding Training

Safeguarding Children Level 1 is basic level training which is required to be completed by all YAS staff. Safeguarding Children Level 2 is more in-depth training and is required by staff who have direct contact with children and vulnerable adults as part of their job.

Number of Eligible Workforce Trained



Training position	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Child - Level 1	88.1%	87.7%	87.9%	92.3%	91.9%	93.2%	94.4%	93.9%	90.8%	95.1%	95.7%	95.2%
Child - Level 2	52.7%	0.0%	30.7%	36.2%	33.4%	34.1%	51.4%	50.9%	57.0%	75.1%	78.5%	79.8%
Adults	87.2%	86.1%	86.3%	91.2%	91.0%	92.3%	93.2%	92.7%	89.6%	93.5%	94.2%	93.8%

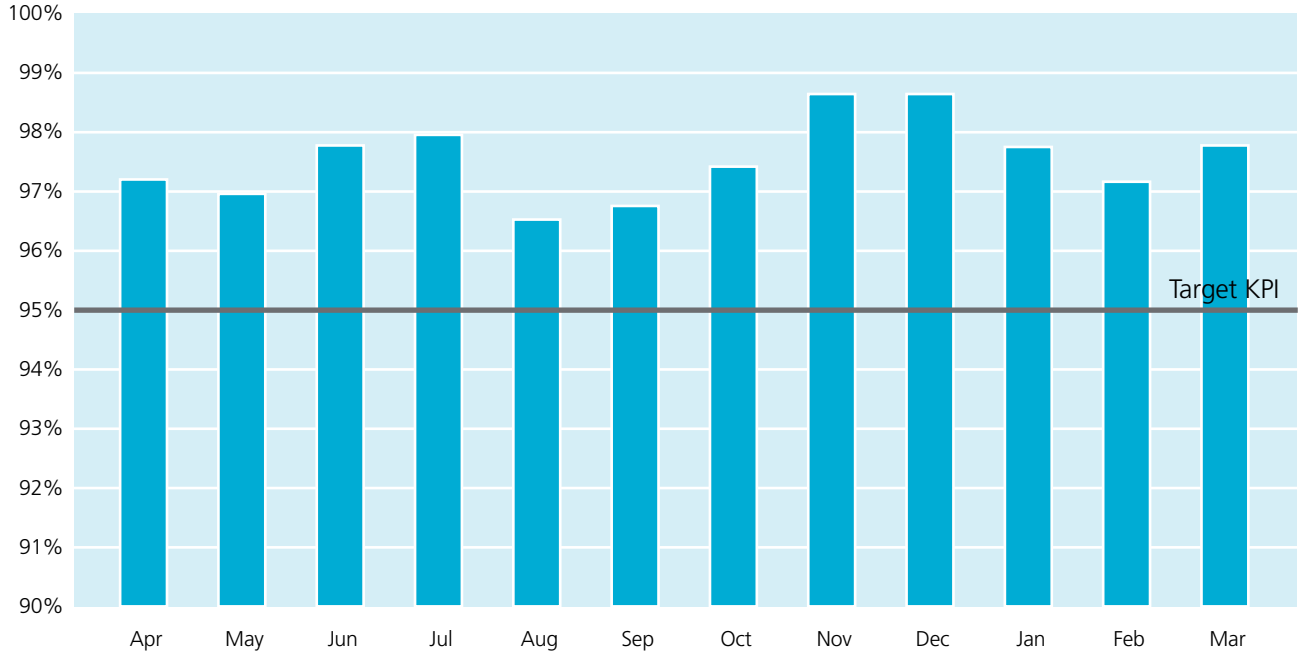
Indicator 8 Vehicle Cleaning and Hand Hygiene

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.
- The compliance of staff with hand hygiene procedures.

In 2011-12 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 of time. During the year we have recruited additional cleaners and developed our processes to ensure standards are consistently met. We continue to build on our experience from 2010-11 and the lessons we have learned have helped us to consistently exceed the target of 95%.

% of Vehicles Cleaned Within Schedule: April 2011 - March 2012



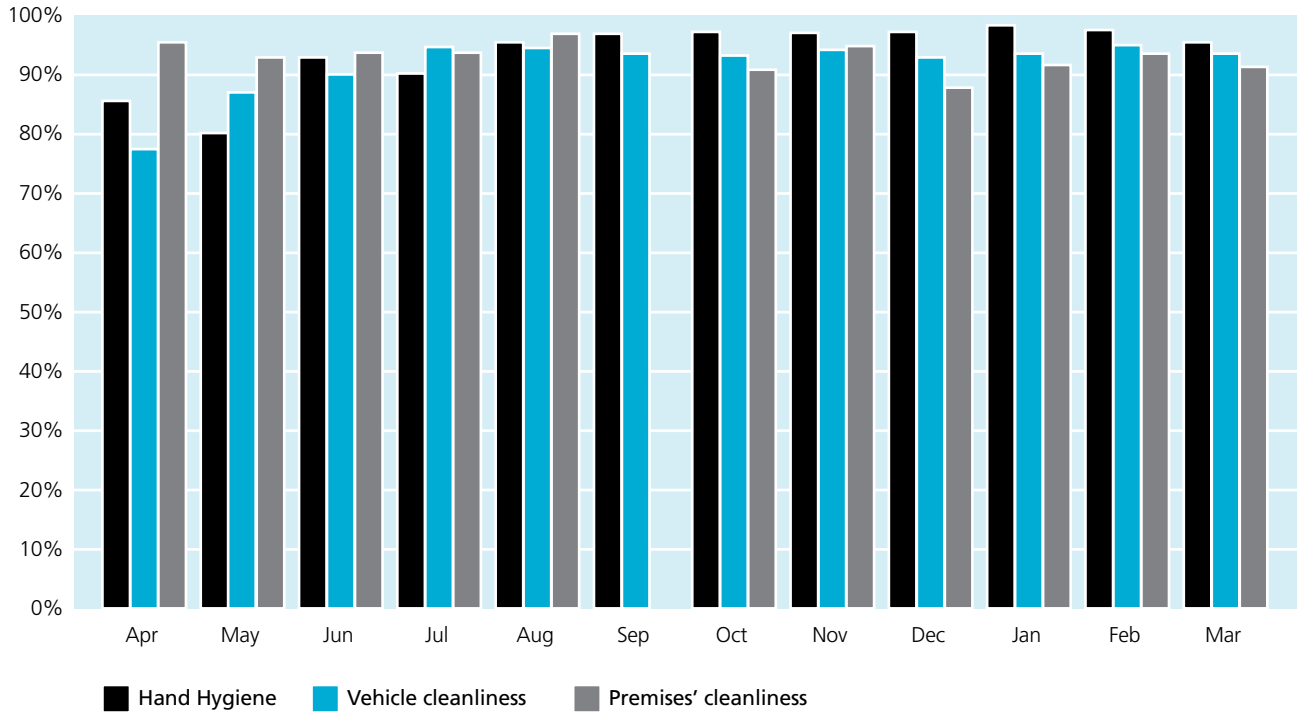
Infection Prevention and Control Audits

YAS has introduced a robust audit process for cleanliness and infection prevention and control. Areas identified to increase compliance throughout the coming year include the following:

- Hand hygiene, all clinical staff members to carry alcohol gel bottle on their person.
- Vehicle cleanliness promotes and increases the reporting of damage to stretchers or upholstery on vehicles.
- Premises' cleanliness, infection prevention and control audit reports to be displayed on notice boards in ambulance stations to increase staff awareness.

The premises' cleanliness audit was not completed in September 2011 due to a change in the focal area for the audit. The three audits were amended in October 2011 following the CQC inspection to focus on areas where improvement was identified.

Infection Prevention and Control Audits (percentage compliance) 2011-12



Indicator 9 Service Experience

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

In 2011-12:

- The Patient Experience Group continued to meet 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 continued to use patient stories at its public meetings. This has included anonymised case studies and video footage of patients talking about their experiences. By using the voices and experiences of real patients it helps Board members maintain their focus on high quality patient care at all times.

The Dignity and Respect Campaign launched during 2010-11 has continued to focus on the Dignity Code:

- We took advice from staff and patients in developing our YAS Dignity Code.
- It takes best practice from the Department of Health and applies it to an ambulance setting.

Dignity and Respect leaflets have been given to all staff and posters have been placed around the Trust buildings. We also have Dignity and Respect Champions throughout the Trust.

The Dignity Code is now included in:

- staff corporate inductions
- staff training sessions
- a dedicated section on dignity and respect on the YAS intranet
- patient stories (filmed and narrative)
- modular Object Orientated Dynamic Learning Environment (MOODLE). This is a virtual learning environment containing news and learning information for staff. The site includes forums, patient stories, videos, questions and answers and weblinks. Positive patient experience including dignity and respect is themed throughout.

All our surveys also contained questions relating to dignity and respect.

We have made significant improvements during 2011-12 for patients and service-users to be able to give us their feedback about our services via the following channels:

- We launched the A&E Service-user Experience Survey questionnaire which is accessible to our service-users online. We have sent the same survey/questions to 570 randomly selected service-users on a monthly basis (this is approximately 1% of our 999 calls per month). Although we are pleased with the 25-30% response rate so far, work is ongoing to look at ways of improving this. The results have been shared with staff and managers so they can improve services in the future.

- Results from the A&E Service-user Experience Surveys indicated a consistent theme, namely the negative experience of patients who underwent telephone triage. The numbers were small, so an additional investigation was performed by way of a 'deep dive' survey during December 2011. The results have been shared with staff and managers so they can take note and any appropriate action on the findings.
- Processes are being improved to ensure patients do not undergo repeated telephone assessments (this trend is evident in the survey narrative responses).
- Call-handlers have improved the explanations they offer to patients when they are transferred for triage.
- Work will progress through the CQUIN (described earlier) regarding public education and raising public awareness of ambulance triage and other healthcare pathways.
- We have placed laminated notices in both A&E and PTS vehicles. The purpose of these is to ensure that service-users are clear about how they can tell us what they think of our services and also to let patients know that we may contact them to find out what they thought of our services, including how to let us know if they do not want this to happen. The notice displays a telephone number where they can leave a message should they want us to actively send a survey to them.
- During 2011 we revised the comments cards available to all PTS users so that they have larger, easy-read print and added a dignity and respect question. We removed the section asking patients to tell us their details in order to maintain their anonymity.
- We have completed a PTS survey for patients. This contains more questions than the comments cards.
- A repeated theme relating to clinical care of patients with spinal injuries (in particular relating to spinal immobilisation) was recognised. Training on new equipment and spinal immobilisation is now included in the trauma training programme.
- A Patient Experience Workplan has been developed for 2012-13.
- We have recorded several patient stories (filming or narrative of their story) as another method of gathering patient experience. These are seen at each Trust Board meeting held in public and are also proving a very powerful learning tool within training.

Results of the PTS Annual Survey for 2011-12:

- Satisfaction is extremely high with the friendliness and helpfulness of staff, feeling safe whilst being transported, and the transport being clean and comfortable in all areas.
- The percentages of respondents ranged from 91% to 100%.
- Respondents are also satisfied with the time the transport picked them up from home, the journey time being an acceptable length, and felt the transport was available when required.
- Some patients expressed that we did not achieve the target to get them in on time for their appointment. Dissatisfaction was shown across all areas with the length of time waiting for transport home. This theme is a key part of the improvement work we are taking forward into 2012-13.

Statements from Local Involvement Networks (LINks), Overview and Scrutiny Committees (OSCs) and Primary Care Trusts (PCTs)

All the views and issues put forward to us, have been considered, some of which have already been addressed.

The regulations of the Health Act 2009 require us to engage in a consultation period of 30 working days with our LINks, OSCs and lead commissioning PCT for comments on our Quality Accounts prior to publication.

We acknowledge the feedback we have received and are pleased to publish extracts from the statements overleaf from our Lead Commissioner, a selection of the LINks and OSCs.

In compliance with the regulation we have published the statement from our commissioners in full.

All the views and issues put forward to us, have been considered, some of which have already been addressed. Others will be used as a basis for further discussion and engagement and help us to further improve our services in the year ahead.

NHS Bradford and Airedale

NHS Bradford and Airedale (part of the NHS Airedale, Bradford and Leeds cluster PCT) is the lead commissioner for Yorkshire Ambulance Service NHS Trust and has reviewed their draft of the Quality Accounts for 2011-12, ensuring that all lead and associate commissioners' comments regarding the content and presentation have been shared with the Yorkshire Ambulance Service NHS Trust, and have received written assurance from the provider that all commissioner feedback will be incorporated into their final Quality Accounts.

Associate commissioners include:

- NHS Barnsley
- NHS Leeds
- NHS Calderdale
- NHS North Yorkshire and York
- NHS Doncaster
- NHS Rotherham
- NHS East Riding
- NHS Sheffield
- NHS Hull
- NHS Wakefield
- NHS Kirklees.

Quality has been described as having three elements: effectiveness, patient experience and safety. These Quality Accounts provide an overview of the delivery of quality against these three dimensions. Overall, it is felt that these Quality Accounts are well presented and demonstrate a commitment by the Yorkshire Ambulance Service NHS Trust to providing safe, high quality care for patients. NHS Bradford and Airedale and the associate commissioners acknowledge the improvements referenced within these Quality Accounts and in particular the following areas which demonstrate the Trust's ongoing commitment to quality improvement.

Yorkshire Ambulance Service NHS Trust has:

- developed clinical leadership and assessment skills' programmes to be undertaken by staff
- ensured that the right care is delivered to patients at the right time and in the right place
- demonstrated a commitment to patient, public and staff engagement and has highlighted that this has influenced their future priorities for improvement
- made significant progress in continuing to develop alternative care pathways with healthcare providers which have the potential to allow more patients to stay at home and reduce hospital admissions
- made good progress with the frequent callers work and has been involved in a number of case review meetings to support these individuals. The Trust has also worked collaboratively with the University of York to develop a prediction tool to identify individuals who are at risk of becoming frequent callers
- continued to make improvements in incident reporting and management of Serious Incidents which were targets within the 2010-11 Quality Accounts.

Yorkshire Ambulance Service NHS Trust has demonstrated participation in both national and local clinical audits which demonstrates that the Trust has a commitment to improving practice through review and action.

Yorkshire Ambulance Service NHS Trust has reviewed its priorities for improvement that were set out in their 2010-11 Quality Accounts for achievement in 2011-12.

NHS Bradford and Airedale

They have provided clear information and evidence that the majority have been achieved and highlighted areas for continued improvement which will be focused on in 2012-13. Specifically the Trust has identified the following:

- Quality targets for PTS have not all been achieved and, in particular, wait times have not shown a significant reduction.
- There is a requirement to develop new ways to better represent the diversity of communities.
- Yorkshire Ambulance Service NHS Trust has met all of the 2011-12 contractual quality requirements and also opted to implement the Commissioning for Quality and Innovation (CQUIN) scheme and has achieved the majority of the targets and in some indicators has actually exceeded the agreed targets.

Associate commissioners' comments include:

- The information in these Quality Accounts is accurate and fairly interpreted as far as the supporting information we have as a commissioner.
- Over the past 12 months, Yorkshire Ambulance Service NHS Trust has worked with commissioners to improve the quality of services for patients and we support the improvement priorities identified for 2012-13 and look forward to working with the Trust to achieve these aims.

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

NHS Bradford and Airedale fully supports the future priority areas identified for 2012-13. It is noted that the majority of these are linked to the 2012-13 CQUIN goals and have therefore been agreed as areas for improvement by all commissioners and Yorkshire Ambulance Service NHS Trust.

NHS Bradford and Airedale commend the work of Yorkshire Ambulance Service NHS Trust over the last 12 months and continues to support their commitment to quality improvement.

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 committee (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 Yorkshire Ambulance Service has continued to demonstrate its commitment to engage with the SoHC on developments in healthcare across all of North Yorkshire. In every case these developments have been brought forward by the hospital trusts or by the emerging Clinical Commissioning Groups.

Yorkshire Ambulance Service has always been willing to engage with the Committee and to set out how the developments would impact on Yorkshire Ambulance Service and on patients and to set out the measures that it will be putting in place. In terms of the priorities for 2012-13 we welcome the continued emphasis on response times Priority 1. We are concerned that the Quality Accounts as one of the aims supporting this priority is to "maintain our response times to patients with life-threatening conditions…" Response times in rural areas need to be improved rather than just maintained. However, we do note as Priority 6 there are plans to improve the experience and outcomes for patients in rural and remote areas. Hopefully improved response times will be part of the work. In the past we have commented that in its Quality Accounts Yorkshire Ambulance Service should include measures to work more effectively with the Yorkshire Air Ambulance service covering the county.

We suggest that such measures should also be part of your work to improve experiences and outcomes for patients in rural and remote areas.

We fully support a priority to improve the PTS. This is a particular concern in rural areas. Improvements to the quality of care for people with dementia are also welcomed. Both priorities are excellent news.

Summing up, we feel that Yorkshire Ambulance Service's work on its Quality Accounts demonstrates a strong commitment to improving the quality of care and to sharing information in an open way with the Committee.

County Councillor Jim Clark

Chairman North Yorkshire Scrutiny of Health Committee

Yorkshire Local Involvement Networks

13 LINks have been invited, through the Regional Ambulance Group, to contribute to the feedback on the draft Quality Accounts for Yorkshire Ambulance Service. Three LINks have made contributions and these contributions are summarised by the North Yorkshire LINk host in the following statements:

Yorkshire LINks are very pleased to provide comments on the Yorkshire Ambulance Service NHS Trust's draft Quality Accounts for 2011-12.

LINks involvement with Yorkshire Ambulance Service has focussed on both A&E response and on the ability of the PTS arm to perform to an acceptable standard. LINks would like to congratulate the Trust on achieving a year-end performance in excess of 75% Red 1 target and in the manner it overcame the difficulties of severe weather during the late winter months. However, response times continue to be a priority especially in rural parts of the region.

These draft Quality Accounts are clearly set out and accessible for a public audience and LINks welcome the Trust's intention to publish a summary version in an easy-to-read style.

LINks are very pleased to see that PTS is a priority but would like to suggest an aim of adapting PTS to the changing nature of many clinics which are being moved from hospitals into community settings.

LINks welcome the aim to improve the care and support for people with dementia.

LINks recognise that there are few gaps in the Quality Accounts 2011-12. Gaps that are identified in the document refer to information gaps rather than issue gaps.

LINks would like to see the following included:

- Planned actions to develop patient pathways in addition to diabetes and end-of-life.
- Patient Safety Alert data.
- An aim of adapting the PTS to the changing nature of many clinics which are being moved from hospitals into community settings.

It has been very useful to have ongoing dialogue regarding the Quality Accounts in the past and it is strongly suggested that this is developed further in the future.

LINks would suggest that the Trust should not rely on written feedback from service-users.

The LINks would like to acknowledge the work and support given by Yorkshire Ambulance Service to the February 2012 public event and throughout the last year.

Sheffield LINk

The Sheffield LINk is grateful for sight of Yorkshire Ambulance Service (YAS) NHS Trust's draft Quality Accounts for 2011-12 and welcomes the opportunity to provide comments.

The document appears to us to be clearly set out and readily understandable by a public audience for which the Trust is to be commended.

We are pleased that the Trust intends to publish a summary version in an easy-to-read style.

In ***Priorities for Improvement*** we would like to see some specific quantified outcome measures that the Trust are aimed to be achieved over 2012-13.

We would suggest that there is reference to PTS changing due to the nature of many clinics which are being moved from hospitals into community settings.

It is pleasing to see an aim to ***'Improve the care and support for people with dementia'*** as this is a priority area for Sheffield LINk.

The ***'2011-12 Ambulance Response Performance'*** information was very helpful in that it highlighted the 12 PCT areas and identified the differences in response times between them. However we would have liked to have seen figures for the last three years as in the complaints table, so that performance over time can be compared.

The data on ***'PTS 2011-12 Performance'*** would be more useful if broken down into PCT areas.

Sheffield LINk always asks trusts to include information on ***Patient Safety Alerts (PSAs)*** in Quality Accounts. We would like to see information reported in this document on the number of PSAs received during the year, their subjects, the actions taken and status of the Trust in respect of each.

We recognise that we are just one of the 13 LINks within YAS's area and we do not have any negative feedback to offer from a Sheffield perspective. However, in respect of the ***'Complaints, Concerns, Comments and Compliments'***, there have clearly been some significant increases in negative comments and some reductions in the number of compliments. It would be very helpful if these tables could be presented in a format that permitted an analysis of the differences across and between the 12 PCT areas.

Finally we feel the inclusion of ***patient stories*** gives the document a 'real' character and the inclusion of a ***Glossary of Terms*** at the end is very helpful, and these are improvements to be commended.

Mike Smith

Chair, on behalf of Sheffield LINk

Kirklees Council's Well-being and Communities Scrutiny Panel

Thank you for providing us with a copy of your Quality Accounts 2011-12 and inviting the Panel's comments on the report.

Members of the Panel have carefully reviewed the information contained within the report, and are broadly supportive of the Trust's priorities as set out in the report.

The Panel would welcome further detail on how the Trust hope to achieve a number of the priorities, for example, Priority 6 'Improve the Experience and Outcomes for Patients in Rural and Remote Areas'.

The Panel notes the engagement of partners, and would like to encourage closer working with scrutiny in Kirklees.

Bradford LINk

Yorkshire Ambulance Service Quality Accounts were admirably clear in particular the opening section spelt out the aims the Trust had set itself very well. However it was not always obvious how far progress had been made on some of these fronts from the rest of the document.

The readiness of the Trust to give examples of complaints in full was extremely welcome and demonstrated good practice in dealing with complaints, learning from mistakes and putting systems in place to minimise the possibility of these problems recurring.

Could further thought be given to facilitating the response of patients who are too ill, too old or too vulnerable to give feedback by existing methods and have no relatives to speak up for them?

Problems that have been brought to our attention have been to do with delays in serving rural areas eg the Wharfedale area.

We note and welcome improved outcomes for patients by virtue of new equipment and good training of staff. It is now well understood that pre-hospital care is an important factor in optimising outcomes for patients.

We applaud the extent to which the Trust actively seeks to use learning from research findings to improve performance.

We are pleased to see the increased awareness of safeguarding issues and in particular the availability of training for staff in child safeguarding – we would urge that suitable training is also provided in safeguarding vulnerable adults.

Finally we wondered whether or not it would be possible to demonstrate performance by reporting outcomes as well as inputs eg in the table for clinical performance indicators would it be possible to report survival rates for patients as well as reporting the rates for procedures undertaken.

The East Riding of Yorkshire Council Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

The East Riding of Yorkshire Council Health, Care and Wellbeing Overview and Scrutiny Sub-committee welcomes this opportunity to comment on Yorkshire Ambulance Service's (YAS's) Quality Accounts.

YAS attended one meeting of the Health, Care and Wellbeing Overview and Scrutiny Sub-committee during 2011-12 to provide the Sub-committee with an update on service provision, and also one meeting to consult with the Sub-committee on the Foundation Trust application.

The Sub-committee welcomed the fact that YAS took on board comments made on last year's Quality Accounts regarding a lack of reference to Equality and Diversity and that the 2011-12 Accounts acknowledge the importance of Equality and Diversity and has its own section.

The introduction of a new data management system is particularly welcomed so that data across the service is seamless and fully joined up and unnecessary duplication is avoided; all of which saves time and money and will help provide the patient with a better experience.

Although YAS is achieving above the nationally-set response targets overall for both Red 1 and Red 2, the Sub-Committee notes with concern that although response times have improved since 2011-12 figures, East Riding of Yorkshire now has the worst response rate for Red 1 and Red 2. The Sub-Committee acknowledge that the large rurality of the East Riding presents problems for the Service; however, it is vital that the Service continues to work towards increasing these response figures to ensure that response times fall in line with other urban areas across Yorkshire and the Humber region and is at least meeting the nationally-set response targets.

The Quality Accounts state that staff completed a number of surveys throughout the course of the year, yet nowhere is there any indication as to the results/responses of these surveys and therefore any positive outcomes/improvements to the service. The views of staff are an important marker of an organisation's workforce wellbeing and managerial competence and hence an organisation's ability to deliver high-quality care. The Sub-committee would like to see more coverage of this in future Quality Accounts but do welcome the support given to staff to undertake further professional studies and research.

The Sub-committee welcomed Yorkshire Ambulance Service's involvement in the national project on Cardiovascular Quality and hope that the pilot can be rolled out across the entire service area.

The Sub-Committee hopes that YAS is successful in its bid for the NHS 111 number contract.

In terms of priorities for 2012-13, as noted earlier with regard to performance against ambulance response times, the Sub-committee feel it is imperative that the service prioritises improving response times in the East Riding and welcome this as a Priority for 2012-13. The Sub-committee also welcomes the priority on improved PTS, as there is anecdotal evidence to prove dissatisfaction of patient experience. Likewise, the priority that wishes to improve the experience and outcomes for patients in rural and remote areas is particularly relevant to East Riding patients and therefore the Sub-committee welcome this as a priority.

The Sub-committee also supports the service in its priority raising public awareness to support appropriate use of ambulance services. All too often we hear stories of ambulances being called for inappropriate circumstances and the more people who can be educated on this subject the better.

Financial Summary

2011-12

Contents

Operating and Financial Review

We achieved the target of responding to 75% of the most urgent 'Red' calls within 8 minutes for the first time.

Strategy Development

Work has continued throughout the year to develop our five-year Integrated Business Plan (IBP) which describes our strategic goals and aims in relation to our ambitions to achieve NHS Foundation Trust status in 2012-13 and to meet the challenges and opportunities presented by the new Health and Social Care Act.

These include developing a more personalised health and social care system aligned to people's individual health and care needs and helping patients live independently with care provided closer to home.

As recognised within the Act we must confront pressures on healthcare funding due to demographic changes which see an increasingly aged population with complex health needs and financial challenges, resulting in economic challenges within the wider economy. An important element of our response is our bid to become the provider of the NHS 111 service in Yorkshire and the Humber, which was submitted in April 2012.

Service Performance

During 2011-12 we made significant progress in the delivery of national performance standards achieving the target of responding to 75% of the most urgent 'Red' calls within 8 minutes for the first time. The Trust again achieved the national standard to provide transport within 19 minutes for 95% of appropriate 'Red' calls.

During the last quarter of the year focus moved to more local delivery performance standards across the healthcare economies that commission our services. We were able to deliver these standards across four of our five primary care trust clusters: Airedale, Bradford Leeds, Calderdale, Kirklees and Wakefield; Hull and East Riding; and South Yorkshire and Bassetlaw. We also took steps to move closer to the delivery of these standards in York and North Yorkshire.

We also underlined our commitment to improving the quality of care we provide for our patients through the successful delivery of a number of CQUIN schemes. These included developing clinical leadership and assessment, increasing the uptake of alternative care pathways for falls, diabetics, stroke, end-of-life care, management of frequent callers and developing tools to support service-users further.

We faced a number of challenges within our non-emergency Patient Transport Service (PTS), including adapting to the loss of the contract to provide transport services to renal patients in South Yorkshire. In February the Trust commenced a wide ranging project to identify and progress opportunities to improve service delivery, focusing on patient experience and service quality. Early results have demonstrated tangible improvements in the number of patients being delivered to and collected from their hospital appointments in a timely manner.

Looking Forward to 2012-13

Our annual business plan for 2012-13 has been agreed and provides a strong framework for continuing to develop and improve our services for the year ahead. Key developments include:

- introducing staff training and equipment to reduce patient mortality from major trauma
- working with our healthcare partners to develop our own and other community-based services to ensure care is delivered in the most appropriate setting to meet the needs of our patients
- continuing the roll-out of plans to improve the quality of our PTS
- progressing our ambitions to provide NHS 111 services across Yorkshire and the Humber
- enhancing our facilities as a Category 1 responder with the opening of the Health Gold Cell which will support the strategic management of an unplanned and/or pre-planned event within the West Yorkshire area and across the Yorkshire and the Humber footprint of the SHA. The facility is equipped with the latest information technology, allows real-time intelligence to be gathered and enables the joint command teams to set the strategic direction of any event. It will ensure that healthcare organisations can work more effectively with internal and multi-agency partners
- implementing schemes which continue to improve the efficiency of our services whilst maintaining the highest standards of care.

Financial Performance

During 2011-12 we strengthened our financial performance against our statutory and other financial duties delivering our planned financial surplus and national efficiency target. We also made significant progress in improving our compliance with the Better Payment Practice Code which monitors the time it takes us to pay our suppliers.

Achievement of Financial Duties and Auditors Local Evaluation

Financial duty	2009-10	2010-11	2011-12
Income and expenditure breakeven	✔	✔	✔
Capital resource limit duty	✔	✔	✔
External finance limit duty	✔	✔	✔
Better Payment Practice Code duty	✘	✘	✘
Capital cost absorption duty	✔	✔	✔
Auditors' Local Evaluation - use of resource rating	Good	Good	Not measured

✔ Met ✘ Failed

Income and Expenditure

We planned to realise an operating surplus of £415,000 in 2011-12 and actually managed to deliver a surplus of £428,000. We maintained appropriate control of expenditure in the period whilst achieving 93% of our Cost Improvement Plan on a recurrent basis. We made a technical adjustment to our accounts for an impairment of £408,000 in respect of in-year property revaluations giving a net retained surplus of £20,000.

We are planning to deliver a surplus of £1,975,000 in 2012-13 being 1% of total planned income in line with the requirement of the ***Operating Framework for the NHS in England 2012-13***.

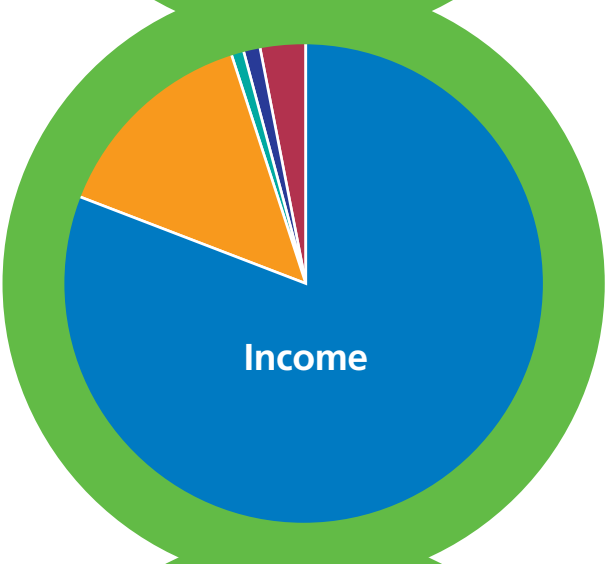
Income

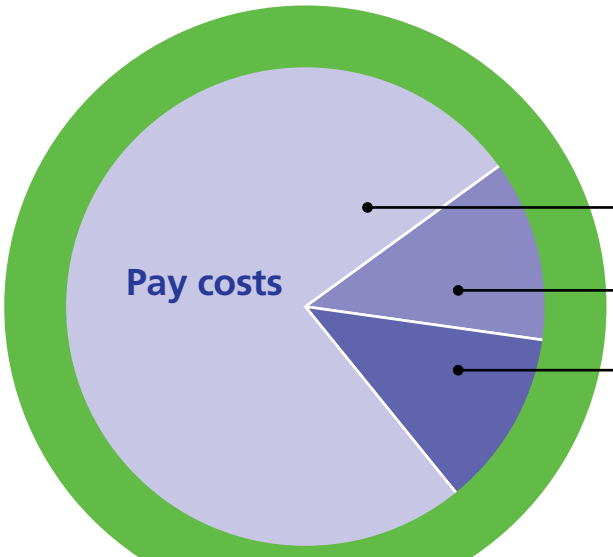
We recognised income of £200,333,000 in 2011-12. This is £4,611,000 higher that income received in 2010-11 primarily due to non-recurring A&E contract income.

The financial plan for 2012-13 projects income to be £195,840,000 before any growth in A&E demand.

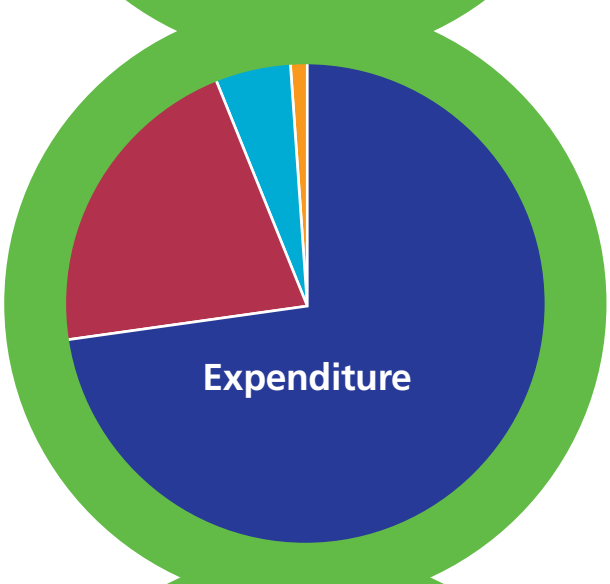
The breakdown of 2011-12 income can be seen in the figures below and chart opposite:

A&E	**£162,580,324**	**81%**
PTS	**£28,071,003**	**14%**
GPOOH	**£1,787,141**	**1%**
HART	**£2,845,532**	**1%**
Other	**£5,049,000**	**3%**





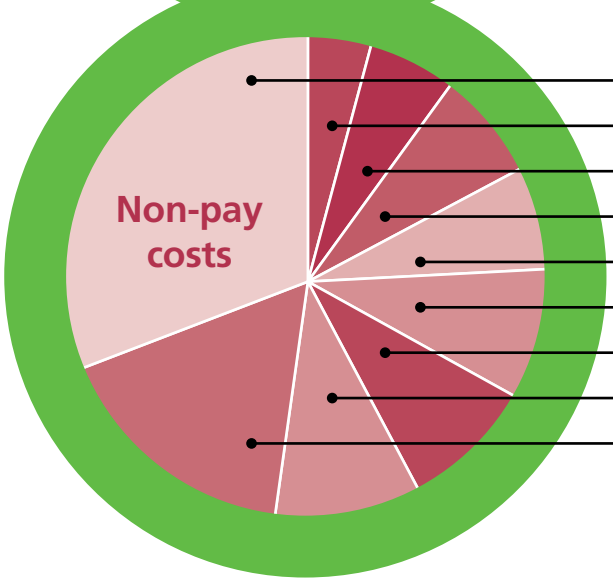
A&E	76%
PTS	12%
Support Functions	12%



Expenditure

We spent £200,313,000 on revenue items in 2011-12 which is £3,334,000 lower than 2010-11 and was utilised as follows:

Pay costs	£145,199,000	73%
Non-pay costs	£43,859,000	21%
Depreciation/ Impairment	£9,055,000	5%
Dividend	£2,200,000	1%



Vehicles	31%
Transport	4%
Travel	6%
Insurance	7%
IT	7%
Consumables	9%
Estates	9%
Other	11%
Depreciation/Impairment	17%

Cost Improvement Plans

We planned to achieve £9,670,000 savings in the year equating to 5% of our planned income. We achieved 93% of these savings recurrently in 2011-12. The balance was non-recurrent savings of £667,000 which will have to be found recurrently as part of the £10.3m Cost Improvement Plan for 2012-13.

Capital Expenditure

The Trust's Capital Resource Limit (CRL) was set at £9,214,427 for 2011-12. We spent £9,393,753 on capital expenditure and received £182,171 for assets sold. The net effect of this was a CRL undershoot of £2,845 which therefore achieved the target.

Cash/External Financing Limit (EFL)

The EFL is, in effect, a limit on the Trust's cash balance, restricting its use of external funding. This year there was an anticipated increased cash balance of £1,256,000 and therefore a reduction in the EFL of this amount. The difference between the closing and opening cash balance (£4,869,000 and £3,612,000 respectively) was £1,258,000 which meant that the Trust had £2,000 more cash than planned and therefore undershot the EFL, thereby achieving this target.

Capital Cost Absorption Duty

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 £63,373,000 and £62,377,000 at the end giving an average of £62,875,000. The public dividend capital reflected in the accounts was £2,200,000 which equates to 3.5% thereby achieving the target.

Better Payment Practice Code (BPPC)

Current trade creditors have reduced by £872,000 to £1,670,000 at the end of 2011-12. This improved performance is borne out by the associated improvements against the BPPC whereby the achievement of the target of invoices paid within 30 days has increased from 75% to 85%. The implementation of the new document management system should deliver performance of over 90% in 2012-13.

We are planning to deliver a surplus of £1,975,000 in 2012-13 being 1% of total planned income.

Governance Statement

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding 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 and governance arrangements, as described in the Trust's Governance Handbook. The Executive Director portfolios and associated management structures have been refined during the year, to ensure effective strategic and operational leadership and to provide greater clarity on accountability across all areas of Trust business.

The corporate risk management framework is set out in our Risk Management and Assurance Strategy. I ensure that this document, which describes our strategic approach to processes and monitoring arrangements for managing risk, is reviewed and updated on an annual basis. The strategy describes the strategic and operational risks faced by the Trust and the mechanisms for providing the Trust Board with assurance that these risks are managed efficiently and effectively.

The Trust meets with the NHS North of England and our lead commissioner, Bradford, Airedale and Leeds Primary Care Trust Cluster on a regular basis to reassure that both the national and local targets are being met and that risks are mitigated to tolerable levels. The Trust also 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 involvement networks (LINks).

2. The governance framework of the organisation

The Trust Board adheres to and is compliant with, the principles outlined in the *Combined Code on Corporate Governance* (2003). The Board recognises its accountabilities and provides leadership within a framework of prudent and effective controls which enables risk to be assessed and managed.

The Board sets the strategic aims for the organisation and ensures that resources are in place to meet its objectives. It receives reports at each meeting on the principal risks and associated actions as detailed in the Trust Board's Assurance Framework.

The Trust Board meets on a two-monthly basis and consists of; the Chairman and five other non-executive directors (NEDs), the Chief Executive, the Executive Director of Finance and Performance, and four other Executive Directors (three voting and one non-voting). In addition; the Board functions are coordinated and supported by the Director of Corporate Affairs/Trust Secretary. The Board is primarily responsible for:

- formulating strategy – vision, values, strategic plans and decisions
- ensuring accountability – pursuing excellent performance and seeking assurance
- shaping culture – patient focus, promoting and embedding values
- engaging with internal and external stakeholders to support delivery of Trust aims and objectives.

Over the year, the Trust Board has significantly developed its ability to focus on strategic issues whilst assuring itself of the performance of the whole organisation. It has achieved this through the following:

- Longer range agenda planning approach to ensure a focus on key decision and governance dates during the year.
- Regular Board Strategic Development Sessions, in addition to the bi-monthly public meetings, to cover key strategic and development issues which have included:

- our Foundation Trust application
- the Trust's five-year Integrated Business Plan
- strategic development of the Trust including stakeholder engagement and workforce
- financial priorities
- quality governance
- Board governance and committee arrangements.

Attendance sheets are signed by Board members at every meeting and attendance is recorded in the minutes, with apologies noted. In an executive director's absence a suitable nominated associate director attends. Attendance at Board meetings is monitored by the Director of Corporate Affairs/Trust Secretary on behalf of the Chairman and any notable exceptions are addressed by the Chairman or Chief Executive as appropriate.

This year, as an aspirant Foundation Trust, the Trust has completed a self-assessment using the Board Governance Assurance Framework (BGAF), commissioned by the Department of Health. The self-assessment will be complemented by an external review to be conducted in 2012-13. The Board Governance Assurance Framework deploys a standardised process to help the Board build on strengths and address weaknesses. It supports the Trust in the development of robust governance arrangements in line with Foundation Trust requirements.

During 2011-12 the Trust has commissioned external assessments in relation to its quality governance arrangements, its financial reporting procedures and as part of Phase 1 of the Foundation Trust Historical Due Diligence exercise. These assessments have supported the Trust in strengthening its governance arrangements during the year. A key focus has been on the development of quality governance structures, systems and processes, in line with the Foundation Trust Quality Governance Framework.

The Trust's arrangements for quality governance are fully aligned to the requirements of the Foundation Trust Quality Governance Framework and are designed to ensure compliance with the Essential Standards of Quality and Safety.

A Clinical Quality Strategy sets out the priorities for clinical quality and this is underpinned by annual implementation plans for each of the key workstreams.

Quality is a central element of all Board meetings. The Integrated Performance report focuses on key quality indicators, and this is supplemented by more detailed reports containing both qualitative and quantitative information on specific aspects of clinical quality.

The Trust Board has been underpinned throughout 2011-12 by four key committees/groups:

- the Audit Committee (see Section 5)
- the Finance and Investment Committee
- the Trust Executive Group; and
- the Senior Management Group.

Reporting directly to the Trust Board, the Trust Executive Group (TEG) is accountable for the operational management of the Trust and the delivery of objectives set by the Board. One of its primary functions is the management of organisational governance arrangements and as such, it provides a formal route to support the Chief Executive in effectively discharging his responsibilities as Accountable Officer. The TEG assists in the delivery of operational success and value for money by reviewing information on operational and financial performance and quality. It has also focused on the broad range of human resource and workforce development issues.

The Senior Management Group (SMG), which was established in May 2011, supports the Trust Board in developing an integrated approach to governance. The group provides the Trust Board with assurances that a comprehensive risk registers process is maintained and that the established relationship between the Corporate Risk Register and Board Assurance Framework is functioning effectively. The SMG is responsible for monitoring achievements against the Trust's strategic objectives, specifically those relating to performance, risk, compliance, quality and safety. The SMG also oversees the performance management of the Trust's operating systems and procedures to provide assurance to the Board on governance and compliance. Throughout 2011-12 the SMG has been routinely provided with risk management information and assurance from:

- operational management groups in A&E and PTS
- Risk and Assurance Group
- Health and Safety Committee
- Infection Prevention and Control Committee
- Information Governance Group
- Clinical Governance Committee.

The Finance and Investment Committee (F&IC) was introduced from May 2011, following a review of Trust committees conducted in 2010-11. The F&IC is a sub-committee of the Board and is chaired by a Non-Executive Director. It provides a vehicle for scrutiny of Trust budgets and significant business cases, and supports the Board with assurance on financial governance and risk issues.

A further review of the Trust's Corporate Governance Review was undertaken in 2011-12, resulting in further development of Board committee and management group arrangements. As a result of this exercise, a Quality Committee was introduced as a sub-committee of the Board in March 2012. This committee is chaired by a Non Executive Director and supports the Board with assurance on issues of clinical governance and quality, workforce, risk and safety.

In addition to the introduction of the Quality Committee, significant changes were made following the review, to the Trust's management groups, to rationalise and streamline the arrangements. These changes have helped to reduce duplication and have increased the clarity of accountability and flow of information within the management groups.

To strengthen the management of key change programmes and projects aligned to the five-year Integrated Business Plan, including delivery of the Cost Improvement Plan, the Trust has also agreed the establishment of a Programme Management Group. This will commence in April 2012, with executive leadership and Non-Executive Director involvement.

As Chief Executive, 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 Executive 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, the Quality Committee, Audit Committee and other management groups with expert advice and reports on risk management and assurance. The Director ensures that the Board has access to regular and appropriate risk management information, advice, support and training where required.

The Executive Director of Finance and Performance has lead responsibility for financial risk management. The Director advises the Trust Board, the Audit Committee and Finance and Investment Committee, the Trust Executive Group and Senior Management Group 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 Executive 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, Quality Committee, Clinical Governance Committee (to March 2012, and subsequently the Clinical Governance Group), and the other management groups 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 learning from examples of good practice.

The Trust has also appointed a Corporate Affairs Director/Trust Secretary to play a pivotal 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.

3. Risk assessment

Risk assessment is the overall process of risk identification, risk analysis and risk evaluation. The process assists the Trust to manage, reduce or eradicate identified risks in order to protect the safety of patients, staff, visitors and the organisation as a whole. The identification of risk takes many forms and involves both a proactive approach and one which reviews risks retrospectively. Assessment of risk is therefore a dynamic and ongoing process.

Risks are identified proactively by the Board and senior management team as part of the five-year and annual business planning cycles.

In addition, risks can be identified on a daily basis throughout the Trust by any employee. The identified risks vary significantly in scope, content, likelihood and impact and hence the measures for addressing them have also varied. Having identified a risk, a thorough risk assessment is carried out following the guidance for ongoing risk assessment, described in the Trust Risk Escalation and Reporting Procedure.

When risks have been identified, each one is analysed in order to assess what the likely impact would be, the likelihood of this impact occurring and how often it is likely to re-occur. When evaluating risks consideration is given to any existing controls for that risk and importantly the adequacy and effectiveness of those controls.

Risks that cannot be managed locally are passed up through the line of management, to the Trust Executive Group and ultimately to the Trust Board, which is notified of all significant (extreme level) risks within the organisation that cannot be adequately eliminated or controlled. The Trust Board has ultimate responsibility for deciding how the Trust then manages those risks.

The organisation's major risks are separately identified: those that have been managed in the year and 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.

The principal risks to the strategic objectives identified in the Board Assurance Framework 2011-12, were:

- failure to maintain financial viability
- increased competition, resulting in loss of service and income
- inability to improve the effectiveness of clinical care and patient outcome
- inability to innovate against a changing commissioner landscape
- inability to secure the capacity and capability required to deliver the clinical and financial improvements required
- inability to deliver organisational change management programmes required to sustainably perform against changing service demands
- non-compliance with regulatory or legislative standards, either causing or leading to an adverse impact on service delivery.

Mitigation plans were in place for each of these principal risks and the Audit Committee has scrutinised the controls and assurances as part of its annual work programme, through reports from the accountable executive directors.

A number of new operational risks with a potential impact on the strategic goals emerged during the year and required additional management action. These have been reported to the Audit Committee and to each meeting of the public Board via the Integrated Performance Report. The most significant risks were as follows:

- Delayed activation/response to Red emergency calls, through loss of the Computer Aided Dispatch (CAD) system associated with essential IT or electrical upgrade work. A significant event in 2011-12 highlighted the need for a review of the change control process for the management of maintenance or repair work involving key Trust systems. These cross-departmental processes have since been significantly strengthened to reduce future risks to business continuity.
- Non-compliance with elements of the Essential Standards of Quality and Safety, relating to aspects of mandatory training and personal development review completion, cleaning of station premises and medicines management. These issues were recognised and being addressed through the Trust's risk management system, but were also highlighted following the Trust's inspection by the Care Quality Commission (CQC) in October 2011. Subsequently the Trust has successfully implemented actions to improve operational performance, which led to the Trust being found to be fully compliant with all standards in a follow-up inspection in January 2012.

All corporate risks subject to ongoing risk management plans will be recorded on the 2012-13 iteration of the Board Assurance Framework and will continue to be managed through the Corporate Risk Register.

The Trust achieved its operational target for immediately life-threatening calls in 2011-12. The achievement of this target will continue to pose a challenge to the Trust's risks in the future, however, with potential financial and regulatory consequences.

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 is undertaken by the Executive Director of Standards and Compliance, supported by the Trust's Executive Medical Director as the Caldicott Guardian. During the past year there have been no reported serious incidents involving lapses of data security.

4. The risk and control framework

The Trust is subject to constant change in its core business and the wider environment; the risk environment is constantly changing too, therefore priorities and the relative importance of risks for the Trust shift and change.

The Trust recognises that in order to be most effective, risk management must become part of the organisation's culture. The Trust strives to embed risk management into the organisation's philosophy, practices and business processes rather than be viewed or practiced as a separate activity. Our aim is for everyone in the Trust to become proactively involved in the management of risk.

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 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 Corporate Risk Register and Board Assurance Framework enables the Board to examine how it is managing the risks that are threatening the achievement of strategic objectives. Both of these documents are closely aligned and subject to comprehensive executive review on a quarterly basis. Any significant gaps in controls on the Board Assurance Framework are identified and routinely managed through the Corporate Risk Register.

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

Close liaison between the risk and safety managers and business planning managers has ensured that business planning informs and is informed by risk management.

A 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.

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 in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

The Trust has in place an annual Counter Fraud Work Programme, which is monitored via the Audit Committee. During the year the Trust also approved and introduced a new Anti Bribery Policy and procedures in line with new legislation.

5. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways:

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work.
- Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
- The Board 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:

- Care Quality Commission Essential Standards for Quality and Safety – Provider Compliance Assessments
- the Care Quality Commission inspection process
- NHSLA risk management standards compliance inspections
- NHS Connecting for Health Information Governance Toolkit
- ongoing self assessment (utilising the Auditors' Local Evaluation methodology)
- internal audit reports
- external audit reports
- external consultancy reports on key aspects of Trust governance.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee and the Senior Management Group. 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 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.

- Reviews in each Audit Committee meeting of controls and assurances in relation to the principal risks in the Board Assurance Framework, via scrutiny and challenge sessions involving the accountable Executive Directors.
- A biennial comprehensive review of the Board Assurance Framework.
- Monthly integrated 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 Group 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 Senior Management Group 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 Board Assurance Framework.

The Audit Committee reviews all risk and control related disclosure statements and memoranda, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

The Audit 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 Trust is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The Trust Quality Accounts for 2011-12 report on key indicators of quality relating to patient safety, clinical effectiveness and patient experience. The Quality Accounts include comments from key stakeholders which are a positive reflection on developments over the year and of the Trust's engagement with partners. The Quality Accounts have been subject to Internal Audit review and scrutiny by the Audit Committee and I am satisfied that they present a balanced and accurate view of quality within the Trust.

On final review and closure of the 2011-12 iteration of the Board Assurance Framework, a significant control issue was identified relating to the failure to deliver against contracted Key Performance Indicators (KPIs) in the PTS (see Section 6).

Head of Internal Audit Opinion

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. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, most notably in relation to evidencing CQC standards within the Clinical Business Units, PDRs and the efficiency savings programme'*.

Mitigating action has been taken to address the specific concerns identified by the Head of Internal Audit and other risks emerging during the year through the Trust's risk management processes. Assurance on the controls in place to manage these issues in 2012-13 will be reviewed through the risk management and committee arrangements outlined in Section 2 of this statement.

6. Significant issues

The 2011-12 review of the Trust's system of internal control has identified one significant control issue relating to the PTS provision and its failure to fully achieve contracted KPIs.

A multi-faceted risk treatment plan is in place to address this risk. Key elements include strengthening the PTS management team and engaging with a strategic commercial partner to undertake a diagnostic exercise and to take forward a significant programme of Service Transformation in the PTS during 2012-13.

Management of this risk will be monitored during 2012-13 through the Trust Executive Group, Finance and Investment Committee and Board. Additional monitoring and assurance will be provided through the Trust's Service Transformation Programme Group which is being established in April 2012, to oversee the delivery of key developments aligned to the Trust's five-year Integrated Business Plan.

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.

Accountable Officer:

David Whiting
Chief Executive

19 April 2012

Remuneration Report

All permanent executive directors are appointed by the Trust through an open, national recruitment process. All have substantive contracts and have annual appraisals.

Executive director salaries are determined following comparison with similar posts in the NHS and wider public sector and are reviewed by the Remuneration and Terms of Service Committee. In determining the remuneration packages of executive directors and senior managers the Trust fully complies with guidance issued by the Department of Health and the chief executive of the NHS, as supplemented and advised by NHS North of England as the Strategic Health Authority responsible for Yorkshire and the Humber.

Non-executive directors are appointed by the Appointments Commission following an open selection procedure. Non-executive director appointments are usually fixed-term for four years and remuneration is in accordance with the national formula.

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 executive directors and senior managers. When considering the pay of executive directors and senior managers the committee applies the Department of Health annual pay settlement and the framework and guidance for very senior managers in strategic and special health authorities, primary care trusts and ambulance trusts. The current consumer price index (CPI) applied to pensions is 3.1%. The factors used to calculate the 2012 cash equivalent transfer value (CETV) have changed; the new factors used are higher than previous years.

The salary of the most highly paid individual in YAS in the financial year 2011-12 was £128,872. This was 5.912 times the median salary of the workforce, which was £21,798. The median was calculated by scaling up part-time salaries to the whole time equivalent in line with guidance.

All permanent executive directors are appointed by the Trust through an open, national recruitment process.

Salary Entitlements of Senior Managers

Name and title	2011-12			2010-11		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (Rounded to the nearest £000)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (Rounded to the nearest £000)
	£000	£000	£000	£000	£000	£000
David Whiting Chief Executive	125-130	0	5.9	20-25	0	0
Rod Barnes[1] Executive Director of Finance and Performance	45-50	0	3.2	85-90	0	6.8
Sarah Fatchett[2] Director of Operations - PTS	5-10	0	1.2	80-85	0	7.2
Sarah Fatchett Director of Operations	60-65	0	4.5	0	0	0
Keith Prior[3] Interim Director of Operations	15-20	0	0.7	95-100	0	4.1
David Williams[4] Temporary Director of Operations	15-20	0	0	N/A	N/A	N/A
Stephen Moir[5] Executive Director of Workforce and Strategy	75-80	5-10	0	N/A	N/A	N/A
Cath Cox[6] Temporary Director of Human Resources and Organisational Development	10-15	0	0.3	N/A	N/A	N/A
Steve Page Executive Director of Standards and Compliance	85-90	0	3.4	75-80	0	3.2

1 - Appointed 3 October 2011
2 - Role changed 1 May 2011, left 31 December 2011
3 - Left 31 May 2011
4 - Appointed 1 February 2012
5 - Appointed 1 June 2011
6 - From 1 April 2011 to 31 May 2011

Salary Entitlements of Senior Managers

Name and title	2011-12			2010-11		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (Rounded to the nearest £000)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (Rounded to the nearest £000)
	£000	£000	£000	£000	£000	£000
Keeley Townend[7] Director of Information, Communication and Technology	5-10	0	0	75-80	5-10	0
Ian Walton[8] Director of Operations - A&E	5-10	0-1	0.3	80-85	0	1.5
Caroline Wood[9] Acting Director of Finance and Performance	25-30	0	0	50-55	0	0
Simon Worthington[10] Deputy Chief Executive and Director of Finance	20-25	0	1	110-120	0	6
Dr Alison Walker Medical Director	100-105	10-15	6.5	105-110	0	6.3
Della Cannings QPM Chairman	20-25	0	0	15-20	0	0
Dr Elaine Bond[11] Non-executive Director	5-10	0	0	N/A	N/A	N/A
Patricia Drake Non-executive Director	5-10	0	0	5-10	0	0
Roger Holmes CB Non-executive Director	5-10	0	0	5-10	0	0
Richard Roxburgh Non-executive Director	5-10	0	0	5-10	0	0
Nina Wrightson OBE Non-executive Director	5-10	0	0	5-10	0	0

7 - Redeployed 1 May 2011
8 - Redeployed 1 May 2011
9 - Acting Finance Director 19 June 2011 to 2 October 2011
10 - Left 19 June 2011
11 - Appointed 5 June 2011

Salary Entitlements of Senior Managers - Notes

The 'other remuneration' column contents relating to Stephen Moir is for receipt of a cash equivalent payment of equal value to a lease car. Stephen Moir has also received a £6,000 relocation assistance support package as part of his agreed terms of appointment. However, as this was a qualifying tax exempt expense payment it is therefore not included in the remuneration report.

The 'other remuneration' of Keeley Townend relates to a car allowance.

The Medical Director Dr Alison Walker is seconded from another Trust, her gross recharge has been pro-rated to give an accurate comparator. Her 'other remuneration' is on-call payments, and her 'benefits in kind' relates to private use of Trust vehicles.

Pension Entitlements of Senior Managers 2011-12

Name and title	Real increase in pension at age 60/65 (bands of £2,500)	Real increase in pension lump sum at aged 60/65 (bands of £2,500)	Total accrued pension at age 60/65 at 31 March 2012 (bands of £5,000)	Lump sum at age 60/65 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
David Whiting Chief Executive	2.5-5	10.0-12.5	40-45	130-135	744	574	152	0
Rod Barnes[12] Executive Director of Finance and Performance	0-2.5	2.5-5	25-30	75-80	385	279	48	0
Sarah Fatchett[13] Director of Operations	0-2.5	0-2.5	15-20	45-50	211	157	37	0
Stephen Moir[14] Executive Director of Workforce and Strategy	0-2.5	0-2.5	0-5	0	12	0	10	0
Cath Cox Temporary Director of Human Resources and Organisational Development	0-2.5	5-10	10-15	40-45	242	0	41	0
Steve Page Executive Director of Standards and Compliance	2.5-5	5-10	30-35	90-95	548	436	99	0

12 - Appointed 3 October 2011
13 - Left 31 December 2011
14 - Appointed 1 June 2011

Pension Entitlements of Senior Managers 2011-12

Name and title	Real increase in pension at age 60/65 (bands of £2,500)	Real increase in pension lump sum at aged 60/65 (bands of £2,500)	Total accrued pension at age 60/65 at 31 March 2012 (bands of £5,000)	Lump sum at age 60/65 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Keeley Townend[15] Director of Information, Communication and Technology	0-(2.5)	0-(2.5)	10-15	35-40	177	143	3	0
Ian Walton[16] Director of Operations - A&E	0-2.5	0-2.5	30-35	95-100	623	548	5	0
Caroline Wood[17] Acting Director of Finance and Performance	0-2.5	0-2.5	15-20	45-50	217	163	15	0
Simon Worthington[18] Deputy Chief Executive and Director of Finance	0-(2.5)	0-(2.5)	30-35	100-105	581	450	26	0

15 - Redeployed 1 May 2011
16 - Redeployed 1 May 2011
17 - Acting Finance Director 19 June 2011 to 2 October 2011
18 - Left 19 June 2011

Independent Auditor's Report

We have audited the financial statements and the related notes 1 to 45 of Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2012 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. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is described as having been 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 and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices 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. In addition, we read all the financial and non-financial 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 financial position of Yorkshire Ambulance Service NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and
- have been prepared properly 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 prepared properly in accordance with the requirements 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 report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditor

The Trust is responsible for 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.

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, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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 2011, 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 2012.

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 2011, 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 2012.

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, United Kingdom

7 June 2012

Summary Financial Statements

Statement of Comprehensive Income for the year ended 31 March 2012	2011-12 £000	2010-11 (restated) £000
Pay costs	**(145,199)**	(144,072)
Other costs	**(52,909)**	(51,082)
Revenue from patient care activities	**195,284**	190,263
Other Operating revenue	**5,049**	5,471
Operating surplus/(deficit)	**2,225**	580
Investment revenue	**30**	26
Other gains and losses	**113**	81
Finance costs	**(148)**	(123)
Surplus/(deficit) for the financial year	**2,220**	564
Public dividend capital dividends payable	**(2,200)**	(2,243)
Retained surplus/(deficit) for the year	**20**	(1,679)

Adjusted NHS Financial performance	2011-12 £000
Retained surplus/(deficit) for the year	**20**
Prior period adjustment to correct errors	**0**
IFRIC 12 adjustment	**0**
Impairments	**408**
Adjusted retained surplus/(deficit)	**428**

Statement of Financial Position as at 31 March 2012

	31 March 2012 £000	1 April 2011 (restated) £000
NON-CURRENT ASSETS		
Property, plant and equipment	**69,177**	69,317
Intangible assets	**280**	177
Trade and other receivables	**2,035**	2,349
Total non-current assets	**71,492**	71,843
CURRENT ASSETS		
Inventories	**1,627**	1,468
Trade and other receivables	**10,383**	10,553
Cash and cash equivalents	**4,869**	3,611
Total current assets	**16,879**	15,632
Non-current assets held for sale	**441**	0
Total current assets	**17,320**	15,632
Total assets	**88,812**	87,475
CURRENT LIABILITIES		
Trade and other payables	**(13,641)**	(12,651)
Provisions	**(2,594)**	(2,554)
Total current liabilities	**(16,235)**	(15,205)
Non-current assets plus/less net current assets/liabilities	**72,577**	72,270
NON-CURRENT LIABILITIES		
Trade and other payables	**0**	(180)
Provisions	**(5,342)**	(5,122)
Total non-current liabilities	**(5,342)**	(5,302)
Total assets employed	**67,235**	66,968
Financed by taxpayers' equity:		
Public dividend capital	**74,094**	74,094
Retained earnings	**(11,232)**	(11,320)
Revaluation reserve	**4,373**	4,194
Total taxpayers' equity	**67,235**	66,968

Statement of Cash Flows for the year ended 31 March 2012	2011-12 £000	2010-11 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**2,225**	580
Depreciation and amortisation	**8,647**	8,527
Impairments and reversals	**408**	1,881
Dividend paid	**(2,200)**	(2,190)
(Increase) in inventories	**(159)**	(80)
(Increase)/decrease in trade and other receivables	**484**	(1,944)
Increase/(decrease) in trade and other payables	**(1,006)**	2,844
Provisions utilised	**(2,189)**	(1,943)
Increase/(decrease) in provisions	**2,301**	1,599
Net cash inflow/(outflow) from operating activities	**8,511**	9,274
Cash flows from investing activities		
Interest received	**30**	25
(Payments) for property, plant and equipment	**(7,341)**	(9,003)
(Payments) for intangible assets	**(237)**	(194)
Proceeds from disposal of plant, property and equipment	**295**	152
Net cash (outflow) from investing activities	**(7,253)**	(9,020)
Net cash inflow/(outflow) before financing	**1,258**	254
Net increase/(decrease) in cash and cash equivalents	**1,258**	254
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**3,611**	3,357
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**4,869**	3,611

Glossary of Terms

Term/Abbreviation	Definition/Explanation
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 Quality Indicators (AQIs)	AQIs were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients. The AQIs are ambulance-specific metrics which are concerned with patient safety and outcomes.
Ambulance Service Cardiovascular Quality Initiative	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.
Annual Assurance Statement	The means by which the Accountable 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 Accounts.
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.
Board Governance Assurance Framework (BGAF)	Assists Boards through a combination of self and independent assessment processes to ensure they are appropriately skilled and prepared to achieve FT authorisation.
British Association for Immediate Care (BASICS)	A network of doctors who provide support to ambulance crews at serious road traffic collisions and other trauma incidents across the region.
Bronze Commander Training	A course designed to develop and equip ambulance service, health colleagues and Voluntary Aid Society Incident Managers at operational/ bronze level to effectively manage major/catastrophic incidents.
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, based on the point at which a call is connected to the ambulance service.

Term/Abbreviation	Definition/Explanation
Cardio-pulmonary Resuscitation (CPR)	A procedure used to help resuscitate a patient when their heart stops beating and breathing stops.
Care Bundle	A care bundle is a group of interventions (practices) related to a disease process that, when executed together, result in better outcomes than when implemented individually.
Care Quality Commission (CQC)	An independent regulator responsible for monitoring and performance measuring all health and social care services in England.
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.
Chairman	The Chairman provides leadership to the Trust Board and chairs all Board meetings. The Chairman ensures key and appropriate issues are discussed by the executive and non-executive directors.
Chief Executive	The highest-ranking officer in the Trust, who is the Accountable Officer responsible to the Department of Health for the activities of the organisation.
Clinical Hub	A team of clinical advisors based within the Emergency Operations Centres proving 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)	CPIs were developed by ambulance clinicians and are used nationally to measure the quality of important areas of clinical care. They are designed to support the clinical care we provide to patients by auditing what we do.
Clinical Supervisor	Works on the frontline as part of the operational management team and facilitates the development of clinical staff and helps them to practise safely and effectively by carrying out regular assessment and revalidations.
Commissioners	Ensure that services they fund can meet the needs of patients.
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.
Commissioning for Quality and Innovation (CQUIN)	The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.
Department of Health (DH)	The government department which provides strategic leadership for public health, the NHS and social care in England.
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.

Term/Abbreviation	Definition/Explanation
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 care, treatment and safe transport for emergency patients.
Emergency Operations Centre (EOC)	The department which handles all our emergency and urgent calls and deploys the most appropriate response. The two EOCs are based in Wakefield and York.
Equality and Diversity	Equality legislation 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.
Foundation Trust (FT)	NHS organisations which operate more independently under a different governance and financial framework.
Foundation Trust Development Group	This is made up of the YAS Chairman and YAS Trust Executives.
General Practitioner (GP)	A doctor who is based in the community and manages all aspects of family health.
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.
GP Consortia	GP Consortia will be replacing Primary Care Trusts (PCTs) officially from April 2013. They will be responsible for commissioning healthcare services in England.
Green Calls	A local response target. Previously known as Category B calls for conditions which are not immediately life-threatening.
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.
Human Resources (HR)	A function with responsibility for implementing strategies and policies relating to the management of individuals.
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.
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.

Term/Abbreviation	Definition/Explanation
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)	A network of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services.
Major Trauma	Major trauma is serious injury and generally includes such injuries as: • traumatic injury requiring amputation of a limb • severe knife and gunshot wounds • major head injury • multiple injuries to different parts of the body eg chest and abdominal injury with a fractured pelvis • spinal injury • severe burns.
Major Trauma Centre	A network of 22 new centres throughout the UK, specialising in treating patients who suffer from major trauma
MCADD (Medium chain acyl-CoA dehydrogenase deficiency)	MCADD is a rare inherited disorder where the body cannot metabolise fat properly. The disease affects about one in 10,000 babies born in the UK.
Mental Capacity Act (MCA)	Legislation designed to protect people who can't make decisions for themselves or lack the mental capacity to do so.
Monitor	The independent regulator of NHS foundation trusts.
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.
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.

Term/Abbreviation	Definition/Explanation
National Learning Management System (NLMS)	Provides NHS staff with 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)	Drawn from the local community served by the Trust, they oversee the delivery of ambulance services 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.
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 accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.
primary Percutaneous Coronary Intervention (pPCI)	A surgical treatment for heart attack patients which unblocks arteries which carry blood to the heart.
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.
Private and Events Service	Provides medical cover to private and social events for example, football matches, race meetings, concerts and festivals. It also provides ambulance transport for private hospitals, corporations and individuals.
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.
Red 1 and 2 Calls	Previously referred to as Category A calls. 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.
Safeguarding	Processes and systems for the protection of vulnerable adults, children and young people.

Term/Abbreviation	Definition/Explanation
Safety Thermometer	The NHS Safety Thermometer is a tool designed to help hospitals understand where they can potentially cause harm to patients and reduce the risk of this.
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 Incidents (SIs)	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.
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 and has YAS paramedics seconded to it.
Yorkshire Ambulance Service (YAS)	The NHS provider of emergency and non-emergency ambulance services in Yorkshire and the Humber.

Yorkshire Ambulance Service NHS

NHS Trust

An Aspirant Foundation Trust

Contact us:

Yorkshire Ambulance Service NHS Trust
Trust Headquarters, Springhill 2, Brindley Way, Wakefield 41 Business Park, Wakefield WF2 0XQ

Tel: 0845 124 1241
Fax: 01924 584233
www.yas.nhs.uk

The full accounts for the year ended 31 March 2012 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 file, please contact our Corporate Communications department at Trust Headquarters to discuss your requirements.

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