NHS
Yorkshire
Ambulance Service
NHS Trust

Annual Report

Quality Account

Financial Accounts

2016-17

ANNUAL REPORT

Annual Report

- About us
- Mission, Vision & Values
- Chief Executive's Foreword
- Chairman's Welcome

- **Performance Report**
  - Operational Review

- **Accountability Report**
  - Corporate Governance Report
  - Remuneration and Staff Report

QUALITY ACCOUNT

Quality Account

PART 1

- Statement on Quality
- Statement of Accountability

PART 2

- Priorities for Improvement 2017-18
- Statements from the Trust Board

PART 3

- 2016-17 Review
- Performance against Priorities for Improvement 2016-17
- Stakeholder Statements

FINANCIAL ACCOUNTS

Financial Accounts

- **Annual Governance Statement**

- **Independent Auditor's Statement**

- **Financial Accounts**

Annual Report

2016-17

Introducing Yorkshire Ambulance Service

Yorkshire Ambulance Service NHS Trust (YAS) is the region's provider of emergency, urgent care and non-emergency patient transport services.

We serve a population of over five million people across Yorkshire and the Humber and strive to ensure that patients receive the right response to their care needs as quickly as possible, wherever they live. The catchment area for our NHS 111 service also extends to North Lincolnshire, North East Lincolnshire and Bassetlaw in Nottinghamshire.

We employ 5,589* staff, who together with over 1,200 volunteers, enable us to provide a vital 24-hour, seven-days-a-week, emergency and healthcare service.

** is a headcount figure which includes part-time staff and equates to 4,381 whole-time equivalents.*

Our main focus

- Receive 999 calls in our emergency operations centres (Wakefield and York)
- Respond to 999 calls, arrange the most appropriate response to meet patients' needs and get help to patients who have serious or life-threatening injuries or illnesses as quickly as possible
- Provide the region's NHS 111 urgent medical help and advice line
- Delivery of GP out-of-hours (OOH) services in West Yorkshire in partnership with Local Care Direct
- Take eligible patients to and from their hospital appointments and treatments with our non-emergency Patient Transport Service (PTS)

Additional services

- Resilience and Special Services Team (incorporating our Hazardous Area Response Team) which plans and leads our response to major and significant incidents such as those involving public transport, flooding, pandemic flu or chemical, biological, radiological or nuclear (CBRN) materials
- Provide clinicians to work on the two helicopters operated by the Yorkshire Air Ambulance charity
- Vehicles and drivers for the specialist Embrace transport service for critically-ill infants and children in Yorkshire and the Humber
- Clinical cover at major sporting events and music festivals
- First aid and other training to clubs, companies and community groups and actively promote life-support initiatives in local communities

Our frontline operations receive valuable support from many community-based volunteers, including community first responders, who are members of the public who have been trained to help us respond to certain time-critical medical emergencies. We also run co-responder schemes with Fire and Rescue Services across Yorkshire and the Humber as well as a number of volunteer car drivers who support the delivery of our PTS.

We are led by a Trust Board which meets in public quarterly and comprises the Trust chairman, five non-executive directors, five executive directors, including the chief executive, and three directors (non-voting) who are in attendance at Trust Board meetings. We also have two associate non-executive directors who are in attendance at Trust Board meetings.

We are the only NHS trust that covers the whole of Yorkshire and the Humber and we work closely with our healthcare partners including hospitals, health trusts, healthcare professionals, clinical commissioning groups and other emergency services.

Our priorities for 2017-18 include:

- Delivering the best health outcomes for patients in urgent and emergency care through high quality, safe and effective clinical processes and pathways.
- Developing our digital capability to ensure we identify and utilise key technology to support effective and integrated services for our patients.
- Increasing our patient engagement and use their experiences to help shape developments at the Trust.
- Building on our leading role as a provider of non-emergency patient transport services and the NHS 111 urgent care service.
- Acting on feedback from the Care Quality Commission inspections and making further improvements to our services so that we are able to move from a 'Good' rating to an 'Outstanding' rating.
- Ensuring we have robust plans in place to recruit, develop and retain our valued workforce and support the health and well-being of our staff.
- Working with our health and care system partners to provide leadership and resilience and to help improve patient care through a joined-up and efficient approach.
- Working with ambulance and other emergency service colleagues, including our neighbouring ambulance trusts North East Ambulance Service and North West Ambulance Service, which along with YAS form the Northern Ambulance Alliance, to identify and deliver efficiencies in the way we work.
- Creating a robust and effective approach to corporate social responsibility which sets out clear engagement with our local communities, provides community education and support and which contributes to increased public health awareness and better health outcomes.

Our Values in 2016-17

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

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

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

A **Always compassionate**
Our staff are professional, dedicated and caring

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

E **Enhancing and improving lives**
We continuously seek out improvements

Our Mission

Your Ambulance Service - Saving lives, caring for you

Our Vision

Providing world class care for the local communities we serve

During 2016-17 we have engaged with staff and stakeholders to discuss whether these still best reflect the ambitions of the service and work is now completed to refresh the mission, vision and values 2017-18.

Chief Executive's Foreword

Welcome to our Annual Report for 2016-17 which details our performance and developments over the last 12 months and priorities for 2017-18.

It has been another challenging year due to unprecedented increases in 999 demand, budget pressures and a constantly-evolving health landscape.

However, despite this we have continued to perform to a high standard across all our service areas and received a rating of 'Good' by the Care Quality Commission across each of their assessment domains - Safe, Effective, Caring, Responsive and Well-led - following a planned inspection in autumn 2016.

A key component of our success now and in the future is our willingness to look forward, anticipate change and adapt our services to better meet the needs of our patients; as a result of this we are at the forefront of a number of national initiatives.

In April 2016 we became one of the national pilot sites for NHS England's Ambulance Response Programme (ARP) which aims to improve response times to critically-ill patients by making sure that the best, high quality, most appropriate response is provided for each patient first time. We are confident that this new way of prioritising emergency calls will continue to have a significant and positive impact on how we respond to patients.

Following our previous success with piloting various initiatives in NHS 111, we have been designated as part of the West Yorkshire Accelerator Zone which means we are taking the lead in testing various new initiatives before they are introduced and adopted by other NHS organisations. This re-enforces our reputation as being at the forefront of innovation while presenting a clear opportunity for us to demonstrate how we embrace change.

Our Patient Transport Service (PTS) has continued to improve service delivery this year and it was therefore deeply disappointing to learn that we had not secured the Hull contract. This came as a bitter blow to our PTS teams and was hugely unsettling for the staff directly involved. However, we were delighted to secure new five-year contracts to deliver non-emergency patient transport services in the East Riding and South Yorkshire following further competitive tender processes.

We have concluded our contract negotiations with commissioners of our A&E services for the next two years. As highlighted in the latest report into NHS ambulance services by the National Audit Office, funding constraints and growing demand remain ongoing issues for us to manage and we have to drive forward efficiencies in our ways of working, some of which we will continue to explore with our partners across the public sector and particularly with the Northern Ambulance Alliance (NAA).

We have been designated as part of the West Yorkshire Accelerator Zone which means we are taking the lead in testing various new initiatives before they are introduced and adopted by other NHS organisations.

The alliance brings together North East Ambulance Service (NEAS), North West Ambulance Service (NWAS) and YAS and is the first of its type within the ambulance sector.

The Trust is also a member of the West Yorkshire Tri-Service Collaboration Board, comprising of other blue light services. These partnership platforms represent an increasingly important part of our strategic delivery to optimise efficiency and quality benefits in line with Lord Carter's review of efficiency in hospitals.

The transformation of our A&E Operations is also well underway, including the implementation of a management restructure to provide frontline operational staff with better access to their supervisors and changing rota schedules and shift patterns to better meet the needs of patients. This foundation will enable us to better cope with increasing demand whilst reducing the number of patients inappropriately taken to hospital by placing more focus on delivering care at the scene.

As part of looking forward as an organisation, we've developed a new Purpose (Mission Statement) and Vision for the Trust that we feel accurately reflects the direction we are moving in and what our aspirations are for the future. To underpin these statements, we have also reviewed our current WE CARE values and have consulted with staff about six new proposed values; ones that we think truly represent the culture this organisation should have and reflect what staff have told us.

In the coming year we will undoubtedly face further increases in patient demand and the need for even greater financial constraint. Whilst we will need to be both innovative and collaborative in meeting these challenges, the people of Yorkshire can be assured that our core priority remains delivery of improved outcomes for patients.

Rod Barnes
Chief Executive

Chairman's Report

This is my first Annual Report after taking over as Chairman of Yorkshire Ambulance Service NHS Trust on 1 July 2016.

My first day was particularly memorable as I attended the Trust's annual WE CARE Awards which recognises staff who go the extra mile for patients and colleagues. It was a privilege to present awards and hear about the many staff who inspire others and deliver beyond expectations in what can be very challenging situations.

In addition to our internal staff recognition schemes, it has been pleasing to see staff acknowledged externally at a national level, some examples include Jon Richards who received the Paramedic Award at the Association of Ambulance Chief Executives (AACE) Outstanding Service Awards; Alan Baranowski who was awarded the Queen's Ambulance Medal for Distinguished Service in the Queen's Birthday Honours List; and the Sheffield-based Local Intervention and Falls Episodes Team which won the NHS Collaboration Award at the Health Business Awards.

I was absolutely delighted to receive the Care Quality Commission's (CQC's) inspection report in February which rated the Trust as 'Good' in each of the four inspected domains of safe, effective, responsive and well led, giving an overall rating of 'Good'. This is a marked improvement to our ratings in 2015 and accurately reflects the dedication of every member of staff on the frontline and in our support services. It makes me immensely proud that the commitment of staff and volunteers and the great care they provide have been formally recognised.

A number of areas of outstanding practice were identified, including our Red Arrest Team which provides senior clinical support for patients who suffer a cardiac arrest, the introduction of palliative care nurses into our NHS 111 call centres to support end-of-life care, clinical developments within our Hazardous Area Response Team, our volunteer Community First Responder schemes, the placement of public access defibrillators in local communities and our Restart a Heart Day campaign which provides CPR training to secondary schoolchildren.

We have so much to be proud of but we acknowledge that there is always more we can do to improve our services and we will use the CQC's feedback to help shape future developments and raise standards further.

It has been vital for me to gain an insight into the work of our frontline ambulance staff and I have shadowed many employees which has given me an invaluable awareness of the incredible work they carry out on a daily basis amid a vast array of pressures and challenges.

As part of my role, I chair the YAS Forum which is an elected body that supports YAS to engage with the communities we serve. I enjoy meeting with YAS Forum members and welcome their expertise and honesty in helping us to shape the Trust's future.

I have the upmost admiration for the work carried out by Yorkshire Ambulance Service and our NHS partners and feel honoured to be part of such a valued and respected organisation. With ongoing pressures on health services and many fundamental changes to how we and others will provide care in the future, I am confident that we will continue to deliver a consistently high standard of care for our patients and communities and I look forward to being an integral part of that journey.

Kathryn Lavery
Chairman

“

The transformation of our A&E Operations is also well underway, including the implementation of a management restructure to provide frontline operational staff with better access to their supervisors and changing rota schedules and shift patterns to better meet the needs of patients

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Operational Review - Caring for our Patients

A&E Operations

The first point of contact for patients who need to use our emergency 999 service is our Emergency Operations Centres (EOCs). 999 calls are answered by our EOC staff who ask a series of carefully structured questions to determine the nature of the problem and arrange the most appropriate response to meet patients' needs. Call handlers play a key role in providing reassurance and advice over the telephone to people who are often upset and worried by the situation they are faced with.

In 2016-17, our EOC staff received 895,700 emergency and routine calls, an average of over 2,450 calls a day. We responded to a total of 723,935 incidents through either a vehicle arriving on scene or by telephone advice. Clinicians based in our Clinical Hub which operates within the EOC triaged and helped just under 100,000 callers with their healthcare needs.

Our Hazardous Area Response Team (HART) is part of the NHS contribution to the Government's National Capabilities Programme and Counter Terrorism (CONTEST) strategy. Its role is to provide NHS paramedic care to any persons within a hazardous environment that would otherwise be beyond the reach of NHS care. This includes the provision of clinical care within the inner cordon of incidents such as collapsed buildings or inland waterways.

Whilst being a locally-managed resource, is also a national asset and can be deployed anywhere in the UK to provide patient care and is on 30 minutes' notice to move to where they are required. YAS HART has 42 staff divided into seven teams operating 24/7. In 2016-17 the team responded to a wide range of incidents from injured individuals in difficult-to-reach locations through to multiple casualties.

We provide clinical governance and clinicians to the Yorkshire Air Ambulance which operates 365 days a year, predominantly in daylight hours. With new aircraft delivered in 2016-17 there is now greater scope to extend flying hours with night-flying and winching capability. Each aircraft has a pilot, consultant-level doctor and two YAS paramedics.

In addition to our own A&E operational staff, we are also supported by a team of volunteer Community First Responders and British Association for Immediate Care (BASICS) doctors, Emergency First Responders, HM Coastguard and Mountain Rescue Teams which are all available to respond to serious and life-threatening calls all year round.

Ambulance Response Programme Pilot

The demand for ambulance services has been increasing nationally year-on-year, putting a huge strain on the system. The reasons for this are complex, but include a growing and ageing population with changing needs and expectations. Despite this, the way ambulance care is delivered has remained broadly constant.

The Ambulance Response Programme (ARP) was established by NHS England in 2015 to review the way ambulance services operate, increase operational efficiency and to ensure a greater clinical focus. It is helping to inform potential future changes in national performance standards.

Yorkshire Ambulance Service, along with South Western Ambulance Service NHS Foundation Trust and West Midlands Ambulance Service NHS Foundation Trust, was invited to participate in the pilot Ambulance Response Programme which has now progressed through three elements:

- **Dispatch on Disposition which gives call handlers additional time to triage all but the most life-threatening calls to make sure the right resource is sent to each patient first time.**
- **A new system of clinical prioritisation for all 999 calls to better prioritise the sickest patients and to make sure the patient's urgency and clinical needs are matched to the best response to those needs.**
- **A new set of ambulance service measures, indicators and standards to make sure the sickest patients receive the fastest response and that all patients get the most appropriate response allocated to them first time.**

The University of Sheffield has been monitoring and evaluating ARP interventions and this will provide recommendations to help shape the way ambulance services operate in the future. Further details are available at: https://www.england.nhs.uk/ourwork/qual-clin-lead/arp/

A&E Performance against National Targets

Due to the Trust's participation in the Ambulance Response Programme (ARP) and the changes introduced in different phases of the trial, the performance data for 2016-17 does not directly correlate to the previous response categories and so the Trust is unable to publish performance against the national targets. For the evaluation of the trial and possible outcome proposals going forward not to be prejudiced prior to publication, the Trusts involved in the trial are unable to share their data externally during the trial period, however this will be released once the evaluation report is published.

Cardiac Arrest

Work has continued to develop and enhance the level of patient care delivered by the Red Arrest Team (RAT) paramedics to patients in cardiac arrest. The team is now fully embedded and provides leadership and advanced clinical skills at cardiac arrests across the region. Training has been delivered to clinical supervisors and will be extended to a number of paramedics who will be able to provide cover for the scheme particularly in rural areas.

Major Trauma

The Trust continues to work with the major trauma networks across the region to ensure that those patients involved in traumatic incidents receive the best possible care. This year the Trust has worked with the South Yorkshire network to provide an in situ simulation of a major trauma incident and involved staff from both YAS and the acute trusts. We have also worked with the North Yorkshire and Humberside Major Trauma Network on the trauma intermediate life support course where YAS provides a number of candidates and instructors for each programme. In addition, we have run a mass-casualty table-top exercise with Public Health England which was designed to stress test the West Yorkshire network in both the pre-hospital and in hospital settings.

Deteriorating Patients and Sepsis

Sepsis is a rare but serious complication of an infection that, without quick treatment, can lead to multiple organ failure and death.

To aid early identification of sepsis the Trust has developed a Pre Hospital Screening Tool in conjunction with Emergency Department consultants across Yorkshire. This year the screening tool has been updated using evidence from National Institute of Health and Care Guidance (NICE) guidance and the UK Sepsis Trust, and covers adults and children. YAS has adopted the National Early Warning Score (NEWS) as a system of detecting deteriorating patients and communicating with other healthcare professionals and the updated screening tool will now align with NEWS, and will continue to improve the management of septic patients in the pre-hospital environment.

Urgent Care Pathways

Urgent care pathways provide frontline ambulance clinicians with alternative options for managing patients to ensure they receive the most appropriate care available for their condition.

The pathways range from managing falls to referrals for patients with acute exacerbations of chronic breathing problems. New pathways developed in 2016-17 include the Doncaster single point of access for falls referrals, pathways for epilepsy patients in Bradford, the development of a falls services in West Yorkshire and a new pathway accessing the Minor Injuries Unit in Sheffield. Our alcohol pathway was highly commended in the Faculty of Public Health (FPH) and Public Health England (PHE) Award for contributions to public health in this year's Advancing Healthcare awards.

Further details about our clinical developments and public health initiatives during 2016-17 can be found in our Quality Account.

Ambulance Quality Indicators (AQIs)

Ambulance services are also measured against a combination of national system indicators and quality criteria. These are used to benchmark between ambulance trusts, promoting best practice and providing a framework for us to demonstrate and effectively plan for continuous service improvement.

The AQIs focus on three key areas of quality: Effectiveness, Patient Experience and Safety across five domains.

Upper Quartile Achievement

Survival to Discharge (STD) from out of hospital cardiac arrest – a patient being fit enough to leave hospital after suffering an out-of-hospital cardiac arrest is the most important quality indicator in resuscitation.

In 2016-17 the Trust completed the rollout of external chest compression devices to assist with cardiopulmonary resuscitation (CPR). These automated machines enable ambulance clinicians to provide effective and safe circulatory support in prolonged cardiac arrests and whilst moving the patient. They form part of the equipment used by our Red Arrest Teams which provide clinical leadership and extended clinical skills at cardiac arrest incidents.

In addition, we have continued to provide CPR training in local communities and extensively to school children through our Restart a Heart initiative.

Return of Spontaneous Circulation (ROSC) for patients who have suffered cardiac arrest is heavily influenced by the early commencement of Basic Life Support (BLS). We have continued to expand our Community First Responder (CFR) schemes and our co-responder schemes with Fire and Rescue Service colleagues across the region. In addition, we have increased the number of community Public Access Defibrillators (cPADs) available for use by the public. The Trust's Restart a Heart Day campaign is becoming more successful every year and 2016 was the best yet when we shared our concept with all UK ambulance trusts to support the roll-out of the event nationally. Over 150,000 youngsters received CPR training across the UK which is an incredible achievement.

Areas for improvement - Lower Quartile Rating

STEMI 150 – this measures the proportion of confirmed ST elevation heart attack patients undergoing treatment in specialist coronary care units within 150 minutes of an ambulance being requested. Every case that breaches the 150-minute target is reviewed and the reason for the breach identified. The Trust is responsible for only a very small proportion of the breaches with the majority due to factors outside our control.

Stroke 60 – this measures the proportion of patients assessed face-to-face and potentially eligible for stroke thrombolysis within agreed local guidelines arriving at a hospital with a hyper-acute stroke unit within 60 minutes of an emergency call. Cases that breach this guideline are recorded and the reason identified.

However, it is important to note that STEMI and stroke care bundle data in 2016-17 indicates that a consistently high level of care is being delivered to patients across all areas. Stroke care has shown outstanding performance emulated by December 2016's achievement of 98.8% and January 2017's performance of 99.1%. STEMI care performance also continues to depict high levels of achievement.

Fleet investment

As part of our fleet replacement programme, we have put 109 new emergency ambulances on Yorkshire's roads this year. The new vehicle design, which seeks to provide the highest quality environment for pre-hospital patient care has been a collaborative effort between staff representatives from across the Trust, including clinicians, Fleet, Procurement and Medical Devices Teams. The 109 Fiat Ducato vehicles have been built by Goole-based O&H Vehicle Conversions who have played an integral role in the innovative engineering design to reduce the weight of the ambulance, deliver reduced running costs and lower CO_2 emissions.

Patient Transport Service

Our Patient Transport Service (PTS) is one of the largest ambulance providers 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 includes those:

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

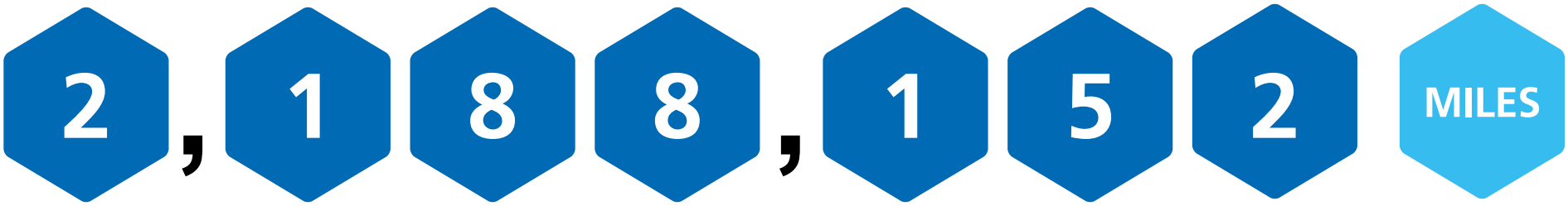
Our non-emergency PTS provides much-needed support to patients and their carers and is an extremely important part of our service.
Our PTS Team is made up of over 670 staff who undertook 1,020,621 non-emergency journeys in 2016-17.

Our PTS Team undertook

1,020,621

non-emergency journeys

Our team of Volunteer Car Service drivers covered a staggering



The PTS Transformation Programme is well underway and aims to ensure we have a PTS that provides an improved high quality, safe and efficient care to its patients, whilst being sustainable for the future.

So far, achievements in the Transformation Programme include:

- Developing a new service delivery model which has an improved flow for booking patients into the system, defining required resources and so optimising the resources to transport patients.
- Increasing the number of volunteer car drivers and private sub-contractors allowing us greater flexibility in delivering the service.
- Piloting the auto-planning of PTS journeys to increase the efficiency of patient collection and drop-offs to help reduce operating costs through more efficient automated planning.
- Piloting of a centralised resourcing function to ensure the most efficient deployment of staff and vehicles across Yorkshire.

PTS Volunteer Car Service (VCS)

Provides an invaluable service supporting PTS across the region, driving patients to and from medical appointments. Our team of VCS drivers has grown substantially from 62 to over 195 volunteers. This larger team covered a staggering 2,188,152 miles and carried out 116,664 patient journeys. This is a 40% increase on last year's mileage which was 1,553,900 and a 66% increase on last year's journeys which was 70,014.

PTS Patient Portal

A new online Patient Portal has been developed by PTS which allows patients to access and view their booked transport. It also allows patients to mark themselves ready via smartphones, view past and future journeys and cancel journeys. The aim is to improve the patient experience by ensuring that the correct transport is allocated to the right location at the correct time. The Patient Portal covers all of Yorkshire and was trialled by over 50 patients before going live in 2017-18.

PTS Contracts

During 2016-17 the PTS contracts in Hull, South Yorkshire and the East Riding of Yorkshire were put out to competitive tender. This was a challenging time for the service and the Trust is very proud of the professional conduct of staff during this period of uncertainty.

Whilst we were very disappointed to learn that Yorkshire Ambulance Service was not the preferred provider in Hull, we were delighted to secure a new five-year contract to deliver non-emergency health care patient transport services across South Yorkshire and the non-emergency medical transport services contract in the East Riding of Yorkshire.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NHS
AMBULANCE

NHS 111 and Urgent Care

NHS 111

Our Yorkshire and Humber NHS 111 service, which serves a population of 5.3 million people, continues to experience a year-on-year growth in patient calls with 1,570,254 calls answered in 2016-17, a rise of 3.9% from the previous year.

Our NHS 111 service was inspected for the first time by the Care Quality Commission (CQC) in October 2016 with the service being rated as 'Good' across all areas. The report detailed areas of excellence in care, practices and training including some aspects of innovation and workforce planning assessed as 'Outstanding'.

There are three areas within the report that the service is recommended to progress - clinical recruitment, staff support and audits, and the ability for staff to raise concerns linked to the culture which form part of our service development plans.

Service Developments

Locally this year, NHS 111 has supported the development of the region-wide Clinical Advisory Service that went live in December 2016. This has increased the specialist clinical support available for 999 and 111 callers in areas such as mental health, palliative care and pharmacy.

Key Performance

- 93.3% of calls answered within 60 seconds against a target of 95% (4.2% up on 2015-16).
- 79.7 % of clinical calls received a call back within two hours; whilst this was a decrease from 2015-16, more calls are being managed by clinical staff.
- Of the calls answered, 8.8% were referred to 999, 14.7% were given self-care advice and 6.5% signposted to the emergency department (ED). The remainder were referred to attend a primary or community care service or attend another service such as dental.
- In an independent survey 95% of patients agreed/strongly agreed that they were treated with dignity and respect, with 96% of patients feeding back that they followed the advice that they were given. 90% would recommend NHS 111 to their friends and family as overall satisfaction for the service continues to be extremely positive with 48 compliments received.

GP in-hours booking has been piloted across 27 practices in West Yorkshire; this involved surgeries making an appointment a day available to NHS 111 to book a patient into their surgery where their GP was deemed to be the most appropriate service to provide their care. The pilot will be utilised to inform a wider regional service.

NHS 111 has successfully introduced a flexible workforce model which provides clinicians with the necessary technology and support to enable them to work from home.

Working with NHS Digital, YAS has supported a pilot of the national NHS 111 Online service which went live on 1 March 2017. This is an exciting innovation and is been piloted with the Leeds clinical commissioning groups to inform the potential of a national online tool for the future.

YAS continues to support the national development of the NHS 111 service, particular around our workforce and was accepted as an Early Adopter for an NHS England initiative testing out ideas for national workforce competencies and career framework for staff working in Integrated Urgent Care/NHS 111.

YAS has also been successful in phase two of NHS England Workforce Investment pilots and is progressing two projects:

- Quality Audits: To look at how we can change the culture that currently exists within our call centres about how people view call audits. To help improve staff understanding, to improve confidence and the feeling of being supported.
- Supervision and Leadership: Making time for one-to-ones, ensuring they are effective and valued and to determine the optimum supervisor model in the call centres.

The NHS 111 Team's success has been recognised formally with awards including:

- the Wakefield and North Kirklees CCG Innovation Award for showing innovation in the evaluation and development of an NHS Pharmacy Team which supported the work of the Pharmacy Urgent Repeat Medication Scheme.
- National Professional Planning Forum Awards for our workforce management team - Wayne Deakin (Planning Hero Award) and John Senior (Best Newcomer Award).

Clinical Quality Developments

We continued to work with commissioners and suppliers including NHS Pathways to enhance service and referral pathways for patients calling NHS 111. During 2016-17 we successfully implemented two upgrades to the clinical content of the NHS Pathway which involved staff training and development on the new systems.

West Yorkshire Urgent Care

Our sub-contractor Local Care Direct supported 247,339 patients through the West Yorkshire Urgent Care service, a decrease of 5.2% from 2015-16. Whilst demand has fallen, it remains significantly above the contract base level. Working with commissioners, an independent review of the service has been undertaken which has highlighted changes to the current operating model, contract and finances for 2017-18 and to develop the service for the future.

Future Plans

The contract for NHS 111/West Yorkshire Urgent Care will be in its final year during 2017-18 and YAS has agreed to work with commissioners in terms of transitional arrangements to help with the development of their integrated urgent care service for the future.

West Yorkshire Urgent and Emergency Care Vanguard /West Yorkshire Acceleration Zone

As part of the West Yorkshire Urgent and Emergency Care Vanguard, the Trust has played a leading role in the development of the Clinical Advisory Service (CAS) which went live in December 2016. This service will continue to develop and support callers into both 999 and NHS 111 and provide advice to frontline staff which will help more patients to receive the care and treatment they need closer to home in their own communities.

At the end of 2016 West Yorkshire was selected by NHS England to become an Acceleration Zone for transforming services in urgent and emergency care and this has supported the development of home/ remote working for clinicians and increased clinician capacity in NHS 111.

Q-Volunteering

In November 2016 the Department of Culture, Media and Sport asked ambulance services to bid for funding to support the development of volunteering in the health sector.

The successful bid was to set up a project in conjunction with the British Red Cross to explore the relationship that YAS has with the voluntary sector and to understand how this can support patients in their community with urgent care needs. The project will also examine how we can better co-ordinate and maximise the huge benefits that our volunteer Community First Responders (CFRs) and car drivers bring to the organisation.

NHS 111 has supported the development of the region-wide Clinical Advisory Service that went live in December 2016. This has increased the specialist clinical support available for 999 and 111 callers in areas such as mental health, palliative care and pharmacy

Leadership and Learning

YAS Leadership Conference

A leadership conference was held at the start of 2016-17 to provide leaders and managers with a briefing about the operating plan for the year. Updates were also delivered on the previous year's performance and the importance of developing quality leadership to help the Trust achieve its objectives.

Apprenticeships

The deployment of apprenticeship training programmes across the Trust continues to evolve with a mixture of new starters and existing staff being signed up to start their programmes during 2016-17. The overall engagement with Apprenticeships remains strong as we prepare for the new Apprenticeship Levy with 54 starters in the last year.

We continued with our established apprenticeship schemes in the Patient Transport Service, Private and Events team, Corporate Affairs, Estates and Finance.

We continued with our established schemes in the Patient Transport Service, Private and Events team, Corporate Affairs, Estates and Finance. New schemes are now up and running in the EOC, with a view to growing this scheme through 2017-18.

Our second annual Apprenticeship Graduation Ceremony took place which was a true celebration of achievement and recognised the hard work and valuable contribution apprentices make to the ambulance service and our patients.

We have been actively promoting our apprenticeship scheme to reach all sections of our community, ensuring our apprentices reflect the population we serve. We have attended various career events within schools and colleges complemented by our own webpage www.yas.nhs.uk/apprenticeships

Leadership and Management Development

The Management Essentials Programme is now established as a key aspect of induction for newly-recruited and promoted managers and leaders across the Trust and is supported with a range of resources available through the Trust's virtual learning site.

For existing leaders we continue to build on capability around people management activities to embed an employee-centred approach. These workshops promote employee wellbeing and the fair and consistent application of Trust policies.

Learning Technologies

We continue to deliver learning for our staff through our online learning management system (YAS 247). Developments this year have included making content accessible on multiple platforms including mobile phones and tablets.

Our library of on-demand video content continues to grow with topics supporting clinical standard operating procedures. This facility allows staff to access resources at any time and from any device.

The Learning Technologies Team continued to support the development of promotional videos for Restart a Heart Day and the YAS Apprenticeship scheme. As well as providing access to conference events through hosting video footage for those who could not attend; this has included the College of Paramedics best practice day, the Trust's leadership conference and the Chief Executive's monthly Teambrief sessions.

Continuing Professional Development (CPD)

The Clinical Directorate continues to provide a range of high quality CPD events across the region and in 2016-17 these included a medico-legal event, three clinical events, a best practice day and six clinical simulation events.

Community and Commercial Education

The YAS Community and Commercial Education Team offers first aid training interventions for both the general public and private businesses across the Yorkshire region.

Corporate clients include Mars, Crown Prosecution Service, The Wilberforce Trust and St Gemma's Hospice. National contracts have been arranged via the National Ambulance Service First Aid Training consortium (known as NASFAT) for larger employers across the UK including Bourne Leisure, IKEA and Mitchells & Butlers.

First aid training courses are offered on a fully accredited basis by the Office of Qualifications and Examinations Regulation (Ofqual) and at the most recent external quality assurance audit in December 2016 the team was rated 'outstanding'.

The team works closely with the wider Community Engagement Team and is proud to support the following community projects:

- South Yorkshire Safer Roads Partnership
- Doncaster Metropolitan Borough Council's 'Reduce your Risk' campaign
- Biker Down – first aid training especially for cyclists/motorcyclists
- Heartstart – CPR training courses supported by the British Heart Foundation.


NHS
FIRST RESPONDER
GMB PRIDE

Diversity and Inclusion

Embracing Diversity - Promoting Inclusivity

YAS has defined a clear agenda to promote an inclusive, supportive, healthy and equitable working environment that is consistent with our values.

During 2016-17 we have made progress on some of the Workforce Race Equality Standard (WRES) indicators. We continue to develop further areas around the standard and have intensified our efforts to ensure the standard is being implemented across the Trust.

We have developed a strategic Diversity and Inclusion Steering Group which is chaired by the Executive Director of Operations who has been assigned as the 'Executive Sponsor' for Diversity and Inclusion. The role of the group is to steer the development and implementation of the Trust's first Diversity and Inclusion Strategy which has the following refreshed set of strategic and operational objectives:

- Education Empowerment and Support
- Effective Community Engagement and Involvement
- Promoting Inclusive Behaviour
- Improving Policy and Practice
- Reflective and Diverse Workforce
- Enhancing and maintaining knowledge and awareness about demography

Refreshed Objectives

- **Education Empowerment and Support**
- **Effective Community Engagement and Involvement**
- **Promoting Inclusive Behaviour**
- **Improving Policy and Practice**
- **Reflective and Diverse Workforce**
- **Enhancing and maintaining knowledge and awareness about demography**

These objectives are broken down into a comprehensive action plan and the formal launch of the strategy was planned for 2017-18.

We continue to engage and involve our staff equality networks, including the Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) networks, which have heavily influenced the development of our Diversity and Inclusion Strategy.

The Trust has recently developed a Disability Staff Network in readiness for the NHS England Disability Equality Standard. The first meeting of this network took place in February 2017 the group is in the process of defining the group's role and remit.

We recognise and acknowledge that our leaders and managers play a vital role in creating an organisational culture which values diversity and promotes a culture of dignity and respect. To ensure that leaders and managers are equipped with the knowledge and tools to drive this forward, we have created a leadership development opportunity around the diversity and inclusion agenda in the form of a workshop.

The Trust has now trained over 300 managers on this one-day mandatory training programme. Positive feedback has been received and we are already seeing a positive impact within the workplace. In addition to the managerial cohort, all members of the Trust Board attended the training in February 2017.

Staff Engagement

NHS Staff Survey

The results of the 2016 NHS Staff Survey were published by The Picker Institute on behalf of NHS England.

The survey showed marked improvement in a number of areas including rates of staff appraisal and identified areas where further work is required such as the ability for staff to contribute towards improvements at work.

The Your Voice, Our Future cultural audit and staff survey feedback from 2015 and 2016 has identified a number of key areas of required improvement. As a result, a project began in February 2017 with the specific objective of redesigning our organisational values through colleague engagement in order to more accurately reflect what our culture should be.

Long Service and Retirement Awards

On 6 September 2016 we honoured a total of 290 staff members, who had clocked up a combined 6,465 years' service between them, at our annual Long Service and Retirement Awards.

The awards ceremony took place in Harrogate, North Yorkshire and 140 members of staff attended the event to collect their awards from Chairman Kathryn Lavery, Chief Executive Rod Barnes, and special guest Mr Christopher James Blundell, Her Majesty's Deputy Lieutenant of North Yorkshire.

The Long Service and Retirement Awards honoured service achieved up to 2015. In total, 61 individuals were congratulated for achieving 20 years' service and 28 individuals for reaching the 30 years' service milestone.

Five staff were recognised for an incredible 40 years of service, three of whom attended the ceremony – Jane Barstow, NHS 111 Senior Clinical Advisor – Nurse (Rotherham), Peter Bethell, Advanced Emergency Medical Technician (Pocklington) and Janette Gallagher, NHS 111 Clinical Team Leader – Nurse (Wakefield).

Our longest serving member of staff at the awards was Ian Cambray who joined the ambulance service on 1 April 1975 and has served over 41 years and 5 months - and is still in service today!

The honours also included the Queen's Long Service and Good Conduct Medal, which was awarded to 20 staff on the day for 20 years' exemplary frontline emergency service and 28 retirees were also recognised for their valuable service to the Trust and people of Yorkshire.

We also presented two posthumous awards to families who have lost their loved ones in service. Neil Hare and Melvin Salisbury sadly passed away whilst in service and we were honoured that members of their families could attend the ceremony to receive awards on their behalf. Presentation of the posthumous awards was very emotional and staff gave a standing ovation for the families and Neil and Melvin's service.

Freedom to Speak Up Guardian

The Freedom to Speak Up Review (February 2015) was undertaken to provide advice and recommendations to ensure that NHS staff in England feel it is safe to raise concerns.

YAS launched its Freedom to Speak Up initiative in July 2016 with the appointment of a Freedom to Speak Up Guardian supported by Freedom to Speak Up Advocates representing all business functions across the Trust.

YAS Teambrief

We have continued with the YAS Teambrief initiative to encourage more face-to-face communication between managers and their staff. Initial briefings are provided by the Executive Team on a monthly basis to managers and supervisors across the Trust who are then asked to cascade these key organisational messages to their staff.

YAS TV

The Trust enhanced its existing internal communications channels with the launch of an electronic notice board, known as YAS TV, in July 2016. Screens in every ambulance station and buildings across the Trust now display important information including details of our strategy and plans, clinical and operational alerts, and other good-to-know items. The content is refreshed regularly and it is an instant way to get information to frontline staff.

WE CARE Awards

The fifth annual WE CARE Awards ceremony was held in York in July 2016 when staff and teams were honoured for their dedication, commitment and for going the extra mile for patients and colleagues.

At the special awards dinner congratulations went to over 200 members of staff who were nominated. The winners and those who were highly commended in each category were also announced.

In addition, Chief Executive Rod Barnes presented commendations to a number of frontline staff in recognition of exemplary actions at emergency incidents.

Staff Forum

YAS Staff Forum members represent the views of staff who can raise any suggestions, comments or concerns with them. They are then able to take these to their regular meetings with the wider YAS Forum and Chief Executive.

Joint Steering Group

Representatives from the Trust Management Group and recognised unions meet on a regular basis to discuss topical issues affecting staff.

Partnership Working

Community Engagement and Public Education

The Trust has over 8,000 public members which is representative of the diverse local population which makes up the Trust's extensive geographical area. Our target of securing over 75% of eligible staff as members has also been exceeded.

We are keen for our members to act as ambassadors for the Trust and engage with local communities in raising awareness of YAS's services and topical public health issues. The YAS Forum, which is made up of elected public, staff and appointed members, has been working diligently to support this objective through its own engagement work with local groups. The appointed members represent the wide external stakeholder interests of the Trust.

The Trust also held a programme of roadshows which took place across the Yorkshire and Humber region. These events provided members of the public with an opportunity to learn more about the ambulance service, first aid training, and find out about possible careers and volunteering opportunities at the Trust. Events were held in Sheffield, Bradford, Scarborough, Leeds and Hull and over 1,100 people came to the event in Centenary Square, Bradford in May alone.

An example of this is the Family Fun Day held at the Al Mahdi Mosque in Bradford in August 2016. More than 200 members of the local community attended the event to find out more about the Trust, learn cardiopulmonary resuscitation (CPR) and to view a selection of emergency vehicles, which included an ambulance, a rapid response vehicle (RRV) and our Community Medical Unit.

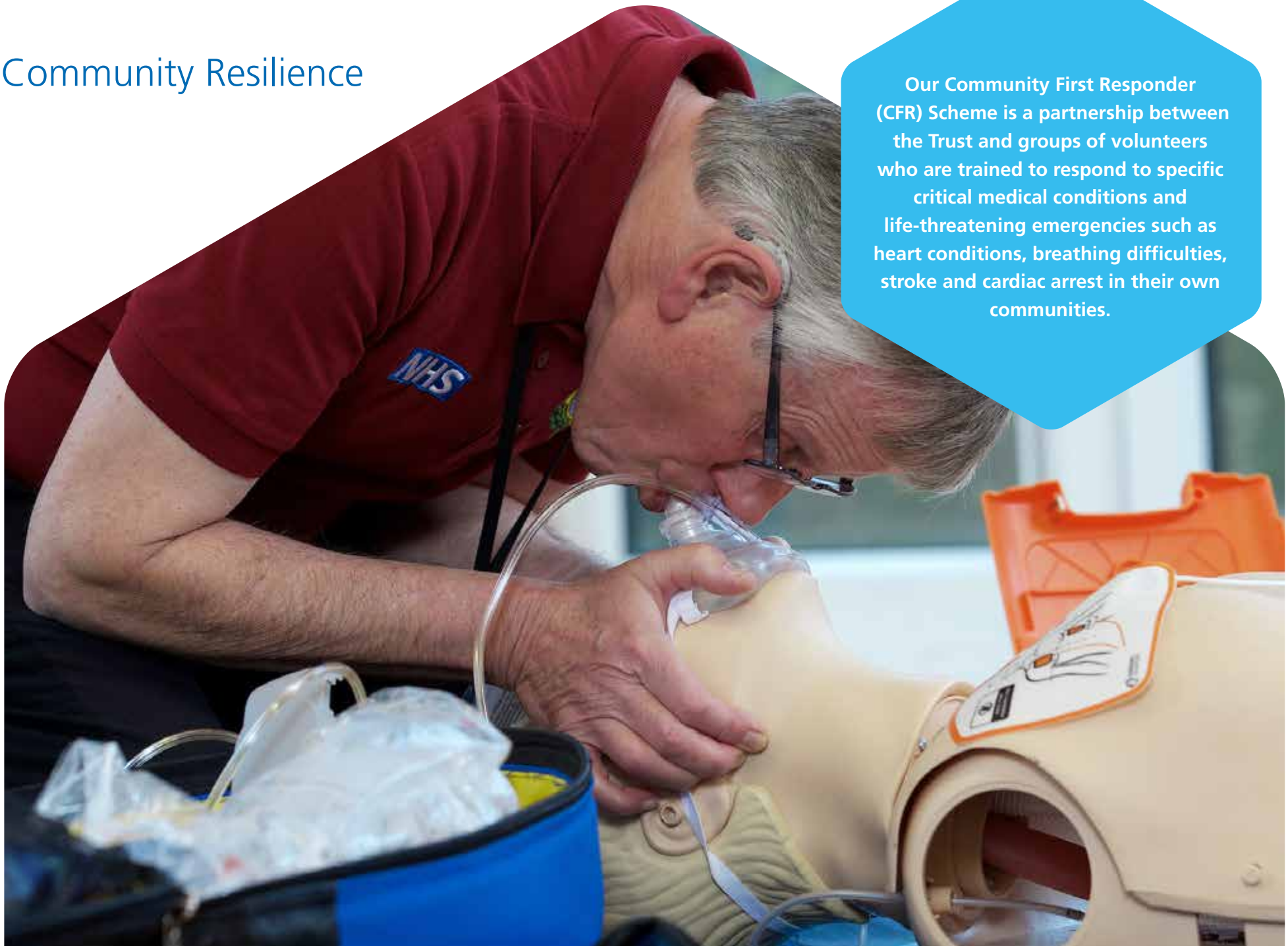
YAS staff were on hand to teach CPR and first aid familiarisation. Children were also entertained, taking part in the CPR sessions, playing a health-educational game of giant snakes and ladders and learning when it is appropriate to call 999. Chief Executive Rod Barnes, the Deputy Lord Lieutenant of West Yorkshire Stan Hardy and the Lord Mayor and Lady Mayoress of Bradford attended to meet local residents.

In 2017-18, the Trust's community engagement programme will continue to help deliver key public health messages as well as raising awareness of the work undertaken by the ambulance service. Roadshows are being planned in Rotherham, Doncaster, Leeds, Wakefield, Bradford, Scarborough, Sheffield and Hull to meet with members of the public, provide information about our services and listen to their views.

The free First Aid Awareness training courses continue to offer members and local community groups the opportunity to learn key live-saving skills. Last year we delivered 135 courses, reaching around 2,900 participants, including adults and children with learning disabilities, college students, army cadets, primary and junior school children, Scouts, Beavers, Cubs, Brownies and Girl Guides, the Leeds Migrant Access Project, Sikh Gudwara Temple and the Leeds travelling community.

Events provided members of the public with an opportunity to learn more about the ambulance service, first aid training, and find out about possible careers and volunteering opportunities at the Trust

Community Resilience



Our Community First Responder (CFR) Scheme is a partnership between the Trust and groups of volunteers who are trained to respond to specific critical medical conditions and life-threatening emergencies such as heart conditions, breathing difficulties, stroke and cardiac arrest in their own communities.

We currently have 1,015 CFRs across Yorkshire and the Humber who belong to 324 CFR schemes. In addition, we now have 37 co-responder schemes which include Mountain Rescue, Coastguard, Lifeguards, St John Ambulance, North Yorkshire Rangers and Fire and Rescue Services.

There are also 3,389 static defibrillator and community Public Access Defibrillator (cPAD) sites at places such as airports, railway stations, shopping centres, some GP practices and police custody suites. 923 of these locations have public access 24/7, 365 days a year.

In 2016-17, the number of calls attended by Community Resilience, which includes our volunteer CFRs, was 22,260 incidents, compared to 18,261 the previous year. Their quick response means they are on hand in the vital first few minutes of an emergency to provide life-saving treatment.

This positively contributes to patient outcomes as demonstrated by the Trust's Ambulance Quality Indicators, such as Return of Spontaneous Circulation (ROSC), stroke and out-of-hospital cardiac arrest survival to discharge data.

Success Stories

YAS aims to deliver the best care possible for the people of Yorkshire and Humber. Some achievements over the last year included:

- CFRs have attended 208 cardiac arrests, with 22 resulting in a survival to discharge outcome for the patient. On 79 of the 208 occasions a CFR arrived on scene as the first resource and commenced CPR prior to ambulance back-up arriving.
- Working in conjunction with parish councils, clinical commissioning groups, Rotary and Lions clubs and many more, there has been a significant increase in the number of community Public Access Defibrillators (cPADs) at both busy and remote areas across Yorkshire, almost doubling from 488 in 2015-16 to 923 in 2016-17.
- Rotherham became the first borough in the UK to use its libraries to loan out British Heart Foundation (BHF) CPR kits to the public. In addition, CPADs are being placed in each of 15 communities through a partnership between YAS, the BHF, Start-a-Heart 24:7 and Westfield Health.

- Doncaster Fundraiser Pat Gardner continues to work with the Community Resilience Team and the YAS Charitable Fund on defibrillator installations across Yorkshire. In 2016-17 she donated seven automated electronic defibrillators (AEDs) to Leeds Armouries, Whitby Abbey, Wentworth Woodhouse, Elsecar Heritage Centre, Cannon Hall, James Heriott Museum and Bempton Cliffs RSPB.
- As well as providing volunteers for the YAS Restart a Heart Day in October 2016, we have provided hands-only CPR training to an additional 30,943 members of the public of all ages.

Ambitions for 2017-18

- As well as recruiting and retaining CFRs, we aim to be able to increase the number of hours they contribute from four hours to seven hours per week (CFRs gave 325,258 hours in 2016-17).
- In conjunction with CCGs, parish councils and community groups, we aim to increase the number of static and cPAD sites by a further 10%.

Ellen Hallas' Story

Ellen Hallas, 50, of Thurnscoe, Barnsley, collapsed while working on a production line at Kostal UK Ltd in Goldthorpe, Rotherham, in December 2016, owing to an existing heart condition; hypertrophic cardiomyopathy.

She was placed in the recovery position by work colleague Hilary South before her daughter Rachel, 25 - a Team Leader at the firm and qualified Community First Responder with YAS became aware of the situation and quickly realised she needed to start cardio-pulmonary resuscitation (CPR) in an attempt to save her mother's life.

Rachel then assisted her colleagues Gavin Haynes and Paul Saunders, both trained first aiders, who used the on-site defibrillator to restart Ellen's heart and continued CPR until she started breathing again, supported over the phone by the ambulance call taker. The ambulance crew arrived shortly afterwards to continue Ellen's care before taking her to Barnsley Hospital. She remained in hospital for five weeks and was fitted with an Implantable Cardioverter Defibrillator (ICD) which, in the event of cardiac arrest, automatically delivers a shock to help restart the heart.

Rachel has been a volunteer Community First Responder for Yorkshire Ambulance Service in her local area for two years, having joined specifically due to her mum's heart condition so that she knew what to do if her mum was ever in difficulty.

She said:
"I went into autopilot when I saw mum had collapsed. When I began as a Community First Responder I didn't know if I would be able to attempt CPR on anyone, never mind a close family member. I'm really glad I had those skills and knew what to do as I don't think my mum would still be here if I hadn't."

Ellen said: *"I am in awe of the people who saved my life; I can't thank them enough. It shows how important it is for workplaces to have defibrillators on their premises because without the kit at Kostal and the efforts of my daughter and colleagues who did CPR, I wouldn't be here today."*

Interested in finding out more about becoming a community first responder?

Contact our Community Resilience Team:
Phone: ***0333 130 0516***
Email: ***responders@yas.nhs.uk***

Charitable Fund

Yorkshire Ambulance Service has its own Charitable Fund which receives donations and legacies from grateful patients, members of the public and fundraising initiatives throughout Yorkshire.

The Charitable Fund supports the work of the Trust and uses funds to provide additional training and equipment for services over and above the level that would normally be delivered as part of our core NHS funding.

The Trust, through the Board, is responsible for the management of these funds as Corporate Trustee. We ensure these funds are managed independently from our public funding by administering them through a separate Charitable Fund Committee.

A fundraiser supports this work and raises the profile of the YAS Charitable Fund.

During 2016-17 the Charitable Fund continued to work in partnership with a number of local groups and associations by part-funding community public access defibrillators across the region.

We once again supported our Restart a Heart Day campaign which saw over 20,000 youngsters receive cardiopulmonary resuscitation (CPR) training on 18 October 2017.

Other projects included state-of-the-art training equipment being introduced at four ambulance stations in memory of a well-loved colleague, support of our BASICS doctors, the Emergency Services Museum in Sheffield and the provision of free first aid training across Yorkshire and the Humber.

Make a donation

If you would like to make a donation to the YAS Charitable Fund:

- **Text YCMU followed by £1, £2, £3, £4, £5 or £10 to 70070**
- **The donation will be taken directly from your phone bill if contract, or from your balance if you have a pay as you go phone. Standard network rate messages apply.**
- **Donate via our fundraising page - uk.virginmoneygiving.com/charities/yas-3**

The Charitable Fund can be contacted in the following ways:

- **01924 584210/07824 540107**
- **charitablefunds@yas.nhs.uk**
- **www.yas.nhs.uk/charitablefund**
- **www.facebook.com/YASCF**
- **www.twitter.com/YorksAmbulance**

How We Work

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 quarter and our Annual General Meeting is held in September each year. These are open to members of the public.

We always welcome comments about our services so that we can continue to improve.

If you have used our services and have a compliment, complaint or query, please do not hesitate to contact us, email patient.relations@yas.nhs.uk

Please note, our complaints procedure is based on the Principles for Remedy, which are set out by the Parliamentary and Health Service Ombudsman.

Environmental Policy

Yorkshire Ambulance Service is committed to ensuring that our buildings, fleet 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 and patient care.

The Trust has an Environmental Policy in place to ensure the reduction of its actions on the environment. 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, Procurement and Fleet departments.

All 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.

Looking Forward to 2017-18

The year ahead is set to be an exciting time for new fleet additions. YAS will become the first ambulance service in the country to have hydrogen electric powered vehicles in its fleet. The vehicles are funded by the Office of Low Emission Vehicles. We have also won funding for a hydrogen diesel retrofit project for some of our vehicles.

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 as well as our operations through our fleet and our estate. This is set out in our policies on sustainable procurement.

We are looking to roll out more solar panels on our buildings, introduce waterless urinals across the entire estate, install more bike racks, develop a more efficient fleet and ensure that we continue to reduce our carbon footprint through a variety of different initiatives.

YAS Sustainability Report 2016-17

Yorkshire Ambulance Service was the first ambulance service in the country to draw up a Carbon Management Plan, identifying the areas in which we can reduce our carbon footprint. 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.

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

We have incorporated the following points in our Carbon Management Report:

- We installed solar panels on our new fleet of double crewed ambulances which trickle charge batteries to reduce carbon dioxide and nitrogen oxide emissions.
- We have stopped sending waste to landfill (a small amount is still produced as 'flock' from incineration) and are working to reduce the amount of waste that we generate through more paperless operations and returning waste to the suppliers. Waste diverted from landfill now goes to recovery for fuel.
- We have five sites that have solar generation systems installed on their roofs, contributing 173,000kWh of energy per annum into our energy system.
- We have installed LED lighting panels at many of our sites in order to reduce our energy use.
- We are installing waterless urinals across the estate in 2017-18 as well as upgrading the toilets and taps in an effort to dramatically reduce water consumption.
- We will have three hydrogen hybrid vehicles on our fleet in 2017.
- The Trust was instrumental in driving forward an aerodynamic lightweight ambulance design. The first re-designed ambulances were introduced into the fleet in 2014. Aerodynamic designs have been adopted nationally into procurement requirements.
- Our staff energy reduction and fuel awareness campaign is ongoing throughout 2017-18.
- 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. YAS has put together a Climate Change Adaptation Plan to look to the challenges we face into 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.

Information Governance

Information Governance is to do with the way organisations 'process' or handle information. It covers personal information, ie relating to patients/service users and employees, and corporate information, eg financial and accounting records.

YAS is committed to dealing consistently with the many different rules about how information is handled, including those set out in legislation, regulation, guidelines and best practice.

The Senior Information Risk Owner (SIRO) during 2016-17 was Steve Page, who is the Executive Director of Governance, Quality and Performance Assurance. The SIRO is a senior management board member who takes overall ownership of the organisation's information risk policy, acts as champion for information risk on the Board and provides written advice to the Accountable Officer on the content of the organisation's Governance Statement for information risk.

The Caldicott Guardian during 2016-17 was Dr Julian Mark, who is the Executive Medical Director. A Caldicott Guardian is a senior person responsible for the protection of the confidentiality of patient and service-user information and appropriate information-sharing.

The NHS Information Governance Toolkit is an improvement tool published and managed by NHS Digital, which draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements (or standards).

A total of 35 Information Governance Toolkit requirements support the provision of good information governance within the Trust. Over the past four financial years the Trust has increased its self-assessment submission score by 10% to a score of 83% (rated 'satisfactory' against a satisfactory/unsatisfactory rating regime).

Over the last year, the Trust has made progress against its Information Governance work programme. This year the process of improvements included:

- continuing to make sure our staff are trained in the confidentiality, data protection and information security of personal information through refresher training, team meetings and awareness of Information Governance in staff newsletters and on YAS TV
- continuing to make sure our transfers of paper-based and electronic personal information are proportionate, justifiable and secure
- reviewing our policies, strategies, procedures and protocols to ensure that they reflect Information Governance best practice and legislation
- working with departmental Information Asset Owners to embed effective information risk management procedures within their service areas.

Serious Incidents Requiring Investigation

During 2016-17 there were two personal data-related incidents that met the Information Governance Serious Incidents Requiring Investigation (IG SIRI) criteria at Level 2 severity or above (see Table 1). Such incidents require reporting to the Information Commissioner's Office, Department of Health and other regulators as well as detailing within NHS Trust annual reports.

Both incidents were formally investigated using the Trust's established serious incident investigation procedures. Recommendations for changes and improvement to existing operational practices have been made as part of this process. Following the Trust's containment, investigation and implementation of actions, the Information Commissioner's Office did not feel it necessary to take any further enforcement action in relation to these incidents. The Trust will continue to monitor its information related risks in order to identify and address any risks and ensure continuous improvement of its information governance arrangements.

The Trust had personal data-related incidents at a lower level of severity (Level 1) and these are detailed in the Table 2.

Themes and trends from personal data-related incidents are analysed and presented to the Information Governance Working Group to ensure that the organisation learns lessons and puts in place measures to prevent reoccurrence. All staff are proactively encouraged to report incidents relating to the loss or disclosure of personal and sensitive data.

Table 1: Summary of Serious Incidents requiring investigations involving personal data as reported to the Information Commissioner's Office 2016-17

Date of incident	*Nature of incident*	*Nature of data*	*Number of data subjects potentially affected*	*Notification steps*	*Further action on information risk*
August 2016	Copy payslips disclosed in error	Name; salary; NI No.	1,440	Individuals notified by email and post	Changed access to information to prevent error happening again. Monitoring of records for unusual activity
January 2017	One disciplinary outcome letter disclosed in error	Disposal by Consent (relating to disciplinary matter)	1	Individual notified by post	Access to contact details limited to one database; additional checks to prevent error happening again

Table 2: Summary of other personal data related incidents in 2016-17

Category	*Breach Type*	*Total*
A	Corruption or inability to recover electronic data	
B	Disclosed in Error	8
C	Lost in Transit	
D	Lost or stolen hardware	
E	Lost or stolen paperwork	16
F	Non-secure disposal - hardware	
G	Non-secure disposal - paperwork	
H	Uploaded to website in error	
I	Technical security failing	2
J	Unauthorised access/disclosure	
K	Other	

Fraud Prevention

Yorkshire Ambulance Service NHS Trust is committed to supporting NHS Protect which leads on work to identify and tackle crime across the health service and, ultimately, helps to ensure the proper use of valuable NHS resources and a safer, more secure environment in which to deliver and receive care.

Our local contact for reporting potential fraudulent activity or obtaining advice is via East Coast Audit Consortium (ECAC), Crosskill House, Mill Lane, Beverley, East Riding of Yorkshire, HU17 9JB. www.eastcoastauditconsortium.org

Going Concern Statement

After making enquiries the Board has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. In making this assessment the Board formed a view on appropriateness of going concern, advised by the 30 May 2017 Audit Committee meeting which considered:

- Current and future contracts
- Cash flow and ability to pay debts
- Identification of Cost Improvement Programmes (CIPs)
- Regulatory concerns regarding quality or finance
- Financial duties and ratios
- Delivery of operational performance standards

As a result the Board is not aware of any material uncertainties in respect of events or conditions that cast significant doubt upon the going concern status of the Trust. For these reasons the Board continues to adopt a going concern basis in preparing the accounts.

Corporate Governance Report

The Trust Board 2016-17

Kathryn Lavery
(from 1 July 2016)

Chairman

Della M Cannings QPM
(until 9 May 2016)

Chief Executive

Rod Barnes

Mark Bradley
(from 1 March 2017)

Executive Director of Finance and Performance

Robert Toole (Interim)
(from 11 August 2015 - 28 February 2017)

Steve Page

Executive Director of Quality, Governance and Performance Assurance

(previously Executive Director of Standards and Compliance)

Dr Julian Mark

Executive Medical Director

Dr David Macklin

Executive Director of Operations

Roberta Barker (Interim)
(from 1 February 2016)

Director of Workforce and Organisational Development

Leaf Mobbs

Director of Planning and Development

Dr Philip Foster

Director of Planned and Urgent Care

Non-Executive Directors

Patricia Drake

Acting Chairman from 10 May - 30 June 2016

Erfana Mahmood

Barrie Senior

Mary Wareing

Until 31 August 2016

John Nutton

Ronnie Coutts

Designate up until 24 October 2016

Phil Storr

Associate from 31 January 2017

Tim Gilpin

Associate from 31 January 2017

Directors' Disclosure Statement

Each of the directors in post at the time of the Annual Report being approved can confirm that:

- so far as the directors are aware, there is no relevant audit information of which the Trust's auditor is unaware, and
- they have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information

Trust Board and Committee Membership 2016-17

The Trust Board and Committee membership at Tier 1 committees is as follows:

Committee	*Membership*
Quality Committee	Three Non-Executive Directors Executive Director of Quality, Governance and Performance Assurance Executive Medical Director Director of Workforce and Organisational Development Executive Director of Operations Director of Planned and Urgent Care
Audit Committee	Non-Executive Directors, excluding Trust Chairman and Chairpersons of the Quality and Finance and Investment Committees
Finance and Investment Committee	Three Non-Executive Directors Chief Executive Executive Director of Finance Executive Director of Operations Director of Planning and Development
Charitable Funds Committee	Two Non-Executive Directors Executive Director of Finance (or Head of Financial Services) Trust Secretary Fund Manager Head of Corporate Communications At least one staff member from a frontline service area
Remuneration and Terms of Service Committee	Chairman and all Non-Executive Directors

Declaration of Interests for the Financial Year 2016-17

Name/Dates	*Paid Employment*	*Directorships of Commercial Companies*	*Shareholdings*	*Elected Office*	*Trusteeships or participation in the management of charities and other voluntary bodies*	*Public Appointments (paid or unpaid)*	*Membership of professional bodies/trade association or bodies*
NON-EXECUTIVE DIRECTORS (NEDs)							
Kathryn Lavery Chairman 1 July 2016	Non-Executive Director Navigo, North East Lincolnshire	Director Kath Lavery Associates	None	None	Trustee of YAS Charity Chairman of Hull Kingston Rovers Community Trust Chair of Active Humber Chairman of Humber Business Week	None	Fellow Institute of Directors
Ronnie Coutts 25 October 2016	Serco Ltd	None	None	None	Trustee of YAS Charity Trustee of the Alexander Fairey Memorial Fund Charity No: 10704088	None	None
Patricia Drake Deputy Chairman/NED 4 October 2010 Interim Chairman 10 May 2016 to 30 June 2016	Specialist Advisor Care Quality Commission (CQC)	None	None	None	Trustee of YAS Charity	Vice Chair Locala Justice of the Peace Governor of Calderdale College	Royal College of Nursing
Erfana Mahmood NED 15 May 2012	Chorley and District Building Society Walker Morris	Chorley and District Building Society	None	None	Trustee of YAS Charity	None	Member Law Society
John Nutton NED 5 June 2015	Self-employed Corporate Finance practitioner, Springwell Corporate Finance in association with Cattaneo LLP	The Carbis Beach Apartments Management Company Limited	None	None	Trustee of YAS Charity	None	Fellow Institute of Chartered Accountants in England and Wales
Barrie Senior NED 16 August 2012	Self Employed (NED) AHR Management Services Self Employed Partner, Senior Associates LLP	None	None	None	Trustee of YAS Charity	None	Fellow Institute of Chartered Accountants in England and Wales

Name/Dates	*Paid Employment*	*Directorships of Commercial Companies*	*Shareholdings*	*Elected Office*	*Trusteeships or participation in the management of charities and other voluntary bodies*	*Public Appointments (paid or unpaid)*	*Membership of professional bodies/trade association or bodies*
CHIEF EXECUTIVE OFFICE AND EXECUTIVE DIRECTORS							
Rod Barnes Chief Executive Officer 6 May 2015	None	None	None	None	Trustee of YAS Charity	CEO Lead of Northern Ambulance Alliance Chairman of the Finance Advisory Board NHS Improvement Ambulance Sustainability Review	Chartered Institute of Management Accountants Healthcare Financial Managers Association (HFMA)
Roberta Barker Director of Workforce and Organisational Development (Interim) 1 February 2016	None	Director of J&L People Ltd	None	None	None	None	Chartered Institute of Personnel and Development
Mark Bradley Executive Director of Finance 1 March 2017	None	None	None	None	Trustee of YAS Charity	None	Chartered Institute of Management Accountants Healthcare Financial Managers Association (HFMA)
Dr David Macklin Executive Director of Operations 7 May 2015	None	None	None	None	Trustee of YAS Charity Medical Director, Yorkshire Air Ambulance Charity	Associate Tutor Emergency Services Training Centre, Wirral Board Member, NHS Pathways Programme Board, HSCIC	British Medical Association Fellow Institute of Civil Protection & Emergency Management Faculty of Pre Hospital Care of the Royal College of Surgeons of Edinburgh British Association of Immediate Care Schemes Medical Protection Society Faculty of Medical Leadership and Management

Name/Dates	*Paid Employment*	*Directorships of Commercial Companies*	*Shareholdings*	*Elected Office*	*Trusteeships or participation in the management of charities and other voluntary bodies*	*Public Appointments (paid or unpaid)*	*Membership of professional bodies/trade association or bodies*
CHIEF EXECUTIVE OFFICE AND EXECUTIVE DIRECTORS							
Dr Julian Mark Executive Medical Director 1 October 2013	None	None	None	None	Trustee of YAS Charity	Chair of National Ambulance Service Medical Directors (NASMeD) Board Member of Faculty of Pre Hospital Care of the Royal College of Surgeons of Edinburgh Member of NHS Improvement Clinical Advisory Forum	Faculty of Pre Hospital Care of the Royal College of Surgeons of Edinburgh British Association of Immediate Care Schemes British Medical Association Medical Protection Society Faculty of Medical Leadership and Management
Steve Page Executive Director of Quality, Governance and Performance Assurance (previously titled Standards and Compliance) 1 October 2009	None	None	None	None	Trustee of YAS Charity	None	Nursing and Midwifery Council Registration

Name/Dates	*Paid Employment*	*Directorships of Commercial Companies*	*Shareholdings*	*Elected Office*	*Trusteeships or participation in the management of charities and other voluntary bodies*	*Public Appointments (paid or unpaid)*	*Membership of professional bodies/trade association or bodies*
ASSOCIATE NON-EXECUTIVE DIRECTORS							
Tim Gilpin 31 January 2017	None	MD of TGHR Ltd	None	None	None	School Governor Dixons Multi Academy Trust	Chartered Institute of Personnel and Development
Phil Storr 31 January 2017	MRL Eye Limited	MRL Eye Limited MRL Safety Ltd Medical Response Logistics Limited MRL Environmental Ltd Burn Grange Properties Ltd	None	Vice-Chair Burn Parish Council	None	Visiting Lecturer Loughborough University Visiting Lecturer Bournemouth University Associate - Emergency Planning College	Associate - Emergency Planning Society Institute of Civil Protection and Emergency Management Health and Care Professions Council Federation of Small Businesses
NON-VOTING DIRECTORS (OFFICERS)							
Dr Philip Foster Director of Planned and Urgent Care 6 May 2016	Sessional work at Bassetlaw Hospice	None	None	None	None	None	British Medical Association MDDUS Associate of Palliative Medicine
Leaf Mobbs Director of Planning and Development 13 June 2016	None	None	None	None	None	None	None

Name/Dates	*Paid Employment*	*Directorships of Commercial Companies*	*Shareholdings*	*Elected Office*	*Trusteeships or participation in the management of charities and other voluntary bodies*	*Public Appointments (paid or unpaid)*	*Membership of professional bodies/trade association or bodies*
ARCHIVED INTERESTS: NON-EXECUTIVE AND EXECUTIVE DIRECTORS							
Della M Cannings QPM Chairman May 2010 to 9 May 2016	Sole Trader Specialist Advisor Care Quality Commission (CQC) Ministry of Defence	None	None	None	Director/Trustee of North Yorkshire Youth Ltd (company limited by guarantee and registered charity) Trustee of NHS Providers Trustee of YAS Charity until 9 May 2016	Lay Member of The Lord Chancellor's Advisory Committee for North and West Yorkshire	Institute of Directors Royal Society for the Encouragement of Arts, Manufactures and Commerce
Mary Wareing NED 1 October 2012 to 31 August 2016 (resigned)	Lamont Wareing Ltd	Director - Lamont Wareing Ltd	None	None	Trustee of YAS Charity until 31 August 2016	None	None
Ronnie Coutts (NED Designate) 1 July 2015 to 24 October 2016 (appointed NED substantive)	Serco Ltd	None	None	None	Trustee of the Alexander Fairey Memorial Fund Charity No: 10704088	None	None
Robert D Toole Executive Director of Finance and Performance (Interim) Consultancy Services provider via Limited Company 11 August 2015 to 28 February 2017	None	Director of RDT Management Services Limited	None	None	None	None	Chartered Institute of Management Accountants (Fellow) Healthcare Financial Managers Association (HFMA)

Remuneration and Staff Report

Remuneration Policy

All permanent Executive Directors are appointed by the Trust through an open 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 approved by the Remuneration and Terms of Service Committee, a sub-committee of YAS's Trust Board and which, under current arrangements for ambulance services, requires the approval of NHS Improvement (NHSI).

In determining the remuneration packages of Executive Directors and Very Senior Managers (VSMs) the Trust fully complies with guidance issued by the Department of Health and the Chief Executive of the NHS, as supplemented and advised by NHSI responsible for the North of England. Non-Executive Directors are appointed by NHSI following an open selection procedure.

Non-Executive Director appointments are usually fixed-term for between two and four years and remuneration is in accordance with the national formula.

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 VSMs.

When considering the pay of Executive Directors and VSMs, the Committee applies the Department of Health guidance. The current consumer price index (CPI) applied to pensions is 0%.

Salaries and Allowances of Senior Managers

This table has been subject to audit. Note: There are no disclosures in respect of performance pay or bonuses as the Trust make no payments of these types.

	2016-17				2015-16			
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) All pension-related benefits (bands of £2,500)	(d) TOTAL (a to c) (bands of £5,000)	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) All pension-related benefits (bands of £2,500)	(d) TOTAL (a to c) (bands of £5,000)
	£000	£00	£000	£000	£000	£00	£000	£000
David Whiting Chief Executive[1]	n/a	n/a	n/a	n/a	15-20	11	(12.5-10.0)	5-10
Rod Barnes Chief Executive	130-135	70	30-32.5	165-170	130-135	63	115.0-117.5	240 -245
Ian Brandwood Director of People and Engagement[2]	n/a	n/a	n/a	n/a	60-65	0	72.5 -75.0	130 -135
Steve Page Executive Director of Quality, Governance and Performance Assurance	105-110	65	15-17.5	125-130	105-110	57	(30.0-27.5)	80 -85
Dr Julian Mark Executive Medical Director	125-130	0	27.5-30	155-160	125-130	0	35.0-37.5	160 -165
Dr David Macklin Executive Director of Operations	110-115	67	25-27.5	145-150	110-115	69	70.0-72.5	190 -195
Robert Toole Executive Director of Finance and Performance (Interim)[3]	175-180	0	0	175-180	120-125	n/a	n/a	120-125
Mark Bradley Executive Director of Finance[4]	10-15	0	77.5-80	85-90	n/a	n/a	n/a	n/a
Alex Crickmar Executive Director of Finance (Interim)[5]	n/a	n/a	n/a	n/a	30-35	0	25.0-27.5	55-60
Roberta Barker Director of Workforce and Organisational Development	135-140	0	0	135-140	20-25	0	0	20-25
Leaf Mobbs Director of Planning and Development[7]	80-85	0	50-52.5	130-135	n/a	n/a	n/a	n/a

Notes: *(1) to 14 May 2015 (2) to 11 October 2015 (3) to 28 February 2017. Values for 2015-16 have been restated. (4) from 1st March 2017 (5) Interim Director of Finance from 17 November 2014 to 10 August 2015 (6) from 1 February 2015 (7) from 13 June 2016*

	2016-17				2015-16			
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) All pension-related benefits (bands of £2,500)	(d) TOTAL (a to c) (bands of £5,000)	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) All pension-related benefits (bands of £2,500)	(d) TOTAL (a to c) (bands of £5,000)
	£000	£00	£000	£000	£000	£00	£000	£000
Dr Philip Foster Director of Planned and Urgent Care[8]	115-120	0	0	115-120	n/a	n/a	n/a	n/a
Kathryn Lavery Chairman[9]	25-30	0	0	25-30	n/a	n/a	n/a	n/a
Della M Cannings QPM Chairman[10]	0-5	n/a	n/a	0-5	20-25	0	0	20-25
Patricia Drake Deputy Chairman and Non-Executive Director[11]	5-10	0	0	5-10	5-10	0	0	5-10
Elaine Bond Non-Executive Director[12]	n/a	n/a	n/a	n/a	5-10	0	0	5-10
Mary Wareing Non-Executive Director[13]	0-5	0	0	0-5	5-10	21	0	5-10
Erfana Mahmood Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Barrie Senior Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Ronnie Coutts Non-Executive Director[14]	5-10	0	0	5-10	0-5	0	0	0-5
John Nutton Non-Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
Phil Storr Associate Non-Executive Director[15]	0-5	0	0	0-5	n/a	n/a	n/a	n/a
Tim Gilpin Associate Non-Executive Director[16]	0-5	0	0	0-5	n/a	n/a	n/a	n/a

Notes: *(8) from 6 May 2016 (9) from 1 July 2017 (10) to 9 May 2016 (11) Acting Chairman between 10 May 2016 and 30 June 2016 (12) to 4 June 2015 (13) to 31 August 2016 (14) Non-Executive Director Designate up to 23 October 2016, Non-Executive Director from 24 October 2016 (15) from 31 January 2017 (16) from 31 January 2017*

Pensions Entitlement Table

This table has been subject to audit.

	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2016	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2017	(h) Employer's contribution to stakeholder pension	(i) All pension related benefits (bands of £2,500)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Rod Barnes Chief Executive	0-2.5	0	40-45	115-120	677	26	722	19	30-32.5
Mark Bradley Executive Director of Finance	0-2.5	5-7.5	30-35	85-90	416	75	492	1	42.5-45
Dr David Macklin Executive Director of Operations	0-2.5	0	20-25	55-60	261	8	285	16	25-27.5
Dr Julian Mark Executive Medical Director	0-2.5	0	35-40	90-95	510	20	548	17	27.5-30
Steve Page Executive Director of Quality, Governance and Performance Assurance	0-2.5	2.5-5	40-45	130-135	844	36	894	15	15-17.5
Leaf Mobbs Director of Planning and Development	2.5-5.0	2.5-5	20-25	55-60	308	18	338	12	50-52.5
Dr Philip Foster Director of Planned and Urgent Care	0	0	0	0	0	0	0	0	0
Roberta Barker Director of Workforce and Organisational Development	0	0	0	0	0	0	0	0	0

Notes: *Dr Philip Foster and Roberta Barker have opted out of the NHS Pension Scheme.*

Our Staff

The Trust's Workforce has continued to grow over the last 12 months as our activity continues to increase. The Trust has made endeavours to recruit more substantive staff, particularly in frontline areas in order to decrease our reliance on temporary staff and overtime.

Our staff are committed to providing the highest quality care in order to improve patient experience and patient outcomes and they receive regular professional development updates to ensure that their skills and clinical practice are at the highest possible level. We work with our managers to develop their leadership skills to ensure that our staff are sufficiently supported in terms of their practice, but also in terms of their health, wellbeing and engagement.

We work in partnership with UNISON, GMB, Unite the Union and the Royal College of Nursing as our recognised Trade Unions and our relationship continues to develop with our local and regional representatives. We are all committed to building strong employee relations and our transformation programmes across A&E, NHS 111 and the Patient Transport Service have involved our local representatives at their commencement. We have also worked closely with the National Ambulance Service Partnership Forum on national projects including Paramedic re-banding.

Our transformation within A&E continued with a number of assessment centres taking place within the year for Emergency Care Assistants (ECAs).

A fortnightly ECA training programme has evaluated well and these staff are a very much welcome addition to our workforce and play a key role in supporting our Paramedics and Emergency Medical Technicians.

The transformation has also included a new management structure, which has seen the appointment of three Locality Directors who are tasked with the transformation of the workforce in their dedicated areas.

New rota arrangements have also been introduced in order to better meet our activity levels, but also to improve health and safety in terms of our staff working hours.

Going forward we are committed to ensuring we have the right number of staff who are appropriately qualified to provide the best care possible to our patients.

We are committed to increasing the diversity of our workforce across all the protected characteristics and our Head of Diversity and Inclusion has a clear strategy with which to work with our managers, staff and union representatives on its implementation in order to ensure our workforce is reflective of the population we serve.

Our Head of Diversity and Inclusion has developed and strengthened our diversity forums in order to engage and improve the working environment and opportunities for all staff regardless of any protected characteristics. Our BME and Disability Networks are particularly well attended.

Staff Profile - Roles

	2007 (31 March 2007)	2015 (31 March 2015)	2016 (31 March 2016)	**2017 (31 March 2017)**
Paramedics (including student paramedics)	871	1,437	1,592	**1,685**
Technicians	655	307	402	**587**
Emergency Care Assistants	nil	445	557	**610**
Other frontline staff (including Assistant Practitioners, A&E Support Assistants, Intermediate Care Assistants)	478	391	224	**193**
Patient Transport Service (Band 2, Band 3 and apprentices)	228	713	688	**832**
EOC staff	257	362	360	**374**
NHS 111	nil	401	380	**465**
Administration and Clerical staff	606	629	657	**659**
Managerial (including associate directors)	106	136	150	**167**
Other (Chief Executive, Directors and Non-Executive Directors)	14	15	16	**17**

Staff Profile - Gender

	2007 (31 March 2007)	2015 (31 March 2015)	2016 (31 March 2016)	**2017 (31 March 2017)**
Male	1,869 58.13%	2,553 52.79%	2,638 52.49%	**2,946** **52.71%**
Female	1,346 41.86%	2,283 47.21%	2,388 47.51%	**2,643** **47.29%**

Staff Profile - Age

	2007 (31 March 2007)	2015 (31 March 2015)	2016 (31 March 2016)	**2017 (31 March 2017)**
Average Age - All Staff	40	42	42	**42**
Average Age - Male	42	44	44	**44**
Average Age - Female	37	40	40	**39**

Payroll Multiple Disclosures

(this data has been subject to external audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the median remuneration of the organisations workforce.

The banded remuneration of the highest paid director/member in the Trust in the financial year **2016-17 was £175,000-£180,000** (2015-16, £165,000-£170,000). **This is 7.11 times** (2015-16, 6.78 times) **the median remuneration of the workforce, which was £25,039** (2015-16, £24,853).

In 2016-17, 0 (2015-16, 0) no employees received remuneration in excess of the highest-paid Director/ member. Remuneration ranged from £6,455 to £178,072 (201-16, £6,461- £168,381)

The 2015-16 values have been restated as the original calculations did not include one senior manager engaged on an interim basis.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The median was calculated by scaling up part-time salaries to the whole time equivalent in line with guidance.

Resourcing and Recruitment

Recruitment into frontline roles has continued to be the main focus for the Trust and we are committed to getting these staff in post as quickly as possible. The Trust is aware of its safeguarding responsibilities and ensures that it meets the NHS Employment Checking Standards for all our appointments. We are also committed to ensuring that we are compliant with the Fit and Proper Persons testing process and are rigorous in our execution of this duty.

We are clear on our values. WE CARE is always the focus when we undertake our values-based recruitment and our assessment centres for frontline staff, i.e. Emergency Care Assistants and Emergency Operations Centre staff, to ensure we recruit the best staff for our patients.

Our managers are also assessed in line with our values in order to ensure that they are the right leaders to deliver our vision. We assess our prospective managers through a rigorous process that includes psychometric tests. We ensure that they demonstrate the essential leadership skills to develop our staff and our services. We are committed to ensuring that we utilise the most effective recruitment methods rather than simply relying on traditional interview processes.

As well as being focused on meeting the recruitment needs of the Trust's 999 (A&E Operations) service, we continue to support significant recruitment campaigns for other key service areas including NHS 111, Patient Transport Service and the Trust's successful apprenticeship schemes.

We are committed to ensuring that we utilise the most effective recruitment methods rather than simply relying on traditional interview processes.

Workforce Levels (this data has been subject to audit)

Staff category	Establishment 31 March 2015		Establishment 31 March 2016		**Establishment 31 March 2017**	
	WTE	Headcount	WTE	Headcount	WTE	Headcount
A&E Operations	2,158	2,440	2,188	2,630	**2,333**	**2,933**
PTS	681	812	667	788	**606**	**927**
EOC/NHS 111	651	810	623	795	**689**	**898**
Support staff	490	557	534	600	**543**	**613**
Management	151	160	153	160	**165**	**173**
Apprentices	57	57	52	53	**45**	**45**
Total	**4,190**	**4,836**	**4,217**	**5,026**	**4,381**	**5,589**

Permanent and Other Staff

Employee benefits are split between permanent and other staff.

	Total £000	Permanently Employed £000	Other £000
Salaries and wages	141,276	134,583	6,693
Social Security costs	13,247	13,247	0
NHS Pension Scheme	16,244	16,244	0
Termination Benefits	349	349	0
Total	**171,116**	**164,423**	**6,693**

Recruitment Activity

Staff Category	Number of Advertising Campaigns	Number of Applications
A&E Frontline	47	3,886
Apprentice	45	845
EOC/NHS 111	86	3,976
Management	54	617
Patient Transport Service	68	1,317
Support	132	2,716
Grand Total	**432**	**13,357**

413 people left the Trust including 93 staff who retired, 267 staff who resigned, 11 redundancies, 30 staff who were dismissed and sadly 3 staff who died in service.

Absence Management

Calendar Days Lost

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust Total (2016-17)	**7,264**	**7,229**	**7,026**	**7,799**	**7,917**	**7,706**	**8,063**	**7,875**	**9,084**	**9,121**	**7,979**	**8,498**
Trust Total (2015-16)	7,142	7,496	7,172	7,375	7,727	7,217	7,640	7,727	8,771	8,524	7,737	8,090

Sickness Absence Percentage

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target (%)	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
2016-17	**5.12**	**4.86**	**4.91**	**5.30**	**5.43**	**5.40**	**5.41**	**5.37**	**5.96**	**5.97**	**5.84**	**5.64**
2015-16	5.12	5.18	5.16	5.15	5.48	5.29	5.37	5.55	6.11	5.93	5.66	5.55

The Trust continues to work in partnership with its trade unions to support staff whose health means that they are unable to continue working within their contracted roles. We work closely with our occupational health provider and are reviewing our current action plans to ensure that we improve the support available to staff. We recognise that we need to enhance the measures incorporated in our existing Employee Wellbeing Strategy and have agreed a range of additional interventions to support staff to remain well.

Health and Wellbeing

The Trust's over-arching Employee Wellbeing Strategy remains a document that is fit-for-purpose with particular focus on our staff's mental health; this being our highest reason for absence.

We are working closely with the Trust's occupational health provider to ensure staff receive timely access to counselling and support services and over sixty managers across the Trust have recently accessed mental health awareness training to enable them to support and manage the needs of their teams more effectively.

The following wellbeing work activities are currently underway:

- **Musculoskeletal (MSK) intervention pilot**
  To support our staff within our call centres (EOC, PTS and NHS 111), a registered physiotherapist has begun providing walk-arounds and advice on back care, good posture, and management of MSK issues. After evaluation of the benefits, it is hoped that the intervention will continue to be offered in these environments.
- **Management training on supporting the mental health and wellbeing of staff**
  Managers are accessing opportunities to undertake training from Mind and from Zeal Solutions to support our aim to create environments that support mental wellbeing.
- ***One You* public health campaign**
  The Trust supports the national One You campaign for staff and promotes healthy lifestyles via information, mobile apps, and a 4-week challenge.

The 2016-17 flu vaccination campaign had a disappointing uptake with just over 20% of staff having the vaccination. This was partly due to a change in accessing the flu jab and the Trust is now working on a number of new strategies to significantly increase the uptake in 2017-18.

Exit Packages

Exit packages costing £348,665 for 11 staff were provided during the year. This compares to £215,310 for 5 staff in 2015-16.

Exit Packages agreed in 2016-17

Exit package cost band (including any special payment element)	*Number of compulsory redundancies*	*Cost of compulsory redundancies*	*Number of other departures agreed*	*Cost of other departures agreed*	*Total number of exit packages*	*Total cost of exit packages*
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	5,615	1	5,615
£10,000 - £25,000	0	0	7	127,141	7	127,141
£25,001 - £50,000	0	0	2	72,777	2	72,777
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	1	143,132	0	0	1	143,132
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total	**1**	**143,132**	**10**	**205,533**	**11**	**348,665**

Exit Packages agreed in 2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies*	*Cost of compulsory redundancies*	*Number of other departures agreed*	*Cost of other departures agreed*	*Total number of exit packages*	*Total cost of exit packages*
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,000 - £25,000	0	0	1	22,544	1	22,544
£25,001 - £50,000	0	0	3	124,961	3	124,961
£50,001 - £100,000	0	0	1	67,805	1	67,805
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total	**0**	**0**	**5**	**215,310**	**5**	**215,310**

Exit Packages – other departures analysis

Other exit packages - disclosures (Exclude Compulsory Redundancies)	*Number of exit package agreements*	*Total value of agreements*	*2015-16 Number of exit package agreements*	*2015-16 Total value of agreements*
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	7	152	0	0
Mutually agreed resignations (MARS) contractual costs	3	54	5	215
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	**10**	**206**	**5**	**215**
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

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

No ex gratia payments were made during the year. The disclosure reports the number and value of exit packages taken by staff in the year. The expense associated with these departures has been recognised in full in the current period.

Leadership Portfolio Review

2015-16 saw a review of the Trust Board's leadership portfolio and with our new Chairman's background in workforce, further work to support our leaders will take place. Our focus for 2016-17 has been to recruit substantively to two key positions on the Trust Board; Executive Director of Finance and Director of Workforce and Organisational Development. The new Executive Director of Finance Mark Bradley joined the Trust in March 2017 and recruitment is underway for the Director of Workforce and Organisational Development; these posts will complete our senior leadership team.

The transformation within A&E Operations has resulted in a new management structure which aims to provide robust leadership to support our staff and allow further development of our services to support increased activity. A management review of our NHS 111 and Patient Transport Service leadership teams will also be completed in 2017-18. The new structures will ensure the capacity and capability of the senior management team meets the changing demands of and urgent and emergency healthcare in the years ahead.

Financial Review

Income and Expenditure

We planned to realise a retained surplus of £5.1m in 2016-17 and delivered £2.7m. The shortfall against plan reflects changes to income and expenditure as set out below. We are planning to deliver a surplus of £53k in 2017-18.

Income

We recognised income of £255.4m in 2016-17. This is £6.5m higher than income received in 2015-16. The increase reflects increased activity and investment in our A&E services amounting to £3.1m, and £3.9m penalties charged in 2015-16 but not charged for 2016-17. The balance reflects other movements in contracts and activity.

The financial plan for 2017-18 projects income to be £266.6m, an increase of £11.2m.

Expenditure

We spent £251m on revenue items in 2016-17 which is £9.2m higher than 2015-16. The breakdown of total expenditure can be seen below:

The £9.2m increase in expenditure in comparison to 2015-16 mainly relates to pensions costs increase due to loss of rebates amounting to £3.7m and pay inflation and increments of £2.4m. We also faced further cost increases including £1.2m to deliver Vanguard services, a £1m increase to provisions resulting from lower discount rates, additional spend on private providers of £0.9m, and additional spend on training of £0.6m

Quality and Efficiency Savings/Cost Improvement Plans

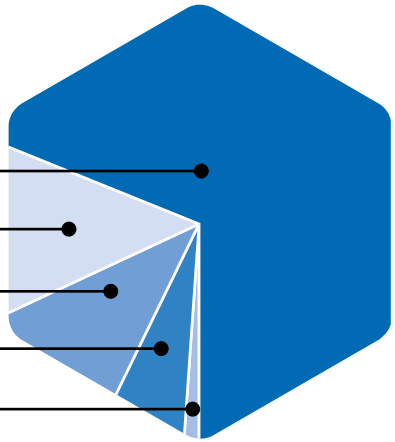
We planned to achieve £9.1m savings in the year equating to 3.5% of our planned income and actually realised savings of £7.7m (85.5% of planned savings).

We achieved 60.8% of these savings recurrently. Recurrent schemes of £12.4m are planned for 2017-18.

Capital Expenditure

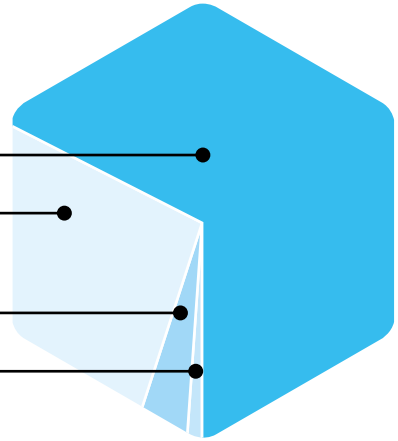
The Trust's Capital Resource Limit (CRL) was set at £12.2m for 2016-17. We spent £12.7m on capital expenditure and received £774k proceeds for assets sold during the year. Therefore the charge against CRL was £11.9m and we thereby achieved the CRL target with a £270k underspend.

2016-17 Income



A&E	£176.2m (69%)
NHS 111	£32.4m (13%)
PTS	£27.2m (11%)
Other	£16.5m (6%)
HART	£3.1m (1%)
Total Income	£255.4m (100%)

2016-17 Expenditure



Pay costs	£171.1m (68%)
Non-pay costs	£70.4m (28%)
Depreciation & Amortisation	£9.1m (4%)
PDC Dividends	£2.1m (1%)
Total Spend	£252.7m (100%)

The majority of Capital Expenditure was on our vehicles (£8.4m) and the equipment within these (£1.9m). We spent £7m on vehicles for our A&E services, and a further £0.8m for vehicles used by our HART team.

Remaining capital expenditure related to medical equipment (£2.1m), station refurbishment and upgrades (£1m), and information technology equipment (£1m).

Cash/External Financing Limit (EFL)

The EFL is a control over cash expenditure which restricts the use of external funding. Undershooting the control is acceptable: overshooting would be a breach of this control.

This year the planned cash outflow before financing was £2.087m. The actual cash outflow before financing was £1.657m, an undershoot of £430k, caused by lower than planned capital expenditure

Capital Cost Absorption Duty

The Capital Cost Absorption Duty measures the return the Department of Health makes on its investment in the Trust. It is set at 3.5% of the average carrying amount of all assets less liabilities, less the average daily cash balance in the Government Banking service or National Loans Fund accounts. The average relevant net assets figure for the period was £60.3m. The public dividend capital reflected in the accounts was £2.1m which equates to 3.5%, thereby achieving the target.

Better Payment Practice Code (BPPC)

The Trust subscribes to this code, which aims to ensure payments are made within 30 days unless otherwise agreed.

During 2016-17, the Trust paid 31,420 invoices, of which 27,588 were paid within 30 days giving an overall BPPC position of 87.8% against the target of 95%.

We paid 551 NHS invoices in the year, of which 447 (81%) were paid within 30 days. We paid 30,869 non-NHS invoices of which 27,141 (87.9%) were paid within 30 days.

The comparative values for 2015-16 were:

30,962 invoices in total, of which 27,038 (87.3%) were paid within target. This splits between NHS 30,344 NHS invoices and 618 non-NHS invoices, of which 26,550 (87.5%) and 488 (79.0%) (respectively) were in paid within target.

The implementation of an improved process for the Trust's "Procure to Pay" function is expected to support improvements to performance during 2016-17.

Pensions Liabilities

For employees who are members of the NHS Pension scheme, contributions are deducted from pay and added to employer contributions. Both elements are paid over to the NHS Pensions Agency (which administers the scheme) one month in arrears.

At the end of the year, we have accrued £2.149m in our balance sheet for March contributions. Details of the accounting policy on pension costs can be found in the full accounts for the year at Note 8.3. Pension entitlements in respect of Senior Managers are contained within the remuneration report that follows.

External Auditor's Remuneration

In addition to their audit work of £61k, we paid our external auditors £30k for VAT services.

Sickness Absence Data

Each year the Department of Health publishes sickness absence figures for the Trust. The number of days lost to sickness absence between January and December 2016 was 52,239. This equates to an average of 12.3 sick days per Full Time Equivalent (FTE) employee. The comparable values for the same period during the previous financial year were 53,910 days, equating to an average of 13.0 days per employee.

Cost Allocation and Charges for Information

In charging for the services the Trust has delivered, it has complied with HM Treasury guidance on Managing Public Money to recover full costs.

Exit Packages and Severance Payments

Payments the Trust makes in relation to exit packages and severance can be found in the 'Our Staff' section of this report.

Off-payroll Engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Total Number	**7**
Of which:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	2
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	1

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	**7**
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	**7**
Number for whom assurance has been requested	**7**
Of which:	
assurance has been received	4

Consultancy

Consultancy spend of £976k mainly relates to work on the Hub and Spoke Programme and Estates (£260k), People and Engagement (£157k), Business Development (£137k) and Accident and Emergency (£118k).

Quality Account

2016-17

PART 1

- Statement on Quality
- Statement of Accountability
- Engaging with Staff, Patients and the Public about Quality

PART 2

- Priorities for Improvement 2017-18
- Process to Monitor, Measure and Report Priorities for Improvement 2016-17
- Statements from the Trust Board

PART 3

- Performance against Mandatory Indicators
- Performance against Priorities for Improvement 2016-17
- Review of Quality Performance 2016-17
- Statements from Stakeholders
- Statement of Directors' Responsibilities in Respect of the Quality Report

PART 1

Statement on Quality from the Chief Executive

Welcome to our NHS Trust Quality Account 2016-17. We have a lot to celebrate this year including the significant improvements we have made to the quality of care we provide for people who suffer life-threatening emergencies such as cardiac arrest, stroke and major trauma. We remain among the best in the country for these and will strive to maintain this performance in the coming year.

Against the backdrop of a challenging year, where much publicity has been focused on the health service as a whole, I am incredibly proud of our staff, both the support teams and those caring directly for patients, who work tirelessly to ensure that care is delivered at point of need to our local population.

I was delighted that this was recognised through the Care Quality Commission (CQC) report, published in February 2017. The report highlighted the improvements which have been made since the last CQC inspection and also noted many areas of good practice. Notably this included the caring and compassionate attitude of our staff, our ambition for Yorkshire Ambulance Service (YAS) described in our estates and workforce strategy, and our first "outstanding" rating for the strength of our resilience service.

Like other NHS ambulance trusts, we continue to face significant challenges, not least in the unprecedented levels of demand we have seen this year. We have had to continually reassess our resources and resilience both on the road within the Accident and Emergency (A&E) service, our non-emergency Patient Transport Service (PTS) and for NHS 111. Our aim and continued commitment is to respond to patients with life threatening conditions as quickly and safely as possible and we are a key partner in the joint working across the region to develop and implement new and exciting ways of working to better serve the people of Yorkshire and the Humber.

We continue to be actively engaged in the national Ambulance Response Programme (ARP) pilot which began in April 2016. This pilot gives us more time to assess non-life threatening 999 calls and decide on the most appropriate response for patients' needs. It has also helped to inform potential future changes in national performance standards. Since its introduction we have seen a marked improvement in the way we have deployed our resources. This has resulted in a significant increase in the number of resources being stood down following confirmation that there was no immediate threat to life; thereby enabling that resource to be available for the next emergency call.

Collaborative working with commissioning groups and partner organisations has continued to allow YAS to develop new ways of working that deliver timely emergency and urgent care in the most appropriate setting.

YAS remains dedicated to making a positive difference to the wider health economy and recognises that we have a unique role to play in the future provision of services, both across emergency and urgent care.

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 care at the heart of all the Trust's activities.

As Accountable Officer and Chief Executive of the Trust 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 and the Quality Account Toolkit. It contains the sections mandated by the Act and also measures that are specific to YAS that demonstrate our work to provide high quality care for all. We have chosen these measures based on feedback from our patients, members of the public, Health Overview and Scrutiny Committees, staff and commissioners.

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

Rod Barnes
Chief Executive

Engaging with Staff, Patients and the Public about Quality

In order to ensure that the YAS Quality Account reflected the views of all our stakeholders we consulted with a wide range of groups and individuals including our staff, our recently formed Critical Friends Network, Expert Patient, Trust Members, YAS Forum Members, regional Healthwatch and Health Overview and Scrutiny Committees. We also analysed our data systems: incidents, near misses, complaints and patient feedback are all mechanisms we use to establish trends and themes which inform our Strategy and contribute to our Quality Account.

A key priority during 2016-17 has been the establishment of the Critical Friends Network (CFN) within YAS. This network is made up of patients and members of the public who have an interest in the ambulance service and recent experience of using one of the services; the newly formed CFN, along with Staff Forum Members, are now consulted prior to new service developments and improvement projects.

The Trust has hosted two events during the year with prospective 'Friends' of the network to explore how it will work in detail and to gain valuable patient input, assisting YAS to co-design this group. Both events were well attended with excellent feedback.

The CFN will continue throughout 2017-18 as a fully established group and will be fundamental to service planning and improvement across the Trust, ensuring the patient voice is at the heart of everything we do.

PART 2 Priorities for Improvement 2017-18

1

PATIENT SAFETY

Improving emergency ambulance response times for patients.

Lead: Dr David Macklin, Executive Director of Operations

KEY DRIVERS

Patient care is a key priority and our involvement in the national Ambulance Response Programme is enabling us to implement improvements in patient care by ensuring that patients are effectively assessed and allocated the appropriate response for their needs.

AIM

The aim of the national Ambulance Response Programme is to help improve the management of demand versus allocation of the appropriate response; which is determined by patient need. Fundamentally, it is about delivering the right care, in the right place and at the right time. It will also help inform potential changes in national performance standards. Whilst national targets for response times will remain a key focus, YAS aims to deliver a safe and responsive service to all patients with different levels of clinical need.

2

PATIENT SAFETY

Development of the Trust's role in care co-ordination across the urgent and emergency care system, with particular focus on care closer to home and improved information sharing across care boundaries.

Lead: Dr Philip Foster, Director for Planned and Urgent Care

KEY DRIVERS

The National Emergency and Urgent Care Review and High Impact Action have described the agenda for improving healthcare by looking holistically and what patients need in a local area. The plans which have been developed locally include the West Yorkshire Vanguard and Accelerator Zone. These provide us with strengthened engagement to review our services across traditional organisational boundaries. This process will contribute to the Trust's focus on responsiveness and development of urgent care services.

AIM

To provide staff with the right skills, knowledge and alternative care pathways to deliver the right care in the right place, first time. This also includes working closely with local health and social care partners to maintain current and develop new pathways for those patients for whom the emergency department is not the most appropriate place for care.

3

PATIENT SAFETY

Maintain effective patient feedback to ensure learning from the patient experience is identified and shared. To develop methodology that ensures robust investigation and clear learning is gained from adverse events; ensuring patient and staff feedback from this process informs organisational learning going forward.

Lead: Karen Warner, Deputy Director - Quality and Nursing

KEY DRIVERS

The recent Care Quality Commission report - Learning, candour and accountability (December 2016) concluded that there is more organisations can do to learn from adverse events and improve the experience of patients.

AIM

To continually improve the experience of patients through effective investigations and enquiries when things have gone wrong, involving both patients and staff.
To develop systems, processes and effective communication that ensures learning is shared both internally and externally.
all patients with different levels of clinical need.

4

PATIENT SAFETY

Develop a patient-centred pathway which enables best practice for patients who have suffered a stroke.

Lead: Dr Steven Dykes, Deputy Medical Director

KEY DRIVERS

A stroke is a time-critical condition for patients and it is important that patients who suffer a stroke receive treatment as quickly as possible. Currently this is measured as a performance target in blocks of 60 minutes: these are broken down as follows:

1-60 minutes: onset symptoms to arrival at hospital

60-120 minutes: arrival at hospital to scan to confirm diagnosis

120-180 minutes: scan to treatment

There is a strong evidence base which now indicates that the overall window of 180 minutes is the optimal time period for treatment in terms of a longer-term outcome for patients.

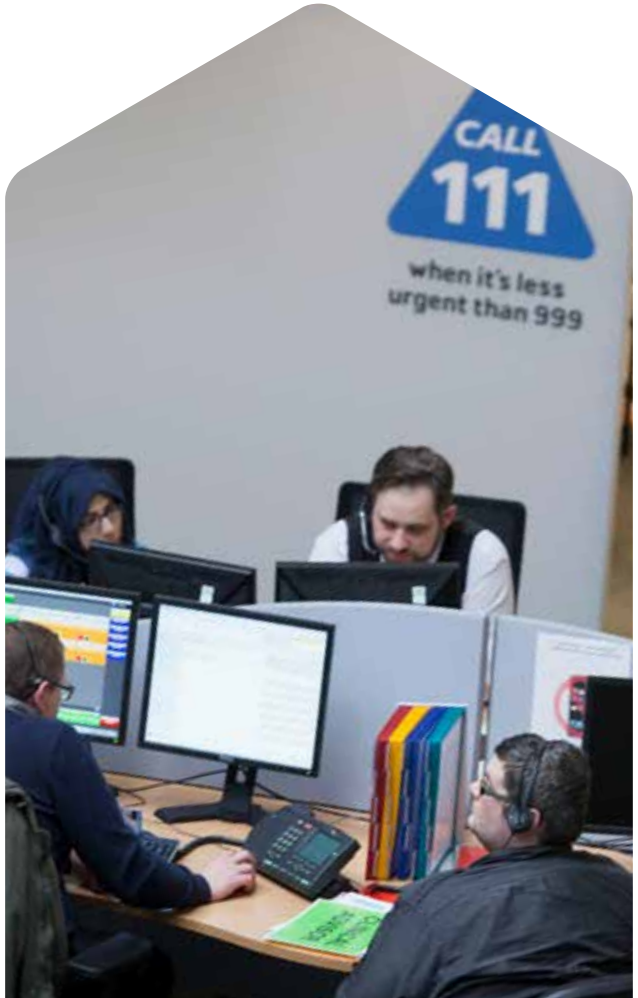
AIM

YAS is looking to work with partners to develop a stroke care pathway which will streamline the whole acute stroke pathway from onset of symptoms to diagnosis. This should then improve outcomes for patients.

Review of Services 2016-17 (Statements from the Trust Board)

During 2016-17 YAS provided and/or sub-contracted seven NHS services:

- A Patient Transport Service (PTS) delivering planned transportation for patients with a medical need for transport to and from premises providing secondary NHS healthcare. PTS caters for those patients who are either too ill to get to hospital without assistance or for whom travelling may cause their condition to deteriorate.
- An A&E response service (this includes management of 999 calls and providing an urgent care service including urgent care practitioners).
- Resilience and Special Services (incorporating our Hazardous Area Response Team) – which includes planning our response to major and significant incidents such as flooding, public transport incidents, pandemic flu and chemical, biological, radiological or nuclear incidents.
- Fully equipped vehicles and drivers for the Embrace Neonatal Transport Service for critically-ill infants and children in Yorkshire and the Humber.
- Clinicians to work on the two Yorkshire Air Ambulance charity helicopters.
- Management of the Community First Responder Scheme, made up of volunteers from local communities.
- NHS 111 service in Yorkshire, the Humber, North and North East Lincolnshire and Bassetlaw in Nottinghamshire, for assessment and access to urgent care where required for patients. This contract also includes delivery of out-of-hours services in West Yorkshire via a sub-contract with Local Care Direct.



In addition, the Trust supports the wider health communities and economies through provision of:

- Urgent and Emergency Care Vanguards - West Yorkshire Urgent and Emergency Care Network and the North East Urgent Care Network.
- Community and commercial education to schools and public/private sector organisations.
- A private and events service – emergency first aid cover for events such as concerts, race meetings and football matches; and private ambulance transport for private hospitals, repatriation companies and private individuals.
- BASICS Doctors, a team of specially trained volunteer doctors who are available to respond to the most severely injured patients requiring advanced medical assessment and treatment.
- A Volunteer Car Service, members of the public who volunteer with transporting patients to routine appointments.
- Free first aid training courses for members of YAS.

YAS has reviewed all the data available to them on the quality of care in seven of these relevant health services.

The income generated by the relevant health services reviewed in 2016-17 represents 100% of the total income generated from the provision of relevant health services by YAS for 2016-17.

Participation in Clinical Audit

We are committed to undertaking clinical audits to confirm that our practice compares favourably with evidence-based practice. It also ensures changes and improvements are made promoting excellent patient care and best practice. The results of clinical audits are reported and cascaded through our management teams to frontline staff.

During 2016-17 six national clinical audits and zero national confidential enquiries, covered relevant health services that YAS provides.

The national clinical audits and national confidential enquires that YAS participated in, and for which data collection was completed during 2016-17, are listed overleaf alongside each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

During that period YAS participated in 100% of national clinical audits and in 100% of 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 2016-17 follow overleaf.

Clinical audit is the cornerstone for maintaining and improving high-quality patient-centred services. It provides the Trust with assurance that we are delivering high-quality clinical care.

The following cases, all relevant audit cases, were submitted, representing 100% of sample request:

1. Myocardial Ischemia National Audit Project (MINAP) (Heart attack).
2. ST Elevation Myocardial Infarction (Heart attack).
3. Acute Stroke.
4. Return of Spontaneous Circulation (ROSC), this means restoring a pulse following cardiac arrest which occurs outside of a hospital.
5. ROSC Outcomes (the number of people who survive after a ROSC and also then come home from hospital).

YAS continues to consistently achieve one of the highest performances nationally for ROSC and out-of-hospital cardiac arrest outcomes.

The following audit samples were a maximum of 300 cases. YAS submitted all relevant cases in line with audit methodology, representing 100% sample rate:

6. Asthma.
7. Single-limb fracture.
8. Febrile convulsions (fitting relating to high temperature in children).
9. Elderly people who fall.
10. Deliberate self-harm in people with mental illness.

The reports of 100% national clinical audits were reviewed by the provider in 2016-17 and YAS has taken the following actions to improve the quality of healthcare provided:

- Audit findings inform the staff education and training programme as well as communications.
- Improved system of data sharing between the Trust and regional acute trusts for the validation of data relating to people who suffer a heart attack.
- Using the national audit findings to inform local audit priorities.

Local Audits

YAS has undertaken a number of local audits during 2016-17. This year we have supported a number of operational clinicians in undertaking clinical audits, the aim was to support staff development and encourage peer review. In addition, the audit programme included a number of observational audits conducted by operational staff:

Monthly audits were conducted for:

- Record-keeping
- Infection Prevention and Control audits in relation to hand hygiene and vehicle and estate cleanliness
- Patient deaths in YAS care
- Care of patients with suspected sepsis.

Other clinical audits included:

- Medication, including antibiotic usage
- Care for patients suffering trauma or requiring wound care
- HCP calls (CQUIN)
- Hypoglycaemia
- Cardiac arrest drug monthly audits
- Anaphylactic care
- Clinical handover (observational)
- Paediatric epilepsy
- Chest pain management
- Management of maternity care
- Private and Events (clinical)
- National Ambulance Non-conveyance Audit (NANA)
- Management of Urinary Catheters.

The reports of these local clinical audits were reviewed by the provider in 2016-17 and YAS intends to take the following actions to improve the quality of healthcare provided:

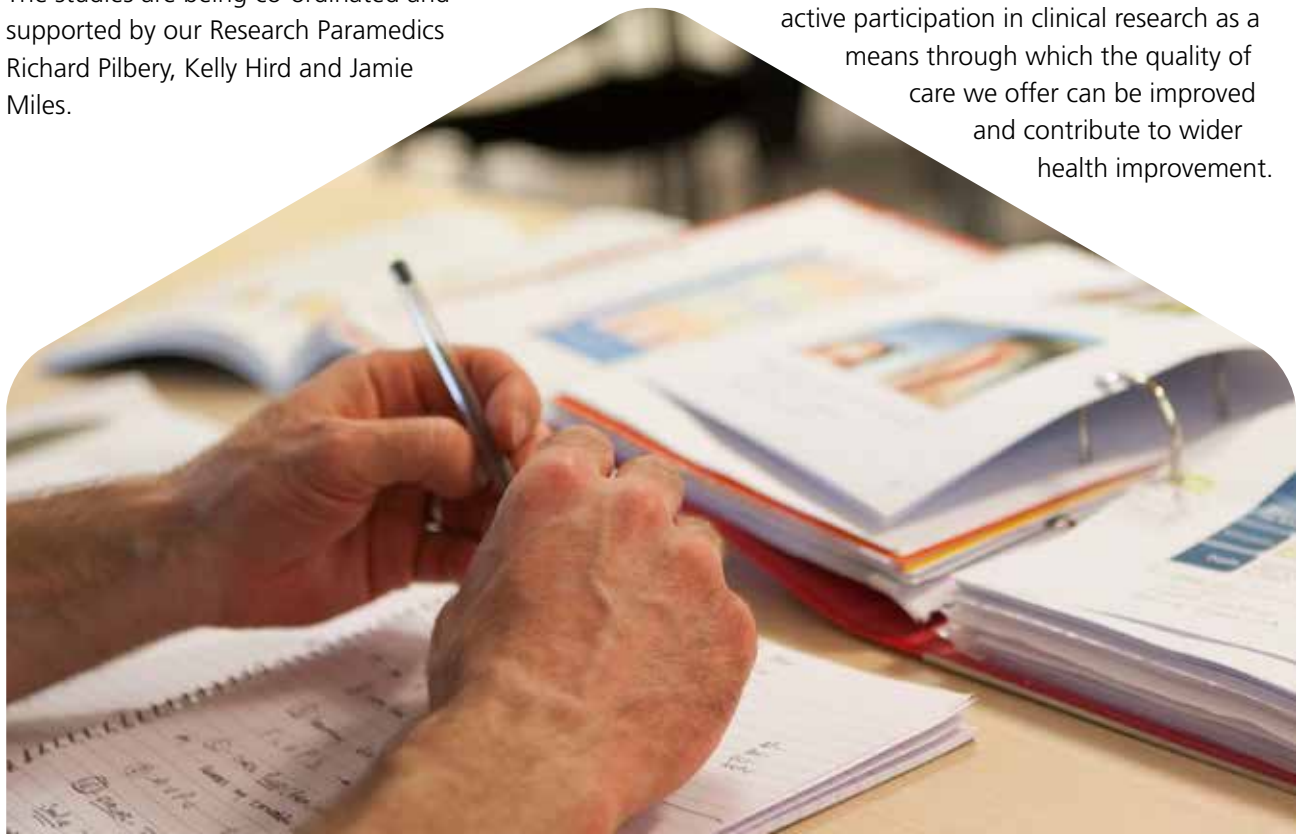
- Utilise the learning from audits within the clinical education programme, to refresh information and provide assurance about comprehension and understanding in the practice setting.
- Provide subject areas to support immersion training, via the simulation training facility in YAS, to reinforce practice to avoid care omissions. handover, systematic assessment
- Further drive the use of SBAR, the communication handover tool, across the region with acute trusts to reduce the widely recognised risk to patients of missed opportunity at clinical information handover.
- Provide on-going support to clinical staff to conduct audit. The key aim is to develop a culture of responsibility, empowering staff to peer review, to challenge practice poor practice and lead the changes required from the ambulance frontline.
- Development of an electronic patient record, ePR, to ensure key data points are collected to help support staff in delivering the best care possible.

Research

In 2016-17 we continued to be highly research active, building on our success of the previous year.

Over 30% of our registered paramedics continued to take part in two large national trials - AIRWAYS-2 and RIGHT2. AIRWAYS-2 is examining which airway device (supraglottic airway or tracheal intubation) gives the best outcomes for patients in cardiac arrest, while RIGHT2 will show whether early administration of glyceryl trinitrate patches improves the outcome for patients who have had a stroke.

The studies are being co-ordinated and supported by our Research Paramedics Richard Pilbery, Kelly Hird and Jamie Miles.



Over 1,100 patients were enrolled into these two trials in 2016-17, which will both continue into 2017-18. This is a major contribution to research participation in Yorkshire and the Humber, allowing patients the opportunity to be part of improving pre-hospital healthcare.

Research and Innovation

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 offer can be improved and contribute to wider health improvement.

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

YAS achieved second place amongst English ambulance services for the numbers of patients recruited into high quality research in 2015-16. This research league table was published by the NIHR (National Institute for Health Research) in October 2016 at http://www.nihr.ac.uk/research-and-impact/nhs-research-performance/league-tables/

Paramedic involvement in research activity is at its highest ever in YAS during 2016-17. YAS now has 421 paramedics trained and participating in two national trials, which represents over 30% of our HCPC-registered workforce. Their performance is excellent, and YAS is the single largest recruiter into the AIRWAYS-2 study.

The number of patients receiving NHS services provided or sub-contracted by YAS in 2016-17 who were recruited during that period to participate in research approved by a research ethics committee was 1,194, plus 9 staff.

During 2016-17 YAS took part in or provided NHS permission for 10 research studies approved by an ethics committee.

1. AIRWAYS-2-Cluster randomised trial of the clinical and cost effectiveness of a supraglottic airway device versus tracheal intubation in the initial airway management of out-of-hospital cardiac arrest

This is a clinical trial involving four ambulance trusts across England that is designed to determine the best method of adult airway management in pre-hospital cardiac arrest. The clinical and cost effectiveness of two procedures, both in current use, are being evaluated. This is a large multicentre clinical trial requiring a period of training and preparation. It received NHS permission from YAS in the period 2014-15, staff and patient enrolment began on 22 June 2015 and will continue until August 2017.

2. Breatheasy

This pre-clinical study performance tested a prototype device in various settings, including pre hospital care. The device was designed to automatically and accurately measure respiratory rates of children and adults, to overcome the need to manually count breaths. Recruitment to this study closed in May 2016.

3. ClosED - Impact of Closing Emergency Departments (ED) in England

This study aimed to establish if local populations and emergency care providers were affected by the closure/downgrading of an ED, focusing on five EDs which closed between 2009 and 2011. The project involved document review on the context of closures and analysis of data around emergency care indicators in resident catchment populations. It was funded by the NIHR Health Services and Delivery Research Programme and ran in YAS until September 2016.

4. EDARA - An Evaluation of Alcohol Intoxication Management Services (AIMS): Implications for Service Delivery, Patient Benefit and Harm Reduction

EDARA is an observational study looking at the effectiveness and acceptability of AIMS, which receive, treat and monitor intoxicated patients instead of having them admitted to emergency departments. It is funded by the NIHR Health Services and Delivery Research Programme and will run in YAS until July 2018.

5. ERA – Electronic Records in Ambulances to support the shift to out of hospital care: challenges, opportunities and workforce implications

ERA investigates and describes the prospects of implementing electronic records and associated technology in ambulances to support out-of-hospital care through assessment of existing practice and interviews with staff. ERA will close in May 2017.

6. How should we respond to the low confidence some ambulance crew members have in managing seizures?

This was a qualitative study to understand how to improve the support given to ambulance crews in the management of seizures that took place between April and September 2016. YAS, four other ambulance services and a professional body nominated staff to be interviewed about the evidence on low confidence amongst some ambulance crew members and on their views about how to redress this.

7. PHOEBE – Pre-hospital Outcomes for Evidence-Based Evaluation

This study aimed to develop methods for measuring processes and outcomes of pre-hospital care. It used literature review and consensus methods to create a dataset to routinely link pre-hospital, hospital and mortality data; developing methods to measure proposed indicators, and explore the practical use of the developed models. This study was a five-year programme of work led by East Midlands Ambulance Service and the University of Sheffield, which began in December 2011 completed in January 2017.

8. Prevalence and trends in UK ambulance service staff suicides

The purpose of this study is to determine whether people who work either as a Paramedic or in other roles in the UK ambulance services are at higher risk of suicide than people who work in other professions. It was commissioned by the Association of Ambulance Chief Executives and a final report is expected in the first quarter of 2017-18.

9. RIGHT-2 - Rapid Intervention with Glyceryl Trinitrate in Hypertensive Ultra-Acute Stroke Trial-2

This is a clinical trial assessing the safety and efficacy of Transdermal Glyceryl Trinitrate (GTN) patches, administered by paramedics for patients suffering acute stroke. This study aims to find out whether early use of the patches (before hospital) improves outcomes for patients. The research is funded by the British Heart Foundation and is taking place in four ambulance services, and hospitals who receive eligible patients. It received NHS permission from YAS in October 2015, staff training began in early November 2015 and patient recruitment runs from November 2015 to November 2017.

10. Sustainability Initiatives in Ambulance Services

This study was carried out by a PhD student from the University of Plymouth, who interviewed staff about opportunities for sustainability behaviours, specifically how ambulance services are contributing to carbon reduction initiatives.

In 2016-17 we also worked with

- The NIHR Clinical Research Network (CRN) Yorkshire and the Humber (as a partner organisation);
- The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Yorkshire and the Humber as a partner organisation in Avoiding Attendance and Admissions in Long Term Conditions;
- Six higher education institutes to carry out clinical research. These were: Swansea University, University of Cardiff, University of Liverpool, University of Nottingham, University of Plymouth and University of Sheffield.

Publications

Bell F and Fitzpatrick D. ***Pre-hospital hypoglycaemia referral pathways.*** *British Paramedic Journal 2016 Vol. 1(3) 29–31*

Hawkes C, Booth S, Ji C, Brace-McDonnell SJ, Whittington A, Mapstone J, Cooke MW, Deakin CD, Gale CP, Fothergill R, Nolan JP, Rees N, Soar J, Siriwardena AN, Brown TP, Perkins GD on behalf of OHCAO Collaborators: Theresa Foster, East of England Ambulance Service NHS Trust; Frank Mersom, East of England Ambulance Service NHS Trust; Robert Spaight, East Midlands Ambulance Service NHS Trust; Gurkamal Virdi, London Ambulance Service NHS Trust; Dawn Evison, North East Ambulance Service NHS Trust; Clare Bradley, North West Ambulance Service NHS Trust; Philip King, South Central Ambulance Service NHS Foundation Trust; Ed England, South Central Ambulance Service NHS Foundation Trust; Patricia Bucher, South East Coast Ambulance Service NHS Foundation Trust; Nancy Loughlin, South Western Ambulance Service NHS Foundation Trust; Jessica Lynde, South Western Ambulance Service NHS Foundation Trust; Jenny Lumley-Holmes, West Midlands Ambulance Service NHS Foundation Trust; **Dr Julian Mark**, Yorkshire Ambulance Service NHS Trust. ***Epidemiology and outcomes from out-of-hospital cardiac arrests in England.*** *Resuscitation Vol 110 133–140*

Johnson M, O'Hara R, Hirst E, Weyman A, Turner J, Mason S, Quinn T, **Shewan J** and AN Siriwardena. ***Multiple triangulation and collaborative research using qualitative methods to explore decision making in pre-hospital emergency care.*** *BMC Medical Research Methodology Vol. 17(11)*

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Pilbery R, Teare MD, Goodacre S and Morris F. ***The Recognition of STEMI by Paramedics and the Effect of Computer interpretation (RESPECT): a randomised crossover feasibility study***. *Emergency Medicine Journal Vol. 33(7) 471-476*

Richley D and **Winter J**. ***Technical errors in ECG recording and treatment delays***. *British Journal of Cardiac Nursing Vol. 12(2) 77-78*

Younger P, **Pilbery R** and Lethbridge K. ***A survey of paramedic advanced airway practice in the UK.*** *British Paramedic Journal 2016 Vol. 1(3) 9-22*

Pilbery R, Lethbridge K **(2016) Ambulance Care Practice.** *Class Professional; London. ISBN-10: 1859595960*

Lethbridge K and **Pilbery R *(2016) First Responder Care Essentials.*** *Class Professional; London. ISBN-13: 9781859596081*

Shanahan M in Wapling A, Sellwood C (Eds) ***Health Emergency Preparedness and Response*** *CABI Publishing; Abingdon ISBN-10: 1780644558*

Medicines Management

YAS adopts an evidence-based approach to the use of medicines within the Trust. This ensures that patients are treated safely and effectively whilst ensuring cost effectiveness. This process is managed by the YAS Medicines Management Group which meets on a monthly basis.

Developments during the last year include:

- There has been a 50% reduction in medicine errors in 2016-17, specifically relating to glucose and saline and aspirin and paracetamol. This has been achieved by application of human factors learning gained from previous adverse incidents.
- Introduction of new medicines to the YAS formulary:
    1. Ketamine for the treatment of pain for the Red Arrest Team
    2. Midazolam for post-ROSC management for the Red Arrest Team
    3. Magnesium sulphate for the treatment of life-threatening asthma for the critical care doctors
    4. Activated charcoal for accidental and intentional overdose for all vehicles
    5. Co-amoxiclav for open fractures for the Red Arrest and Critical Care Teams
- Improvement in Prescription Only Medicines (POM) audit process - the improved database and audit forms have allowed the Medicines Management group to more easily identify themes and trends found during POM audits. There has been a month-on-month improvement in the number and quality of audits being completed across the region. The new database allowed the group to easily identify an expiry issue with GTN tablets, the group made the decision to change to GTN spray to mitigate the risk of medicines bags containing out-of- date stock.
- The Medicines Management Group continues to complete medicines audits. Following a re-audit of antibiotic supply a full antibiotic review was undertaken and three antibiotic workshops were run, open to all the Urgent Care Practitioners. The workshops provided education and also assurance that antibiotics were being supplied in accordance with the patient group directions. Two antibiotics were removed from the formulary and the treatment for urinary tract infection is under review after discussion during the workshop.

National Institute for Health and Care Excellence (NICE) Guidance and NICE Quality Standards

YAS has a clear governance process by which all NICE guidance and NICE quality standards are reviewed, reported and actions planned and monitored.

Patient Safety Alerts

In 2016-17, the NHS Commissioning Board Special Health Authority issued four Patient Safety Alerts which were relevant to Yorkshire Ambulance Service:

- NHS/PSA/RE/2016/003 - Patient Safety Incident Reporting and Responding to Patient Safety Alerts
- NHS/PSA/RE/2016/005 - Resources to Support Safer Care of The Deteriorating Patient (Adults And Children)
- NHS/PSA/RE/2016/007 - Resources to support The Care of Patients with Acute Kidney Injury
- NHS/PSA/W/2016/004 - Risk of Death and Severe Harm from Failure to Recognise Acute Coronary Syndromes in Kawasaki Disease Patients

YAS has a defined process for responding to and communicating Patient Safety Alerts. All alerts are entered and tracked via the DATIX reporting system for audit purposes and those relevant to YAS are discussed and tracked to completion via the Incident Reporting Group (Patient Safety), Trust Procurement Group (Devices and Equipment) and the Health and Safety Committee (Staff Safety).

Goals Agreed with Commissioners

A proportion of YAS income in 2016-17 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 relevant health services, through the Commissioning for Quality and Innovation payment framework.

Trust-wide CQUINs

CQUIN 1a - Introduction of staff wellbeing

A range of initiatives to better support staff have been tested this year. These include providing access to "healthchecks" on line, improved access to physiotherapy services for staff and also the introduction of Physical Competency Assessments. We also introduced a range of resources to support staff mental health including training and how to improve peer support for mental health in the workplace.

CQUIN 1b - Healthy food for staff/visitors

YAS has worked with catering suppliers to ensure healthy food choices are available for all staff and visitors. YAS will continue to ensure there is adequate provision of healthy food and beverages available to all staff and visitors that visit the premises.

Improving the uptake of flu vaccinations for frontline staff)

This year's flu vaccination campaign was less successful than hoped. The reasons for this have been reviewed and a new campaign is in place for 2017-18 with a clear plan to achieve.

Total value £1,137,810

Further details of the agreed goals for 2016-17 and the following 12-month period are available electronically at: http://www.yas.nhs.uk/

A&E CQUINs

CQUIN 2 - Sepsis

YAS has undertaken a significant amount of work to raise the profile and awareness of patients with suspected sepsis. This has been very successful and the audit work has found that our staff are excellent at identifying the signs of possible sepsis and taking of the patient in the right way.

Total value £379,270

CQUIN 3 - End-to-end reviews

YAS undertakes investigations to learn when things have gone wrong and to make improvements to ensure the highest quality of service and care is delivered at all times. Investigations in YAS have improved over recent years however in order to develop the process further it was highlighted that more collaborative working is required to ensure appropriate lessons are learned through working with relevant care providers. Monitoring of the effectiveness of end-to-end reviews and the actions and learning identified is conducted and tracked to ensure implementation. Reviews also take place to assess the effectiveness of the actions based on subsequent incidents reported and quality of care delivered.

End-to-End Review and Mortality Review CQUINs are being extended into the 2017/19 CQUIN schedule.

Total value £568,905

CQUIN 3a - Ambulance Mortality Review

The monitoring of mortality within the health care system is widely used to provide an indicator for patient safety. Within the ambulance services the monitoring of mortality is not commonly defined nor is it usually collected. YAS has over the last 12 months, undertaken a pilot to explore all deaths in the care of the service e.g. where Recognition of Life Extinct (ROLE) has been invoked by YAS paramedics.

Total value £568,905

CQUIN 3b - Assessing the quality of Cardio-pulmonary Resuscitation (CPR)

CPR is a lifesaving intervention for people who suffer a cardiac arrest. To maximise survival from cardiac arrest the focus should be on optimising the quality of CPR specifically, as well as the performance of resuscitation processes in general. Both animal and clinical studies demonstrate that the quality of CPR has a significant impact on survival.

A number of CPD events have been held for clinical staff where findings from the download process have been presented and crews provided with more information as to how it can help improve their own practice. In addition 4 clinical supervisor development days have been held which were attended by nearly all of the Trust's 126 clinical supervisors. Data has been collected and in summary concludes from 245 active resuscitations across Yorkshire and the Humber has shown that the median chest compression rate has been reduced so that it now falls within Resuscitation Council (UK) guidelines and that the median chest compression fraction has been in excess of the recommended target of 80% throughout the year. The data also demonstrates that amount of time that chest compressions are interrupted for both before and after the delivery of a defibrillation shock has been substantially reduced.

Total value £568,905

CQUIN 4a - Health Care Professional calls

Health care professional (HCP) calls form a significant part of the demand within the emergency operations centre (EOC). Work has continued throughout the year and a reporting framework presented to commissioners including details of the reporting framework provides commissioners with a sample report developed.

Total value £379,270

CQUIN 4b - Patient outcome data

YAS are engaging with North of England Commissioning Support to understand how the Secondary Usage Service (SUS) data can be utilised to understand the patient outcome following ambulance service intervention. Currently, SUS data includes ambulance attendances to Emergency Departments.

Ongoing work with commissioners and hospitals. Pilot work with Bradford hospitals is progressing well.

Total value £189,635

PTS CQUINs

CQUIN 1 - Patient Experience

Utilising technology to develop and implement an online system (patient portal) that will enable patient to access and view their own PTS bookings. This will then improve the patient experience by ensuring that the correct transport is allocated to the correct location at the correct time. It is anticipated that the patient portal will enhance communication between the patient and YAS PTS resulting in fewer journeys being cancelled.

To date 44 patients have completed the testing remotely from their own homes. This has been supported by a dedicated member of staff through online messaging and direct contact by telephone. The patients who have tested the patient portal have completed surveys to enable us to understand what works and what may need developing further or changing completely. The Smartphone App has also been tested and feedback provided which is informing next steps.

CQUIN 2 - Patient Experience

To develop and implement a Courtesy Call service that will improve patients experience enabling direct communication with the patient to validate bookings. It was anticipated this would reduce the number of unrequired journeys which will have a positive impact on availability of resources and provide efficiency savings.

Total annual value: £26,471,714

What Others Say About Us

Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and social care in England with the aim of ensuring better care is provided for everyone, be that in hospital, in care homes, in people's own homes, or elsewhere.

- YAS is registered with the CQC and has no conditions on registration.
- The CQC has not taken any enforcement action against Yorkshire Ambulance Service during 2016-17.
- YAS has not participated in any special reviews or investigations by the CQC during the reporting period.

As part of its routine programme of scheduled inspections, the CQC inspectors visited the Trust in September and October 2016 to carry out detailed assessments of five domains of quality and safety (shown below) in all YAS services including NHS 111 and their overall judgement is 'Good'.

Outcomes - 21 August 2015	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Emergency and urgent care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	**Requires improvement**
Patient transport services (PTS)	Requires improvement		Good	Requires improvement	Requires improvement	**Requires improvement**
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	**Requires improvement**
Resilience	Inadequate	Not rated	Not rated	Good	Requires improvement	**Requires improvement**
Overall	**Requires improvement**	**Requires improvement**	**Good**	**Requires improvement**	**Requires improvement**	**Requires improvement**

Outcomes - 1 February 2017	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Emergency and urgent care	Good	Good	Good	Good	Good	**Good**
Patient transport services (PTS)	Requires improvement	Good	Good	Requires improvement	Requires improvement	**Requires improvement**
Emergency operations centre (EOC)	Good	Good	Good	Good	Good	**Good**
Resilience	Good	Outstanding	Good	Good	Good	**Good**
NHS 111	Good	Good	Good	Good	Good	**Good**
Overall	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

Rod Barnes, Chief Executive, said:

"We are delighted with the outcome of the CQC's inspection of our organisation. Their assessment reflects the high quality of service provided by our dedicated staff who work tirelessly every day to provide timely and safe services for our patients. It makes me immensely proud that the commitment of our staff and volunteers and the great care they provide have been formally recognised."

All of our services demonstrated significant improvement since the CQC's inspection in January 2015 and we are also pleased that the CQC has highlighted a number of areas of outstanding practice. These include:

- our Red Arrest Team providing senior clinical support for patients who suffer a cardiac arrest
- partnership working to improve integrated urgent and emergency care across the region
- the introduction of palliative care nurses in our NHS 111 call centres to support end-of-life care
- clinical developments within our Hazardous Area Response Team.

They also praised the Trust's volunteer community first responder schemes, our commitment to supporting the placement of public access defibrillators in local communities and our Restart a Heart campaign to train schoolchildren in the vital skill of CPR.

The Trust has a developed a quality compliance plan which will support the journey from Good to Outstanding.

A specific PTS plan and robust monitoring process has been developed to aide PTS on its continued journey of improvement, which includes:

- Action to strengthen PTS management and leadership.
- Implementation of a PTS workforce and training plan.
- A continued focus on standards of cleanliness and infection, prevention and control.
- Support for a co-ordinated approach to quality improvement built on staff and patient engagement.

Data Quality

YAS did not submit records during 2016-17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This requirement does not apply to ambulance trusts.

YAS Information Governance Toolkit Assessment Report overall score for 2016-17 was 85% (and was graded satisfactory as part of the Information Governance Grading Governance Toolkit which is a performance and improvement tool produced by the Department of Health. It draws together the legal rules and central guidance provided by the Department of Health in relation to the processing (or handling) of information and presents this in one place as a set of 35 information governance 'requirements' (or 'standards'). The purpose of the assessment is to enable NHS organisations to measure their compliance against the law and central guidance and gives an indication as to whether information is handled and processed correctly and protected from unauthorised access, loss, damage and destruction. (Our attainment against scheme). The assessment rating scheme is simply either 'not satisfactory' or 'satisfactory'.

The Information Governance Toolkit assessment also provides an indication of the quality of our data quality systems, standards and processes. One of its 35 'requirements' covers whether there are procedures in place to ensure the accuracy of service-user information on all systems and records that support the provision of patient care.

In 2016-17 YAS took the following actions to maintain and improve its data quality:

- The Information Asset Owners (IAOs) quarterly review process allows us to undertake data quality checks in their respective areas of the business.
- Staff training in the use of our systems that support the provision of care include the importance of accurate data input. Computer system functionality aims to support accurate data entry and data quality audits of both electronic and paper-based care records are undertaken, reported through the Trust's governance meeting cycle and support our Information Governance Toolkit submission. Feedback to staff is provided if and when data quality issues arise.
- Our Business Intelligence Team quality check all reports they produce and have documented procedures for undertaking data quality checks of external reports prior to distribution.

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

- YAS will continue to work on the actions in the above section.
- Our internal auditors carried out an audit of the Trusts approach to data quality in 2016 which provided us with significant assurance with some minor improvements recommended to processes.
- We will continue to raise awareness of data quality through the quarterly IAOs' review process to embed best practice and to strengthen the knowledge of our Information Asset Owners and Information Asset Administrators throughout the Trust.
- Our Business Intelligence Team will continue to develop data quality reports for managers to help them monitor and improve data quality in their teams and have worked closely with our IT Department to improve data quality, developing data analysis reports which access a single source of data.

YAS was not subject to the Payment by Results Clinical Coding Audit during 2016-17 by the Audit Commission.

PART 3

Mandatory Quality Indicators

Ambulance trusts are required to report:

- **Red ambulance response times –** percentage of patients receiving an emergency response within **8 minutes** and the percentage of patients receiving an ambulance response within **19 minutes**.
- **Care of ST Elevation Myocardial Infarction (STEMI) patients –** percentage of patients who receive an appropriate care bundle.
- **Care of stroke patients –** percentage of patients who receive an appropriate care bundle.
- **Staff views on standards of care –** percentage of staff who would recommend the Trust as a provider of care to their family and friends (Friends and Family Test).
- **Reported patient safety incidents –** the number and, where available, rate of patient safety incidents reported within the Trust within the reporting period and the number and percentage of patient safety incidents that have resulted in severe harm or death.

Ambulance Response Times

The demand for ambulance services has been increasing nationally year-on-year, putting a huge strain on the system. The reasons for this are complex, but include a growing and ageing population with changing needs and expectations. Despite this, the way ambulance care is delivered has remained broadly constant.

The Ambulance Response Programme (ARP) was established by NHS England in 2015 to review the way ambulance services operate, increase operational efficiency and to ensure a greater clinical focus. It is helping to inform potential future changes in national performance standards.

Yorkshire Ambulance Service, along with South Western Ambulance Service NHS Foundation Trust and West Midlands Ambulance Service NHS Foundation Trust, was invited to participate in the pilot Ambulance Response Programme which has now progressed through three elements:

- Dispatch on Disposition which gives call handlers additional time to triage all but the most life-threatening calls to make sure the right resource is sent to each patient first time.
- A new system of clinical prioritisation for all 999 calls to better prioritise the sickest patients and to make sure the patient's urgency and clinical needs are matched to the best response to those needs.

"My role is a rapid response vehicle paramedic and as such it is my job to attend patients prior to an ambulance attending. After doing baseline observations decide what other resources are required; if an ambulance is required I decide what level of response is needed, similarly if no ambulance is required I decide which alternative pathway to use and I can treat the patient on scene and leave them at home if this is the best for them. It is also my role to mentor student paramedics as and when needed."

Andrew Hutton, Paramedic, Barnsley

- A new set of ambulance service measures, indicators and standards to make sure the sickest patients receive the fastest response and that all patients get the most appropriate response allocated to them first time.

The University of Sheffield has been monitoring and evaluating ARP interventions and this will provide recommendations to help shape the way ambulance services operate in the future. Further details are available at: https://www.england.nhs.uk/ourwork/qual-clin-lead/arp/

A&E Performance against National Targets

Due to the Trust's participation in the Ambulance Response Programme (ARP) and the changes introduced in different phases of the trial, the performance data for 2016-17 does not directly correlate to the previous response categories and so the Trust is unable to publish performance against the national targets. For the evaluation of the trial and possible outcome proposals going forward not to be prejudiced prior to publication, the Trusts involved in the trial are unable to share their data externally during the trial period, however this will be released once the evaluation report is published.

YAS has taken the following actions to improve its performance and the quality of its services for patients by:

- recruitment of additional 242 frontline staff in A&E Operations
- further review of rota patterns to better align resources with patient demand.

The Trust has continued to work with its healthcare partners in clinical commissioning groups (CCGs) and acute trusts to address the system challenges collectively. This includes addressing the issues of responding to emergency calls in the many rural areas across the region and delayed patient handovers at some busy emergency departments.

Patient Transport Service (PTS)

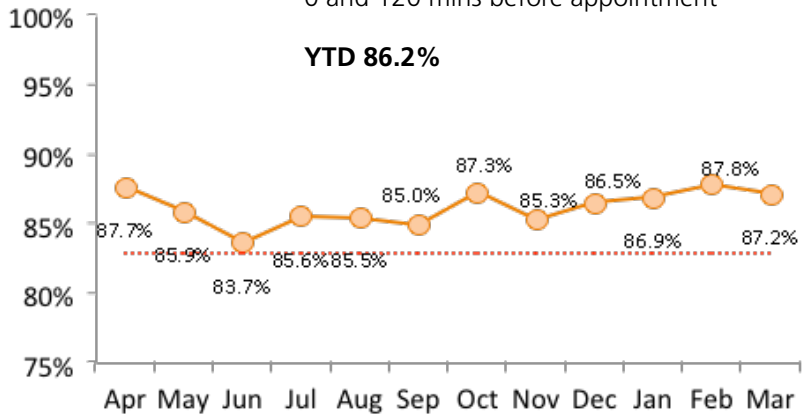
Performance

Consortia performance against individual consortia targets:

- **West Yorkshire:** KPI 2 (inward) achieved target by 1.7% and KPI 3 (outward) missed target by 1% achieving 90.5%.
- **East Yorkshire:** KPI 2 (inward) achieved 86.5% against target of 77.0% + 9.5% and KPI 3 (outward) achieving 91.5% against target of 90.0% + 1.5%.
- **North Yorkshire:** KPI 2 (inward) achieved 87.2% against a target of 82.0% + 5.2%, KPI 3 missed its target by 4.2%.
- **South Yorkshire:** KPI 2 (inward) achieved 88.1% against target of 86.0% + 2.1% and KPI 3 (outward) narrowly missed target by 1.2%

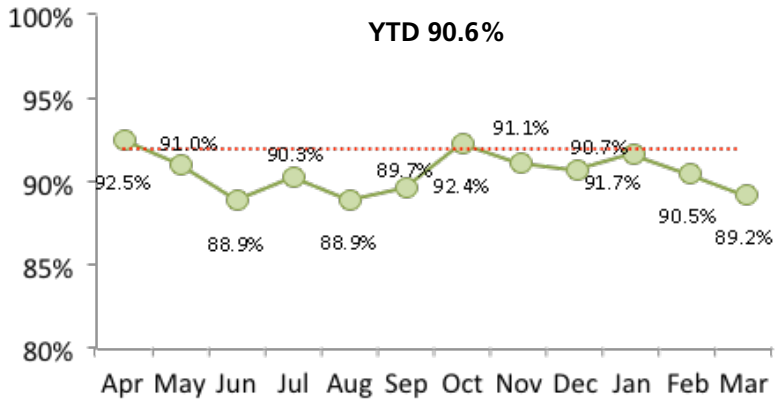
INWARD - % of patients delivered between 0 and 120 mins before appointment

YTD 86.2%



OUTWARD - % of patients collected within 90 mins after appointment

YTD 90.6%



Contract Award for South Yorkshire

We are delighted that the Trust has been successful in securing a new five-year contract to deliver non-emergency health care patient transport services across South Yorkshire following a competitive tender process.

This process concluded in March 2017 and the contract will commence on 1 September 2017.

YAS has been selected to deliver:

- Core outpatient services throughout South Yorkshire and on-day discharge services in Sheffield
- Ad-hoc repatriation work for the four South Yorkshire clinical commissioning groups (CCGs)
- GP urgent services in Sheffield.

Contract Award for East Riding

We have been successful in securing a new five-year contract to deliver patient transport services in the East Riding of Yorkshire following a competitive tender process.

This process concluded in March 2017 and YAS has been selected to deliver all non-emergency patient transport services, which include core outpatient work, transport for priority patients including those attending renal and oncology appointments, and the discharge of patients from hospital who are registered to East Riding Clinical Commissioning Group (CCG).

PTS Transformation Programme

The programme is well underway and aims to create a Patient Transport Service that provides high quality, safe and efficient care to its patients, whilst being sustainable for the future. We are committed to improving the service for staff and patients and I would like to thank all staff for their continued support and hard work. This update highlights the main areas of the transformation, achievements to date and the next steps.

So far, achievements in the PTS Transformation Programme include:

- Developing a new service delivery model which has an improved flow for booking patients into the system, defining required resources and so optimising the resources to transport patients.
- Increasing the number of volunteer car drivers and private sub-contractors allowing us greater flexibility in delivering the service.
- Piloting of auto-planning of PTS journeys to increase the efficiency of patient collection and drop-offs to help reduce operating costs through more efficient automated planning.
- Piloting of a centralised resourcing function to ensure the most efficient use and resourcing of staff and vehicles across Yorkshire.
- PTS is working closely with Doncaster, Rotherham and Sheffield acute hospitals to remove the use of the Patient Administration System (PAS) and move to a PTS online booking system to book patient journeys within this financial year.

Effective Sub-Contractor Management

In June 2016, PTS implemented a new sub-contractor framework to help enable a more flexible approach to how we currently resource and plan our work. Over the last nine months we have visited many taxi companies, community transport organisations and private ambulance providers. We have travelled across the whole of Yorkshire and beyond to ensure we have the capacity to add to our delivery team and now have over 60 providers who meet our quality standards. This allows us greater flexibility in how we deliver our non-emergency transport services to help improve efficiency and the overall patient experience.

- Developing guidelines for patient journeys for all alternative transport providers.
- Developing an online portal for taxis. This is active now and is where taxis receive their PTS work from.
- Creation of internal relationships around sub-contractor usage.
- Over 60 sub-contractors are now on the PTS framework. The PTS team has visited them all.
- Addressing breaches in performance. All breaches are forwarded to our sub-contractors for their information and any breach over 30 minutes requires an explanation. These exceptions are then fed back to teams within PTS for information purposes/lessons learnt.
- Developing a sub-contractor performance management report.

PTS Patient Courtesy Calls

PTS has arrangements in place to improve courtesy calling to patients to help reduce aborted journeys across Yorkshire. The aim is to improve the patient experience by ensuring that the correct transport is allocated to the correct location at the correct time. Furthermore, it is anticipated that courtesy calling will reduce the number of unrequired journeys which will have a positive impact on availability of resources and provide efficiency savings.

Patient courtesy calls helps deliver the following:

- Enables YAS PTS to review patients' pre-booked journey details.
- Reinforces appointment details with the patients.
- Informs patients of their pick-up time.
- Ensures that YAS has the correct contact details.
- Enables YAS to gather contact details.
- Reduces the number of aborted and cancelled journeys.
- Improves the overall patient experience when travelling with YAS.
- Checks that correct mobility requirements have been requested.
- We now have over 60 sub-contractors on the new framework.
- From April 2016 - January 2017 over 52,000 patient courtesy calls were made.

Volunteer Car Service (VCS)

- The VCS now has over 195 volunteers.
- The VCS has delivered over 1.7 million miles transporting patients.

Our Renal Service

The PTS Renal Engagement Lead has been actively engaged with renal stakeholders, and visits the Renal Units on a weekly basis speaking with both staff and patients. Feedback is very positive and it is evident that this face-to-face approach is much appreciated by everyone.

West Yorkshire renal performance continues to improve since we reintroduced the practice allowing nursing staff to forecast in advance when patients will be ready for collection. KPI 1 (patients arrive no more than 30 minutes early for their appointment) achieving 96.4% and KPI 2 (patients travelling up to 10 miles should be on vehicle no longer than 45 minutes) achieving 95.8%.

CQC Report and PTS Renal

Ongoing improvement work is underway and incorporated into the CQC quality compliance plan as described in CQC section of this Quality Account (page 78).

"I monitor spend with cost trackers, ensure that there are sufficient resources to deliver the service and track performance. I am also responsible for approximately 40 frontline staff and a management team made up of five team leaders. I offer support and guidance to staff and deal with compliments and concerns directly from the Trust. I monitor personal development reviews, IPC audits and training compliance; making sure these are within our set target. I am constantly looking at new methods of delivering our service to improve the patients' experience."

Sarah Moody, PTS Service Delivery Manager

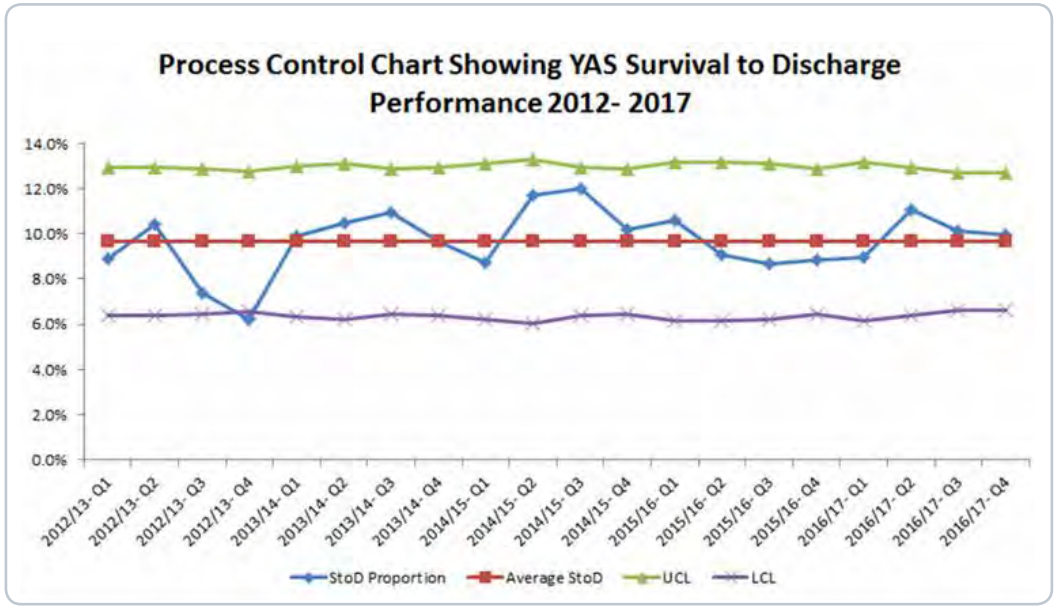
Care of ST Elevation Myocardial Infarction (STEMI) Patients and Care of Stroke Patients

YAS considers that this data is as described for the following reasons:

- Work continues to be led by the clinical managers across the Trust to engage with managers and staff promoting the results of clinical performance indicators with the aim of maintaining performance and promoting best practice.

YAS has taken the following actions to improve the care to patients demonstrated through its year-on-year improvement in the delivery of the ACQI care bundles:

- Feedback about ACQI indicators is given at Trust, operational and individual level, the Clinical Directorate supported a number of CPD sessions and engages staff to discuss the results and make suggestions as to how we can improve.
- Clinical managers for quality and pathways have focused on delivering clear messages to staff in how to assessing patients with suspected heart attack and stroke, supported by clear referral pathways.
- Local acute care pathways are reviewed with stakeholders and updated as required. Incidents in relation to care pathways are investigated and learning shared.
- Record keeping is continually reviewed and feedback given to staff as required.
- The Trust is supporting clinical supervisor attendance at cardiac arrest providing them with additional skills to best manage cardiac arrest.



The above process control chart identifies performance within 'normal variation' for all quarters since 2012, with the exception of 2012-13 quarter 4. As this is the only occurrence of dropping below the lower control limit, it is likely the surrounding circumstances will not be repeated. According to this theory, increasing the number of patients who survive to discharge is directly linked with improving the process by which YAS treat cardiac arrests.

	YAS	National Average	Highest Month 2015-16	Lowest Month 2015-16	YAS	National Average	Highest Month 2016-17	Lowest Month 2016-17
	Apr 15 - Mar 16	Apr 15 - Mar 16			Apr - Dec 16	Apr - Sep 16		
Proportion of STEMI patients who receive an appropriate care bundle	82.9%	78.7%	88.2%	74.4%	87.5%	88.2%	91.7%	82.2%
Proportion of stroke patients who receive an appropriate care bundle	97.8%	97.6%	99.0%	95.7%	98.7%	99.0%	99.1%	97.3%

Staff Views on Standards of Care - including Friends and Family Test (FFT)

Staff Views on Standards of Care	Proportion of staff who agree or strongly agree that if a friend or relative needed treatment they would be happy with the standard of care provided by the Trust
YAS 2014-15	**58%**
National Average 2014-15	54%
YAS 2015-16	**65%**
National Average 2015-16	64%
YAS 2016-17	**71%**
National Average 2016-17	67%

YAS considers that this data is as described for the following reasons:

The Friends and Family Test (FFT) was introduced as part of the National Standard NHS Contract in 2014 for acute provider organisations. This was extended to include the ambulance sector in the 2015-16 contract.

The questions are presented in the following order and format:

We would like you to think about your recent experience of working in the organisation

1. How likely are you to recommend this organisation to friends and family if they needed care or treatment?

The results of Question 1 show that in Quarter 4 of 2016-17, 88% (increase of 17% from Quarter 1 2014) of respondents have scored positively on how likely they are to recommend the Trust as a 'place of care or treatment' in comparison with 7% of respondents who have given a negative response to this question.

2. How likely are you to recommend this organisation to friends and family as a place to work?

The results of Question 2 show that in Quarter 4 of 2016-17, 56% (increase of 21% from Quarter 1 2014) of respondents have scored positively on how likely they are to recommend the Trust as a 'place to work' in comparison with 29% of respondents who have given a negative response to this question.

Whilst the result of the staff FFT questions show a general improvement in the scores since the survey was launched in April 2014, the Trust recognise that significant development is required on the view of how staff relate to whether they would recommend the Trust as a place for work.

Patient Friends and Family Test

A&E - How likely is it that you would recommend Yorkshire Ambulance Service to friends and family? - 2016-17

Extremely likely / Likely	Qtr 1	Qtr 2	Qtr 3	YTD
North Yorkshire	91.3%	83.3%	92.9%	**88.30%**
Hull and East Yorkshire	73.7%	95.7%	88.9%	**85.70%**
Calderdale, Kirklees and Wakefield	87.3%	88.5%	89.2%	**87.70%**
Leeds, Bradford and Airedale	88.6%	84.8%	90.0%	**87.00%**
South Yorkshire	84.9%	98.0%	88.5%	**91.20%**
Unknown Area	38.5%	76.5%	88.9%	**60.00%**
YAS	**84.6%**	**88.9%**	**89.9%**	**86.50%**

PTS - Would you recommend the Patient Transport Service (PTS) to friends and family if they required transport to hospital? - 2016-17

Extremely likely / Likely	Qtr 1	Qtr 2	Qtr 3	YTD
North Consortia	87.0%	84.9%	88.9%	**86.10%**
East Consortia	83.3%	94.1%	94.1%	**87.20%**
West Consortia	79.3%	89.3%	82.4%	**84.00%**
South Consortia	96.3%	94.4%	88.6%	**95.30%**
PTS (inc unknown area)	**84.9%**	**90.8%**	**88.5%**	**87.50%**

Complaints, Concerns, Comments and Compliments

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
EOC	Complaint	18	14	13	15	19	8	15	11	13	19	19	16	**180**
	Concerns	14	10	11	10	11	14	9	12	19	12	11	4	**137**
	Service to Service	10	9	14	29	15	32	30	23	26	16	8	14	**226**
	Comment	1	0	0	0	0	1	1	0	2	1	1	2	**9**
	Compliments	1	2	0	0	1	1	1	0	1	0	0	0	**7**
	Lost Property	0	0	1	2	0	1	0	1	0	0	1	0	**6**
	PALS Enquiries	0	0	2	1	2	2	0	1	0	0	1	0	**9**
PTS	Complaint	13	7	10	25	14	10	9	6	8	6	8	12	**128**
	Concerns	22	27	69	69	36	35	27	25	29	26	19	39	**423**
	Service to Service	31	17	63	73	51	25	43	18	19	20	12	23	**395**
	Comment	4	11	5	7	4	11	3	11	7	8	1	1	**73**
	Compliments	2	1	1	0	4	3	9	6	2	0	0	2	**30**
	Lost Property	2	1	1	1	4	4	1	1	1	4	2	0	**22**
	PALS Enquiries	11	1	4	2	3	3	0	5	1	0	3	3	**36**
A&E	Complaint	17	14	11	9	8	15	23	16	19	22	10	24	**188**
	Concerns	20	15	9	9	20	19	15	13	19	24	14	20	**197**
	Service to Service	16	10	13	13	17	8	15	16	18	21	18	24	**189**
	Comment	8	11	3	2	5	8	4	7	8	3	3	2	**64**
	Compliments	48	82	48	5	63	87	68	63	61	6	0	25	**556**
	Lost Property	31	34	30	23	35	29	25	30	30	28	17	9	**321**
	PALS Enquiries	30	26	23	17	23	20	9	13	14	11	14	8	**208**
111	Complaint	36	47	55	41	41	25	43	41	50	55	32	47	**513**
	Concerns	4	5	3	5	2	3	4	2	4	4	8	4	**48**
	Service to Service	48	60	70	18	20	13	28	23	117	135	81	113	**726**
	Comment	3	5	6	8	2	6	4	2	4	7	4	5	**56**
	Compliments	11	13	13	6	11	5	17	11	14	11	13	11	**136**
	Lost Property	0	0	0	0	0	0	0	0	0	0	0	0	**0**
	PALS Enquiries	0	0	0	1	0	1	0	0	0	0	0	0	**2**

Timeliness of Responding to Complaints

Patients' concerns and complaints are resolved in line with the Complaints Procedure Regulations and Parliamentary and Health Service Ombudsman Principles with a renewed focus on early resolution. The response timescales have been refreshed with the agreement and negotiation of timescales with individual complainants which is proportionate to the complaint and the level of investigation it requires.

Standard operational procedures are in place to monitor individual and team workload and the overall compliance rates are reported to the Board.

Month	% of responses meeting due date	Average response timescale (working days)
April 2016	94	23
May 2016	93	24
June 2016	96	21
July 2016	90	22
August 2016	88	24
September 2016	86	24
October 2016	91	26
November 2016	89	21
December 2016	86	21
January 2017	91	27
February 2017	91	29
March 2017	93	27

All incidents reported

The Trust recognises and values the importance of incident reporting to enable learning and improvement to take place. We encourage our staff to report incidents via the Datix system and they can do this through the 24/7 incident reporting telephone line or via web-based reporting. The following information shows the incidents that have been reported through the Datix system and also includes near miss reporting.

YAS puts patient safety first. An open and honest incident reporting culture is critical for learning and improvements in patient safety. YAS supports and encourages all staff, including NHS 111, LCD and sub-contractors, to report incidents and near misses.

A number of initiatives have taken place or are work in progress to further improve incident reporting across the Trust and in turn improve the consistency of the investigations to improve learning across the Trust.

- Introduction of investigation grades across the Trust to standardise the approach to the investigation of incidents, complaints, claims, inquests and safeguarding events. The grades are based on the level of harm including that caused to a patient and guide managers to conduct a thorough investigation proportionate to the severity which will improve the amount of learning that can be extracted.

New Incidents Reported	Operations - A&E	EOC	PTS	NHS 111	Other	TOTAL
April 2016	405	92	89	48	46	**680**
May 2016	448	88	102	34	28	**700**
June 2016	425	83	131	26	25	**690**
July 2016	415	108	115	54	41	**733**
August 2016	498	98	131	61	40	**828**
September 2016	478	58	84	44	30	**694**
October 2016	581	128	92	52	44	**897**
November 2016	642	106	122	52	46	**968**
December 2016	612	104	92	53	41	**902**
January 2017	702	123	123	65	67	**1080**
February 2017	616	95	99	55	55	**920**
March 2017	676	105	92	49	55	**977**

- Full review and re-launch of the Datix incident reporting system in 2017. This includes streamlined forms to enable timely completion of investigations, specific question sets being included to improve information gathered, additional training delivered across the organisation, 'Datix Surgeries' to assist managers with their investigations and closer working relationships to help support operational colleagues effectively in improving the quality and safety of patient care.
- Continuation of the popular *Safety Update* – a monthly publication issued to all staff focused on learning and improvement. This was launched during 2015-16 and has been well received by staff. Learning is shared from a serious incidents, staff safety incidents, as well as highlighting some of the key work that is being undertaken across the Trust via the Sign up to Safety campaign and assists in passing key messages onto staff in a quick and visual manner.

Incidents reported to the NRLS between 1 April 2016 and 30 September 2016

	Level of Harm		*Severe*		*Death*	
Ambulance Service	Days between incident date and report to NRLS	Number of incidents	N	%	N	%
LAS	122 (109)	294 (1,187)	10 (3)	3.4 (0.3)	2 (3)	0.7 (0.3)
NEAS	28 (102)	680 (1,059)	2 (1)	0.3 (0.1)	11	1.6 (1.5)
NWAS	10 (9)	650 (570)	0 (3)	0 (0.5)	3	0.5 (0.7)
YAS	**13 (16)**	**944 (848)**	**23 (21)**	**2.4 (2.5)**	**0**	**0 (2)**
EMAS	7 (34)	419 (362)	3 (11)	0.7 (3)	5	1.2 (5)
WMAS	22 (35)	563 (314)	5 (3)	0.9 (1)	0	0 (0.6)
EoE	69 (90)	727 (1,016)	0 (0)	0 (0)	0	0 (0)
SECAMB	77 (40)	159 (267)	7 (9)	4.4 (3.4)	1	0.6 (1.9)
SCAS	13 (5)	80 (415)	6 (6)	7.5 (1.4)	0	0 (0)
SWAST	131 (180)	1,070 (1,530)	6 (20)	0.6 (1.3)	0	0 (0)
Total		5,586 (8,082)	62 (77)	1.1 (1)	22 (69)	0.4 (0.9)

Reported patient safety incidents

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operations - A&E	81	100	90	94	94	108	114	94	114	101	74	82
EOC	52	55	38	59	49	27	63	58	60	58	50	52
PTS	25	27	36	30	45	23	27	38	30	32	34	18
NHS 111	48	25	18	39	26	26	26	38	34	26	27	29
Medical Ops	0	2	0	0	1	1	0	0	0	0	0	1
Other	4	4	4	10	10	7	7	8	5	13	11	7
TOTAL	**210**	**213**	**186**	**232**	**225**	**192**	**237**	**236**	**243**	**230**	**196**	**189**

A total 2,589 of patient-safety incidents were reported in 2016-17.

YAS considers that this data is as described for the following reasons:

- Using a web-based system reporting tool that allows staff to directly report incidents.
- A phone line for reporting that operates 24/7.
- Tailored Datix training packages.
- Robust 'Being Open' process with patients and their families.
- New tailored incident learning and reporting training packages have been implemented during 2016-17 which include a patient safety and quality improvement element.

YAS has taken the following actions to improve this percentage and so the quality of its services:

- After staff feedback through surveying a Datix refresh including upgraded incident module has been implemented.
- Continuous feedback of common patient safety incidents and learning via the Safety Thermometer data.
- Education of all new staff at induction in order to achieve open and honest reporting, where learning is valued.
- Education of leaders and managers to ensure they support the organisational aims to increase learning from incidents.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medication incidents	60	61	66	68	82	60	75	69	59	63	47	57

Identification and Investigation of Serious Incidents (SIs)

All incidents coded as moderate harm or above are reviewed by the Quality and Safety Team and escalated where appropriate for review at Incident Review Group (IRG) and considered for serious incident (SI) investigation. The definition of a SI includes any event which causes death or serious injury, a hazard to the public, causes serious disruption to services, involves fraud or has the potential to cause significant reputational damage. These are the main categories, but there may also be other causes.

YAS has declared 46 serious incident investigations in 2016-17 which makes up less than 0.46% of all incidents reported.

Learning from SIs has led to:

- collaboration with hospitals to ensure that pathways for time critical interventions are effectively managed
- real-time safety monitoring
- development of a procedure to determine skill mix and dispatch priority for back-up requests.

During 2016-17 YAS has implemented an end-to-end review process across the organisation. This involves a number of cases that are identified each quarter and involve other providers, where it is felt that multi-agency review would benefit the case and identify the most appropriate learning for all parties.

Serious Incidents	Operations - A&E	EOC	PTS	NHS 111	Other	Total
April 2016	0	1	0	2	1	**4**
May 2016	3	1	0	2	0	**6**
June 2016	0	4	1	1	0	**6**
July 2016	1	3	0	0	0	**4**
August 2016	4	3	1	1	0	**9**
September 2016	3	0	0	1	1	**5**
October 2016	1	3	0	1	0	**5**
November 2016	0	2	0	0	0	**2**
December 2016	1	0	0	0	0	**1**
January 2017	1	0	0	1	1	**3**
February 2017	0	3	0	0	0	**3**
March 2017	0	4	0	0	0	**4**

YAS has worked effectively with GP practices, social services, acute hospitals, community trusts, mental health teams, other healthcare providers and partners such as the police to conduct thorough investigations using an 'end-to-end' approach which follows the patient journey throughout to understand all elements of treatment and care provided.

This has been part of the CQUIN programme for 2016-17 and will continue to be part of this throughout 2017-18. So far this process has resulted in improved processes regarding mental health assessment in the EOC, joint working with Sheffield Teaching Hospitals in relation to PPCI patients and a wider review conducted on inter-facility transfers across the region.

Performance against Priorities for Improvement 2016-17

PRIORITY ONE - Lead: Dr David Macklin, Executive Director of Operations

Patient Safety: ***Delivery of sustainable improvement in emergency ambulance response performance in line with national standards***

YAS has embarked upon a transformation programme designed to deliver a sustainable service by recruiting staff to an improved level, ensuring the skill mix between clinical and non-clinical frontline staff meets patient demand and expectations. Increase in staff means new rotas better aligned to resources against demand by having the right people in the right place. This new resource will assist in the delivery of response performance targets whilst improving on the T19 transportation of patients to suitable treatment facilities. To assist in matching resources to demand a capacity planning function is planned to be in operation by April 2017. All of this will be supported by a new leadership and management structure.

YAS has also piloted the Ambulance Response Programme. This has included a review of the codes of 999 calls to allocate the appropriate response and improve the performance to life-threatening calls in a safe and effective manner.

Achieved	Partially Achieved	Not Achieved

PRIORITY TWO - Lead: Angela Harris, Lead Nurse Urgent Care

Patient Safety: ***Development of the Trust's role in care co-ordination across the urgent and emergency care system, with particular focus on frail older patients, patients with palliative care and patients with mental health conditions***

YAS has successfully secured a Health Foundation grant to conduct work around improving responses for frailty and falls across the region. South Yorkshire firefighters and police joined forces with YAS Trust to launch a new team to attend lower priority incidents in Sheffield, with the aim of reducing the demand on 999 responders. The team responds to help people at high volume, lower priority incidents, which can take police officers and paramedics off the road for many hours. This type of incident includes helping residents who have had a fall, are not seriously injured, but are unable to get up on their own. Their work will also involve carrying out welfare visits relating to low risk missing people and vulnerable people who are risk of anti-social behaviour.

A falls pilot funded by the West Yorkshire Vanguard is also underway across West Yorkshire to improve response to patients who fall.

YAS is working in partnership with GPs, community nurses, therapists and NHS England to identify how we can improve care and support during winter, preventing hospital admissions where appropriate for patients in residential/nursing homes who fall. We are also working with nursing teams to implement a yellow Emergency Care Plan for patients at high risk of admission. By working together with partners we are aiming to identify whether with additional support appropriate care can be provided in the home.

Palliative care is a priority for YAS improving the service we provide to patients and families. Our Lead Nurse is working across all ambulance services to continue to develop shared resources that can be utilised for all professional groups in the organisation. We have an established end-of-life transport vehicle in Leeds working closely with the hospice which we hope to expand in 2017. Alongside this we have nurses in NHS 111, online training resources have been developed for our 111 call handlers and general nurses. Kirkwood Hospice has supported staff to undertake a bespoke training day to improve knowledge and skills for frontline paramedics.

YAS has signed up to the national Mental Health Concordat and is working closely with the CCGs across the region. We have recently increased our number of out-of-hours mental health nurses and have a professional mental health nurse lead that will support this in 2017. We are also working with Public Health England and NHS England.

YAS has signed up to a consensus statement with police and partners to identify how as a regional service we can share best practice and resources to improve care for patients in mental health crisis.

As an employer we have also set up a mental health improvement group and our Chief Executive has advocated the MIND Blue Light Programme.

Achieved	Partially Achieved	Not Achieved

PRIORITY THREE - Lead: Dr Steven Dykes, Deputy Medical Director

Clinical Effectiveness: ***Improvement in patient outcomes with key conditions - cardiac arrest and sepsis***

Work has continued to develop and enhance the level of patient care delivered by the Red Arrest Team (RAT) paramedics to patients in cardiac arrest. Training has been delivered to new clinical supervisors and will be extended to a number of paramedics who will be able to provide cover for the scheme particularly in rural areas. The core competencies of the RAT have been extended and now include the use of transcutaneous pacing using midazolam as a sedating agent and the administration of ketamine as an extended analgesic for adult patients who have suffered traumatic injuries. This will be followed by the introduction of the selective sedation of patients who have a return of spontaneous circulation. The ability of RAT paramedics to provide a focused debrief has been improved with the introduction of data downloads from the defibrillator. This enables the RAT paramedic to download detailed clinical information including the rate of chest compressions and the chest compression fraction as well as information regarding end tidal carbon dioxide levels. This allows frontline clinicians to receive detailed information about the treatment they provide to their patients as well as support and guidance on improving their clinical care

YAS has developed a Pre Hospital Screening Tool in conjunction with Emergency Department consultants across Yorkshire. This year the Screening Tool has been updated using evidence from NICE guidance and the UK Sepsis Trust, and covers adults and children. YAS has adopted the National Early Warning Score as a system of detecting deteriorating patients and communicating with other healthcare professionals. The updated Screening Tool will now align with NEWS, and will continue to improve the management of Septic patients in the Pre Hospital environment.

Achieved	Partially Achieved	Not Achieved

PRIORITY FOUR - Lead: Dr Steven Dykes, Deputy Medical Director, and Clare Ashby, Head of Safety.

Patient Safety: ***Improvement of patient safety aligned to the Sign Up to Safety Campaign, focused on moving patients safely, improving communication within the EOC and improving the care and management of deteriorating patients***

2016-17 has been the second year of the Sign up to Safety programme at YAS with three clear work-streams now established to reduce harm to patients. This is part of a wider national campaign supported by NHS England and the Department of Health.

Sign Up to Safety roadshow, undertaken at all Emergency Departments across Yorkshire throughout the summer, gave frontline staff up-to-date information about the campaign work-stream, management of deteriorating patients, and included: Sepsis, NEWS, effective handovers, clinical pathways, infection prevention and control practices, medication management amongst other topics. Staff were fully engaged and enjoyed the roadshow, and both the Clinical Directorate and Quality Team are looking undertake a follow up roadshow in 2017-18.

Within the EOC the human factors and safety huddle pilot has been completed, evaluated for effectiveness and has been rolled out to all teams within the EOC. The focus of the work is to reduce patient harm by ensuring ways of communicating and systems and processes within the EOC work effectively to promote patient safety by understanding and compensating for human factors within this setting. Incident reporting has been analysed to review these human factors and actions are taken locally to reduce and resolve. Incident reporting within the EOC has increased over this period, which is a positive sign of an increasingly safety focused workforce. Overall the pilot and the wider roll-out has been well received by staff working within the EOC.

The Moving Patients Safely (MPS) work-stream has focused on the safe movement of patients with complex mobility needs, including bariatric patients. A standard operating procedure (SOP) has been developed in order to ensure patients with complex mobility needs receive care in a timely manner and with dignity and respect. Work to fully embed the SOP has become a key part of the MPS work-stream. Other elements include review of the education and training for staff, review of the current equipment provided, including staff surveys on its safe and effective use and development of a risk assessment process for those who may require additional specialised equipment in order to mobilise them from their home, either in a planned or emergency setting. Following the establishment of the Critical Friends Network, the MPS group intend to work with these specific groups to ensure our service delivery model matches their needs.

Achieved	Partially Achieved	Not Achieved

PRIORITY FIVE - Lead: Dr Steven Dykes, Deputy Medical Director

Patient Experience: ***Improving the experience for children***

Children have distinct needs when it comes to life support and clinical care, and it is important for clinicians coming into contact with children to be appropriately trained. Over the past year YAS has provided CPD and simulation events across the region from expert doctors and nurses in paediatric care, and together with the launch of the paediatric screening tool has allowed clinicians to become more confident in treating children. A full review of paediatric clinical equipment has been undertaken, and conforms to national standards, and a new and improved child harness system has been introduced to all ambulances, to ensure the safe and comfortable transport of children to hospital. YAS will continue to work with external partners to innovate and improve the care we deliver to children.

Achieved	Partially Achieved	Not Achieved

Review of Quality Performance

NHS Staff Survey Results - Reporting of Errors, Near Misses and Incidents

	2015 percentage for YAS	National average for ambulance trusts 2015	**2016 percentage for YAS**	National average for ambulance trusts 2016
Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the better)*	**85%**	79%	**84%**	81%
The fairness of incident reporting procedures *(score out of 5.0 - the lower the better)*	**3.27**	2.28	**3.28**	3.38

YAS is committed to the development of a culture that is open, honest and transparent; this includes consistent encouragement to report all incidents, near misses and concerns. The national data shows that YAS is above the average for ambulance trusts in terms of staff perceiving the reporting culture to be fair.

An investigations and learning work plan was been developed and implemented in 2016-17 and included actions to improve the process of feedback to staff who report incidents, providing new training for staff on human factors and the implementation of the Freedom to Speak Up Guardian and supporting advocates.

"I currently work within the Legal Services Department where my core role is liaising directly with the police to assist with requests for information as part of on-going investigations. I am responsible for ensuring Trust procedures and policies are followed when recording, collating and disclosing the requested information for police investigations. The requests are varied but usually consist of 999 audio calls and logs, Patient Care Records and coordinating interviews with members of staff. This is a challenging but rewarding role. Being part of the legal team I also assist with the wider team workload which includes Coroners inquests, Subject Access Requests, FOI requests and claims."

Karen Mitchell,
Legal Services Assistant

Infection Prevention and Control (IPC) Audits

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Overall Compliance	**Hand Hygiene**	98%	98%	99%	99%	99%	99%	99%	99%	98%	99%	98%	98%
	Premises	97%	98%	98%	98%	99%	98%	98%	99%	99%	98%	98%	99%
	Vehicles	98%	98%	99%	98%	97%	98%	98%	98%	99%	98%	97%	98%

Safeguarding

The profile of safeguarding children and adults at risk continues to grow and change and is a key priority across YAS. Both policy and practice have been reviewed to ensure compliance with legislation and good practice guidance. The Safeguarding Team continues to engage and support staff within all departments including The Emergency Operations Centre, Operations, Patient Transport Service and NHS 111 to identify safeguarding priorities to ensure quality patient care.

The Safeguarding Team continues to work Trust-wide, with partner agencies, including commissioners, social care and health partners, to review and improve the quality of the safeguarding service provided by YAS staff. Ensuring YAS employees including, secondees, volunteers, students, trainees, contractors, temporary or bank workers and NHS 111, have the appropriate knowledge and skills to carry out their safeguarding children and adult duties.

Safeguarding processes and practice are being continually reviewed and strengthened; especially with regard to the quality of Safeguarding referrals to Adult and Children Social Care, the education and training of staff and the safeguarding clinical audit processes.

Within the year, safeguarding practice has been enhanced by the introduction of a safeguarding module within Datix. This ensures accurate monitoring of activity, reporting and the availability of trend analysis of current safeguarding processes and work streams.

The Safeguarding Team have contributed to Serious Case Reviews (6), Safeguarding Adult Reviews (4) and Domestic Homicide Reviews (10) across the Yorkshire region.

Ongoing priorities are to review the current Safeguarding Children and Adult Referral Process, to ensure concerns are effectively shared with local authorities, and to review and develop the Mandatory Safeguarding Training Plan, for all YAS staff, inclusive of NHS 111, volunteers and Community First Responders (CFRs).

Safeguarding Training

- Safeguarding Children level 1 Trust-wide compliance has been consistently above 95% in 2016-17.
- Safeguarding Adult level 1 Trust-wide compliance has been consistently above 94% in 2016-17.
- Trust-wide compliance for Prevent basic awareness has consistently increased from 90% to 95.19% during 2016-17
- Trust-wide Compliance Workshop to Raise Awareness of Prevent (WRAP) 86.68%
- Operational frontline staff figure for WRAP A&E Ops is 92.84%.

Number of Referrals

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Child	487	548	511	546	463	460	457	414	435	424	431	469	**5,645**
Adult	697	730	700	709	812	714	727	765	773	803	728	697	**8,855**

PATIENT STORY

Tracey Creaser, PTS Ambulance Driver, pictured with her grandson Tyler

Little Hero

Tracey Creaser, PTS Ambulance Driver at Dewsbury, received an unexpected call on Thursday 29 September 2016 from her partner Rachel. Their three year-old grandson had been playing in the corridor of the flats where they live and had come running in saying he had heard their neighbour Michael calling out. Initially, Rachel told her grandson not to worry, but he pulled her into the corridor saying that Michael needed some help. Rachel went to investigate and they found that Michael had fallen and was on the floor in his flat unable to move.

Rachel called Tracey who instructed them to call 999 straight away. While waiting for the ambulance her grandson continued to talk to Michael to check he was breathing, and reassured him telling him he would be OK. Michael was quite scared and mentioned that he didn't want to go to hospital. The three-year old very calmly told him it would be OK and that the hospital would make him better. He showed true hero spirit by letting in the ambulance crew when they arrived.

Tracey said: *"It turned out that Michael's fall had been caused by a heart murmur, although at the time they thought he had had a possible heart attack. When I returned from work that day Tracey's grandson proudly told me he had saved 'mismas' (his word for Christmas) as Michael is tall and has white hair and reminds him of Santa Claus. We are all so proud; he acted with such courage and bravery for someone so young. He has been in an ambulance before as he has asthma and we think he used the reassuring words we say to him when he's going to hospital to help keep Michael calm."*

Michael said: *"I am so proud of the little boy. If he hadn't heard me I really don't know how long I would have been there. As well as thanking him and Rachel, I would also like to thank the Yorkshire Ambulance Service crew who helped me."*

Clinical Quality: "Right care, Right place"

The following reviews and audits have taken place throughout the year to help improve the service we offer to patients:

- **Mortality reviews:** supports a safe system of care by ensuring all patients where YAS perform (recognition of life extinct) ROLE are clinically reviewed applying a tool to support the identification of learning and sharing this internally and externally.
- **Records review:** highlighting areas of good practice supporting staff in their development as well as provide assurance that there is good adherence to record keeping.
- **Handover audits:** observational audit of staff delivering handover to hospital staff, clinical handover is well recognised as a risk area for patients a good clear structured handover limits errors and the patient risk.
- **RAT:** improving and sustaining the performance of one of the best ambulance trusts when looking at survival from out of hospital cardiac arrest. Good team leadership, reinforcing decisions, sharing experience all contributes to keeping YAS one of the highest performing trusts.

We have also:

- **Service reconfigurations:** working to ensure the care given to patients is safe highlighting when changes have had a negative effect on one part of the population to acute trusts and commissioners.
- **Intelligent data:** The appointment of a clinical analysis has provided opportunity to better understand clinical impacts of the role of the ambulance service. Cardiac arrest review 2014-15 and 2015-16 provides insight into the role of YAS and what clinically is delivered as an organisation.
- **Review process for frequent callers:** provides clinical assurance that the decisions and safety netting is appropriate and taking the best interests of the patient and the wider public impact into consideration.

Alternative Clinical Pathways

YAS continues to increase the number of direct pathways for patients presenting with a suspected hip fracture. York joined Hull in prioritising patients with suspected Hip fracture with the aim of reducing the time in ED and speeding up access to surgery.

Falls

Frail elderly and falls patients account for over 500 calls per day to NHS 111 and 999; this represents one of the most significant areas of demand for NHS 111 and 999. YAS is working with system partners across Yorkshire and Humber to explore different models of care for this cohort of patients.

Clinical Hub Pathway Referral Comparison 2014-15 and 2015-16

Referral Pathway	Total referrals 2016-17	Total referrals 2015-16
COPD	3	5
Diabetic referrals	1,467	1,635
Falls referrals	6,802	6,643
Epilepsy referrals	198	48
Safeguarding	13,947	12,445
Mental Health referrals	8	47
End-of-Life care	1	8
Social care referrals	878	557
Alcohol and Substance	328	323

There is currently one model progress running; a Fire and Rescue response coordinated by YAS. YAS is aiming to pilot two additional models; one, the provision of lifting equipment for ECPs in Sheffield and an integrated model based from Leeds in West Yorkshire; a dedicated response supported by the Clinical Advisory Service. It is anticipated that this integrated service would be able to see a broader range of lower acuity patients and support 999 crews where appropriate.

The aim of this trial, along with the outputs of the other pilots, is to inform the development of integrate services for Yorkshire and Humber and the YAS workforce strategy.

The initial trial is planned to go live in December 2016 for six months. There will be an initial evaluation in March to ascertain the benefit of the pilot on supporting pressures on the system and plans for 2017-18, specifically the value of continuing or expanding the service throughout 2017-18 or curtailing at the end of the pilot.

Mental Health

In mid-December 2014 Yorkshire Ambulance Service (YAS) employed mental health nurses to support front line clinicians in the Emergency Operations Centre (EOC) for various shift patterns over the Christmas period to "better manage" demand and "improve patient experience and outcomes" for patients with mental health issues. The benefits of this service was aligned to the crisis care concordat ensuring patients get a service to support them in mental health crisis.

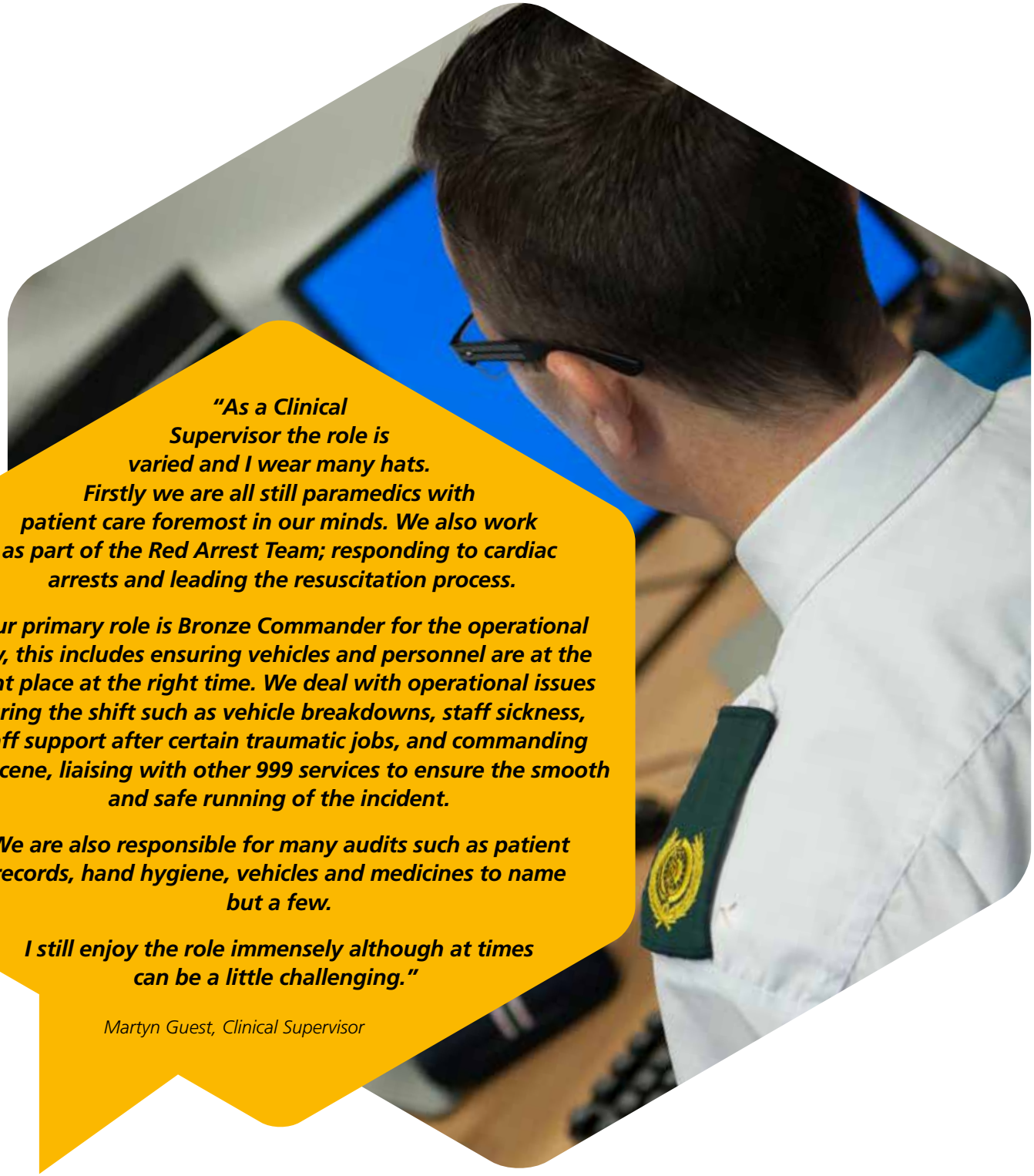
Ruth Crabtree, Clinical Excellence Manager - Public Health Lead (second left) and YAS Clinical Development Manager Liz Harris (third left)

Award Success for Alcohol Pathway

YAS was Highly Commended at the Advancing Healthcare Awards. The achievement was for the YAS onward referral pathway for alcohol misuse in the Faculty of Public Health and Public Health England Award for Contributions to Public Health. This pathway has been highly successful across the Trust.

Clinical Supervision

The clinical supervisor (CS) team across YAS has been involved in redefining the way in which they provide clinical supervision to their staff. The clinical directorate is supporting the CS teams to provide one to one clinical supervision and peer support to paramedics as well as educational development in a frontline setting. This has enabled the amount of clinical supervision provided to increase substantially. This is being facilitated by the clinical development managers (CDMs) and the clinical leadership fellow.
The CDMs take responsibility for the clinical supervision and support for the CS teams and assist them in the clinical component of their role. The clinical leadership fellow is a Health Education England funded post that is principally involved providing simulation training for frontline clinicians. The simulations provided range from high acuity cases involving cardiac arrest and major trauma and low acuity calls where the emphasis is on decision making and minimal on-scene time. The clinical directorate has started a programme where each clinician within the Trust is stood down for a clinical simulation with their CS team each year.



"As a Clinical Supervisor the role is varied and I wear many hats. Firstly we are all still paramedics with patient care foremost in our minds. We also work as part of the Red Arrest Team; responding to cardiac arrests and leading the resuscitation process.

Our primary role is Bronze Commander for the operational day, this includes ensuring vehicles and personnel are at the right place at the right time. We deal with operational issues during the shift such as vehicle breakdowns, staff sickness, staff support after certain traumatic jobs, and commanding the scene, liaising with other 999 services to ensure the smooth and safe running of the incident.

We are also responsible for many audits such as patient records, hand hygiene, vehicles and medicines to name but a few.

I still enjoy the role immensely although at times can be a little challenging."

Martyn Guest, Clinical Supervisor

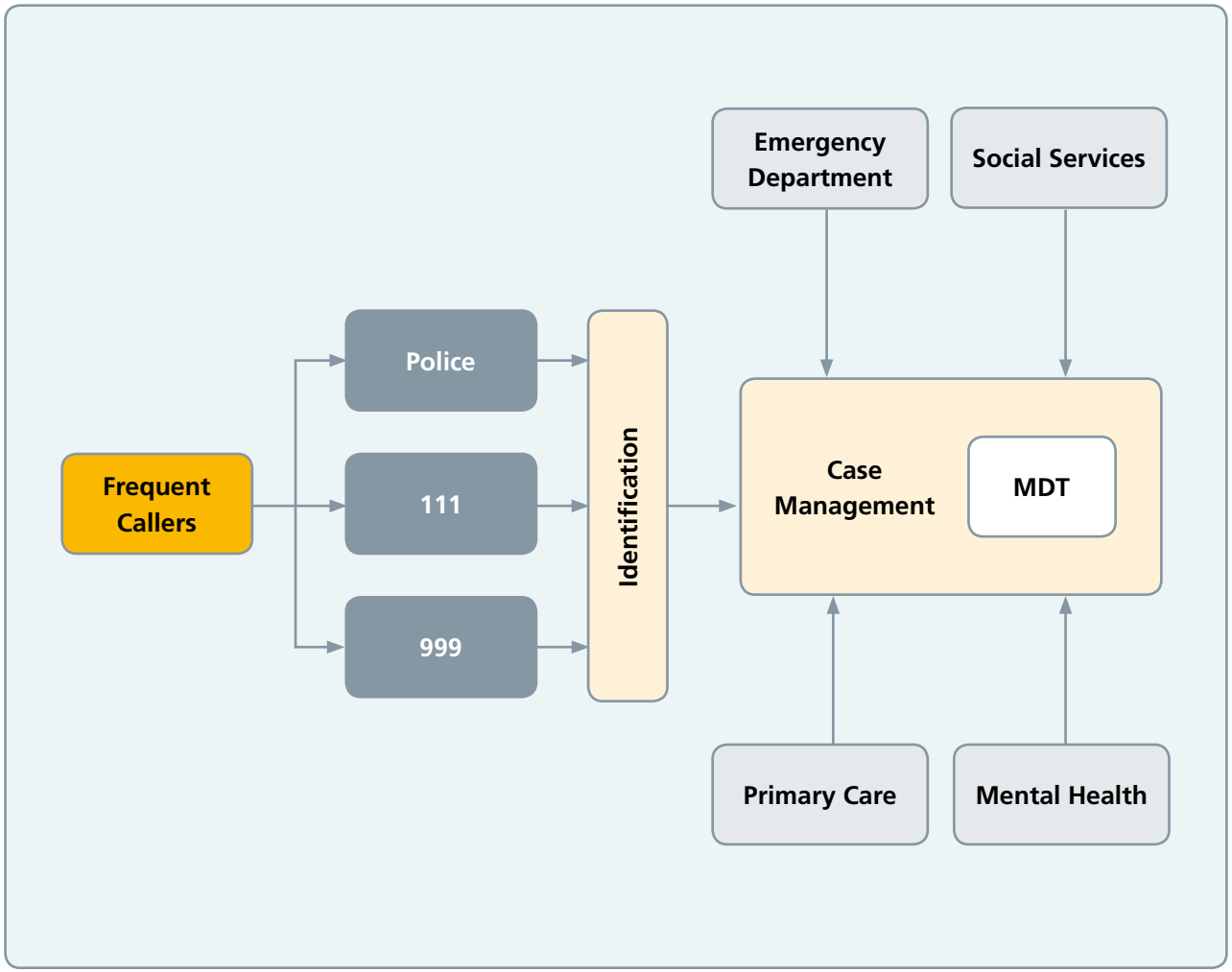
Frequent Callers

The identification and management of frequent callers to the emergency service offered by YAS is essential for the Trust to fulfil its obligation to identify and safeguard vulnerable people. YAS currently provides a coordinated case management approach for frequent individual 999 callers

YAS is looking to expand this existing frequent callers service into NHS 111 and supporting care homes, building on the existing service. This service will case manage patients who continually call NHS 111 to ensure that they have the support that they need to reduce their impact on the UEC service. There would also be a focus on care homes that regularly contact UEC services to provide advice, support, signposting and education. Conversations are ongoing with commissioners for funding in the next financial year.

Impact:

- Reduced calls to NHS 111
- Reduced transfers to 999 and ambulance conveyance from frequent callers
- Reduced ED attendance by frail elderly patients from care homes
- More patients treated at home
- Improved patient outcomes and experience.



Cricket legend Geoffrey Boycott officially unveiled Yorkshire Air Ambulance's new, state-of-the-art helicopter.

Left to Right: Dr Anil Hornis, Pete Vallance, Geoffrey Boycott, Chief Pilot Andy Lister, Kit Von Mickwitz, Dr Paul Onion

Yorkshire Air Ambulance

The partnership between Yorkshire Ambulance Service and Yorkshire Air Ambulance (YAA) charity has continued to grow and develop over the last 12 months. YAA has attended over 1,500 incidents this year from its two operational bases at Nostell and Topcliffe.

April 2016 saw the introduction of a Critical Care Team (CCT) consisting of a consultant level doctor and two advanced trained paramedics. This CCT has been in operation from the Nostell base providing enhanced clinical care across the region both on the aircraft but also by RRV if required. The team structure allows for a broad range of knowledge, experience and clinical skills to be delivered to scene.

Other major developments saw the replacement of YAA`s two MD902 helicopters for two brand new state of the art Airbus H145 aircraft that provide a much improved clinical area with greater access to patients whilst in-flight. The first H145 went in to operation during September 2016 and has since flown over 100 missions; the second aircraft became operational in December.

The H145 is fully night capable and this will allow operations to be extended into darkness from summer 2017 offering better availability particularly during winter months.

A major clinical development to arrive during 2017 will be the availability of blood products on both YAA aircraft. This will be the first time that blood will have been available in the pre-hospital environment across Yorkshire for the treatment of major haemorrhage.

The staff at YAA have undertaken training on business continuity planning and following an assessment by the BSI became the only UK air ambulance to attain the ISO 22301 certification.

NHS 111

NHS 111 regional wide service across Yorkshire and Humber, serving a 5.3 million population, once again experience year-on-year growth in patient calls with 1,570,254 call answered in 2016-17, a rise of 3.9% from the previous year.

The NHS 111 service line was inspected for the first time by the Care Quality Commission (CQC) in October 2016 and rated the service as 'Good' across all domains within its published report February 2017.

"I enjoy my role as an NHS 111 call handler. Every day is different, due to the variety of calls we take and you never know what type of inquiry you are going to get next. It is very satisfying to know that you have helped patients receive the level of care they need."

Caroline Bedford,
NHS 111 Call Handler

The report details some excellence in care, practices, and training including identifying some aspects as 'Outstanding' around innovation and workforce planning.

There are three areas within the report that the service is recommended to progress; clinical recruitment; staff support and audits and the ability for staff to raise concerns linked to the culture which form part of our service development plans.

Key performance information

- 1,570,254 patient calls answered (3.9% up on 2015-16).
- 93.3% of calls answered within 60 seconds against a target of 95% (4.2% up on 2015-16).
- 79.7% of clinical calls received a call back within two hours; whilst this was a decreased from 2015-16 more calls are being managed by clinical staff.
- Of the calls answered, 8.8% were referred to 999; 14.7% were given self-care advice and 6.5% signposted to A&E. The remainder were referred to attend a primary or community care service or attend another service such as dental.
- In an independent survey 95% of patients agree/ strong agree that they were treated with dignity and respect, with 96% of patients feedback that they followed some, or all of the advice that they were given. 90% would recommend NHS 111 to their friends and family and overall satisfaction for the service continues to be extremely positive with 48 compliments.

NHS 111 Service Developments

Locally this year NHS 111 has supported the development of the regional wide Clinical Advisory Service that went live in December 2016 which has increased the specialists clinical support available for 999 and NHS 111 callers; including mental health, palliative and pharmacy.

GP in-hours booking has been piloted across 27 practices in West Yorkshire; the pilot will be utilised to inform a wider regional service.

NHS 111 has introduced homeworking successfully for clinicians to work at home creating a flexible workforce model for the future. Working with NHS Digital, YAS has supported a pilot of the national NHS 111 Online service; which went live 1 March 2017. This is an exciting innovation and is been piloted with the Leeds Clinical Commissioning Groups to inform the potential of a national online tool for the future.

YAS continues to support the national development of NHS 111 service, particular around our workforce and was accepted as an Early Adopter for the NHS England initiative testing out the ideas for national workforce competencies and career framework for staff working in Integrated Urgent Care/NHS 111.

YAS has also been successful in phase two of the NHS England Workforce Investment pilots and is progressing two projects; Improving Audits and Workforce Supervision.

The NHS 111 team's success has been recognised formally as the team was successful in achieving several awards for the work they have undertaken during 2016-17:

- Wakefield/Kirklees CCG Innovation Award: Pharmacy Innovation Scheme Award for showing innovation in the evaluation and development of an NHS Pharmacy Team which supported the work of the Pharmacy Urgent Repeat Medication scheme
- The National Professional Planning Forum Awards for our workforce management team; both the Planning Hero award and the Best Newcomer award.

Clinical Quality/Quality Developments

We continue to work with commissioners and suppliers including NHS Pathways to enhance service and referral pathways for patients calling NHS 111. During 2016-17 we successfully implemented two upgrades to the clinical content of the NHS Pathways system; involving staff training and development on the new systems.

Future Plans

The contract for NHS 111/WYUC will be in its final year during 2017-18 and YAS has agreed to work with commissioners in terms of transitional arrangements to help with the development of their integrated urgent care service for the future.

Planned and Urgent Care

In May 2016, recognising the increasing emphasis for care in the community, a Directorate for Planned and Urgent Care was created. The Directorate includes NHS 111, Patient Transport Services and the Urgent Care agenda.

West Yorkshire Urgent & Emergency Care Vanguard (WYU&ECV)

As part of the West Yorkshire Urgent and Emergency Care Vanguard, YAS has played a leading role in the development of the Clinical Advisory Service (CAS), which went live in December 2016. The service will continue to develop to support callers into 111/999 and to support front-line staff to manage more patients in the community. Our sub-contractor Local Care Direct supported 247,339 patients through the West Yorkshire Urgent Care service, a decrease of 5.2% from 2015-16. Whilst demand has fallen it remains significantly above the contract base level and this year, working with commissioners, an independent review on the service has been undertaken which has highlighted changes to the current operating model, contract and finances for 2017-18 and to develop the service for the future.

We will be working with other NHS providers to create a network of advice to support the CAS.

In addition, we have worked with IT leads across West Yorkshire to allow our clinicians to access the Leeds care record to support better decision making.

West Yorkshire Acceleration Zone (WYAZ)

In December 2016, West Yorkshire was selected by NHS England to become our Acceleration Zone for fast forwarding the Urgent and Emergency Care transformation. This supported the development of home/remote working for clinicians and increased clinician capacity in NHS 111.

Q-Volunteering

In November 2016 the Department of Culture, Media and Sport asked ambulance services to bid for project monies to support the development of volunteering in the health sector.

The successful bid was to set a project to explore the relationship that YAS has with the voluntary sector and to understand how by working across the sector we can support patients in their community with urgent care needs. The project will also explain how as an ambulance service we can co-ordinate and maximise the huge benefits that our Community First Responders (CFR) and Volunteer Car Service drivers bring to the organisation.

We are working closely with the Red British Cross who have seconded a Project Manager.

Inspections for Improvement

The Inspections for Improvement process is a rolling annual programme of Ambulance Station and vehicle inspections undertaken by members of staff within the Quality Governance and Performance Assurance Directorate supported by local staff from the inspection site.

Key areas of standards are reviewed such as Information Governance, Infection Prevention and Control, Health and Safety and Security. The process also promotes standards required by regulators such as Care Quality Commission.

Staff locally are involved and included in the inspection process and encouraged to take ownership of their ambulance station or Patient Reception Centre; dealing with issues as they arise and reporting where they cannot resolve.

"Working on the Estates Helpdesk enables me to be the first point of contact. This job enables me to prioritise calls so we can attend in the most appropriate time frame to the estates issues or queries we receive. I like the fact that I work in a small team of multi-skilled staff who are able to offer advice and guidance with any issues I may come across. The part of my job I enjoy the most is building up working relationships with staff mainly the Clinical Supervisor teams and Locality Managers; this has enabled me to get in insight into what they do and how Estates can support them. I like that no two days are the same."

Sophie Holroyd, Estates Help Desk Administrator

Sign up to Safety

Sign up to Safety is one of a set of national initiatives in England to help the NHS improve the safety of patient care and aims to reduce avoidable harm by 50%.

Dr Steven Dykes, Deputy Medical Director, said:

"By joining Sign up to Safety, we are promising all patients and staff at YAS that we are placing the safety of patient care above all else."

Over 370 organisations from across England have pledged to make care safer as part of Sign up to Safety. Yorkshire Ambulance Service was proud to be one of the first ambulance services to confirm its pledge. The programme helps to deliver locally led, locally driven safety improvement projects.

At YAS we work hard to focus on the areas we know can be improved to make care safer. Clare Ashby, Head of Safety, said:

"We are committed to supporting our staff to be open with patients when things go wrong and most importantly, to continually learn from incidents in order to improve."

During 2016-17 we have continued the *Safety Update* bulletin; following feedback from staff this visual, quick-read poster format was designed to ensure staff got feedback and learning from safety incidents. The bulletin has gone out every month since and is well received by staff. It helps to share learning from incidents and ensure actions are taken to avoid further incidents occurring.

We have zero tolerance to the three harms of medicine errors, patient falls and patient injuries, whilst in our care. These three types of incidents make up the YAS Safety Thermometer data that continues to be used in order to promote patient safety harm free care days within YAS. Staff are made aware of common errors and incidents that may lead to patient harm by a monthly update poster.

Sign up to Safety on the Road

In order to promote the Sign up to Safety campaign, engage with operational staff and celebrate good practice, a series of roadshow events took place throughout August, September and October 2016. These events included members of the Clinical Directorate and Quality and Safety Team visiting emergency departments to discuss aspects of clinical quality and patient safety, in particular those relevant to the four on-going work-streams.

The 'Bright Ideas' scheme is an opportunity for all YAS staff to submit ideas which could, potentially, make a positive difference to patients, staff and services. The objective of the scheme is to contribute to the delivery of YAS's vision and values as well as encouraging innovation, improving morale and encouraging staff participation. The idea could be something new, a change to a working practice or something that YAS should stop doing.

Emergency Communications Centre – Human Factors Study

Staff within the Emergency Communications Centre (EOC) have reviewed their patient safety incidents and, by analysing themes and trends in relation to human factors, have developed a work-stream locally that aims to reduce patient safety incidents that relate to communication, situational awareness and decision making. In order to promote good practice within the EOC they have implemented daily safety huddles that focus on learning from incidents, common errors and actions to take to reduce patient safety incidents.

Staff have found the safety huddles a valuable time to share learning, discuss day-to-day concerns and to develop ideas and solutions to resolve local issues.

Clinical safety

This year we have focussed on:

- Deteriorating adult, including recognition and treatment of sepsis
- Recognising the sick child.

Both work-streams have included a review of current practice, skills and training, followed by robust implementation of recognised tools, including National Early Warning Score (NEWS) and the SBAR handover tool. Collaborative work with emergency departments has enabled a new regional network to be developed and care pathways and consistent protocols have been agreed. A regional screening tool for sepsis has been introduced and has been well received by staff.

Moving Patients Safely

The work-stream 'Moving Patients Safely' progressed into its second year with a clear focus on development of an operational Standard Operating Procedure that supports the safe and effective movement of patients with complex mobility needs. The SOP has been widely tested prior to development and went live in operational services at the end of August 2016. This includes a risk assessment process for people who may have complex mobility needs, undertaken in their own homes with Patient Transport Services (PTS) staff and then shared across both PTS and 999 services.

Incident Category	PTS Incidents 2015-16	PTS Incidents 2016-17
Falls	57	22
Injuries	46	33
Total incidents	**103**	**55**

Falls and injuries are monitored through the safety thermometer and key messages in terms of the actions to take to reduce falls and injuries are delivered to staff through monthly safety update posters. Throughout 2016-17 there was also targeted communications including the monthly safety update around moving patients safely.

As a result of this the Trust had seen a reduction in falls in PTS of 61% and injuries 28%.










YORKSHIRE AMBULANCE SERVICE
SUPPORTS RESTART A HEART

YAS in the local community

Restart a Heart Day 2016-17

A staggering 20,000 youngsters received CPR training across Yorkshire on Restart a Heart Day.

The event was possible thanks to over 600 volunteers who gave up their time to pass on their life-saving skills to youngsters at 105 secondary schools across Yorkshire. For the first time, our concept was rolled out to all UK ambulance trusts and more than 150,000 youngsters learnt CPR across the country.

Community Defibrillators

In January 2014 the YAS Charitable fund (YASCF) began its work to fund AEDs (Automated External Defibrillators) within local communities. This work has been sustained and expanded year-on-year since.

One of the Community Resilience team objectives is to increase the number of community Public Access Defibrillator (cPAD) and static devices registered in CAD by 10% per annum. At the close of 2015–16 there were 489 cPADs registered on our CAD system. At the end of October 2016 there were 715 registered on our CAD system. It is fantastic that we are overachieving on our objectives as each AED can prove to be life saving for local residents.

Out of the 715 cPADs now live on CAD only the initial 115 are YAS assets leaving 600 provided through partnership working with national charities and other organisations such as SADS, and the British Heart Foundation, local charities which include Smile, town and parish councils, local businesses and individuals.

Pupils and staff at Our Lady and St Peter RC Primary School in Bridlington celebrate the installation of their new community Public Access Defibrillator (cPAD)

Public Health

At a national level ambulance, health and public health colleagues share an interest in recognising and further enhancing the ambulance services' current role in the public health agenda and as such a consensus statement based on the recent model between health, public health, the voluntary sector and fire and rescue service is in development.

This national work has highlighted an opportunity for a partnership approach across the region with the Yorkshire and Humber regional centre for Public Health England (PHE).

This partnership aims to develop joint approaches to tackling public health needs locally and this is encompassed by a broad range of objectives including integrating ambulance service data into public health intelligence as well as building upon the national work surrounding Making Every Contact Count (MECC) at a local level.

Ambulance service data holds a wealth of information which could be of major use to public health teams in terms of understanding the health needs of the population and being able to effectively target services. Work is currently underway with PHE's local knowledge and intelligence service to develop a regional ambulance dataset linked to key local authority public health work streams including alcohol misuse, falls and self-harm.

We are also working with each of the fire and rescue Services and police forces across the region on our shared commitment to intelligence-led early intervention and prevention. A regional consensus statement is being developed which will outline how the emergency services across Yorkshire and the Humber will begin to work together more closely on the public health agenda particularly around MECC. Priority areas of focus include falls/frailty, mental health, alcohol and violence.

This year YAS pledged to inspire a smoke-free generation through the Yorkshire and Humber Breathe 2025 campaign. The Breathe 2025 vision is this: to see the next generation of children born and raised in a place free from tobacco, where smoking is unusual.

In recognition of our public health contribution YAS was a finalist for the Public Mental Health and Wellbeing Award at the RSPH Awards 2016 – the UK's premier national health and wellbeing awards event. The event saw the public health community come together to celebrate outstanding contributions to championing the public's health.

Shirley Cramer CBE, Chief Executive of RSPH, said:

"The RSPH Awards is a major highlight of the public health calendar… RSPH congratulates all of the organisations who have been shortlisted or won awards, all of whom have come through against stiff competition and are trailblazers and exemplars in their field."

PATIENT STORY

A 51-year-old lady visited her GP surgery as she had not been breathing well and had previously been prescribed antibiotics. The GP identified that they felt she may be suffering from a possible heart attack and 999 was called.

The A&E crew administered the right drugs, but whilst being transferred to the ambulance, the patient went into cardiac arrest. The crew shocked the patient and conducted cardio pulmonary resuscitation and successfully restarted her heart. She was transferred to Hull Royal Infirmary where she was cared for on the High Dependency Unit at Castle Hill Hospital.

The patient's sister contacted YAS as she would like to thank the crew who attended, her sister had been an alcoholic but now no longer drinks or smokes and is making a slow recovery. The patient also wanted to meet the paramedics to thank them personally for saving her life.

Looking after our staff

Employee Wellbeing

We recognise the need to support our staff and as such are developing a champions and peer support network to raise awareness and provide access to mental health and wellbeing support for YAS staff and volunteers.

In 2016-17 YAS has further promoted:

- **Post Incident Care Process (PIC)**

  We have enhanced our PIC process to include access to a clinical psychologist for cases of severe trauma and to improve our ability to record and monitor individual incidents.

- **Wellbeing Champions**

  YAS has created a group of over 70 Wellbeing Champions. They are disseminating information and providing the Employee Wellbeing Team with valuable feedback. They have been offered some training opportunities, but we really need to continue to build this network in terms of volume and scope.

- **Physical Competency Assessment (PCA) for applicants to front line roles (CQUIN activity)**

  We have begun to trial a PCA for applicants to front line roles. Further sessions are organised and these will continue until the validation of the PCA is complete. We can then evaluate with a view to incorporating into our recruitment process.

- **MSK/Back Care and health checks pilots (CQUIN activity)**

  We have now received information from two of the three potential providers that were contacted regarding delivery of the above. A preferred provider has been selected and is liaising with the involved areas of the organisation to run this pilot.

- **One You campaign and open wellbeing meetings (CQUIN activity)**

  The One You campaign (public health campaign aimed at individuals using resources to enhance their own wellbeing) will be launched in January 2017.

  As part of this campaign, meetings has been arranged to promote and discuss the campaign as well as wider wellbeing topics.

- **Workplace Wellbeing Charter**

  We have committed to working on the above to identify what further work is needed for us to achieve the 'Commitment' standard across all eight categories of the charter.

NHS Staff Survey

The NHS Staff Survey is an important means by which the experience of staff at work and their engagement with patients, colleagues and managers are explored.

The Trust's Staff Survey for 2016 was carried out as a census survey, with every member of staff being invited to respond and share their views. A total of 1,681 staff at Yorkshire Ambulance Service NHS Trust took part in this survey, this is a response rate of 37%. The 37% response rate is above average for ambulance trusts in England which was 34% in 2016.

The overall staff engagement indicator score for YAS in 2016 was 3.38 which represented a very slight increase on the 2015 result of 3.31. The Trust score however is below the national average for ambulance services which is 3.38. YAS believe that it is highly important that focus is given in this area of development and as such each directorate will be responsible for the development of a local action plan that will focus on the nine questions within the staff survey that make up the overall staff engagement score. Local action planning will be supported by the Leadership and OD Team which will help management team to improve staff motivation, advocacy and involvement.

The top five ranking scores for which Yorkshire Ambulance Service NHS Trust compares **most favourably** with other ambulance trusts in England are:

- KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- KF3. Percentage of staff agreeing that their role makes a difference to patients/service users
- KF16. Percentage of staff working extra hours
- KF11. Percentage of staff appraised in last 12 months
- KF2. Staff satisfaction with the quality of work and care they are able to deliver.

The five key findings for which Yorkshire Ambulance Service NHS Trust compares **least favourably** with other ambulance trusts in England are:

- KF9. Effective team working
- KF7. Percentage of staff able to contribute towards improvements at work
- KF24. Percentage of staff/colleagues reporting most recent experience of violence
- KF6. Percentage of staff reporting good communication between senior management and staff
- KF10. Support from immediate managers.

KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (the higher the score the better)

Trust score 2015	Trust score 2016	National average for ambulance trusts 2016
28%	37%	39%

K21 Percentage of staff believes that the Trust provides equal opportunities for career progression or promotion

Trust score 2015	Trust score 2016	National average for ambulance trusts 2016
72%	70%	70%

KF19 Organisation and management interest in an action on health and wellbeing (Higher score the better)

Trust score 2015	Trust score 2016	National average for ambulance trusts 2016
3.12	3.17	3.21

The intelligence gathered from all staff opinion surveys across the Trust informs the Communication and Engagement Strategy and associated action plans at both corporate and local levels.

Staff Recognition Schemes

Recognising and celebrating the successes and dedication of our staff is a priority at YAS. Trust-wide programmes in place include acknowledgement for long service and retirement, as well as the as the annual WE CARE Awards.

Staff working in EOC and NHS 111 are presented with lapel badges to highlight outstanding performance and attendance. The lapel badges are presented with a certificate of achievement and a letter of recognition for:

12 month's perfect attendance

NHS 111 - Compliment received from a patient/caller

EOC - Achievement of ROSC or outstanding contribution to attempted patient survival (i.e. prolonged CPR)

Nominated and selected as Call Handler/Clinician of the month

NHS 111 - Nominated and selected as having gone "Above and Beyond" expectations

EOC - Patient or colleague compliment

EOC - 12 months' high audit compliance

Freedom to Speak Up

In February 2015 Sir Robert Francis QC published an independent review into creating an open and honest reporting culture in the NHS. The review entitled "Freedom to Speak Up" aims to provide advice and recommendations to ensure that NHS staff feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon. Yorkshire Ambulance Service is one of the first ambulance trusts to commit to the recommendations of the review and continues to influence other NHS trusts as they look to implement the 'Freedom to Speak Up' philosophy into their own organisations.

Recognising that our 'Raising Concerns at Work' policy and process was underutilised a Freedom to Speak Up working group was established to focus on a range of activities that were intended to support the development of an open culture in YAS.

Comprising of representatives from across the organisation including operational colleagues, union representatives, staff forum members and support service staff, the working group undertook to develop a Freedom to Speak Up policy and Standard Operating Procedure. A route map' document was also produced to support staff who wish to raise a concern, providing them with a better understanding of the processes and support available to them.

Yorkshire Ambulance Service chose to adopt a single Guardian model supported by a number of Freedom to Speak Up Advocates. This approach was felt to enable better representation and exposure in an organisation consisting of a large number of sites and departments spread across a large geographic area. The value of this approach is already being recognised as staff feel confident to raise concerns with their local advocates.

Our Freedom to Speak Up Guardian Jock Crawford communicates with the National Guardian's Office in London on a regular basis. Regional NHS Guardian and National Ambulance Guardian Networks have now been established and YAS looks forward to hosting some of these events in 2017.

Staff Successes

Sarah Brown, Emergency Operations Centre Quality Auditor won the Analyst of the Year Award at the 2016 Quality and Customer Experience Awards

John Senior, NHS 111 Workforce Information Analyst, won Best Newcomer at the 2016 Data, Analytics and Insight Awards

Queen's Ambulance Medal for Distinguished Service awarded to Alan Baranowski

Jane Barstow receiving her award for 40 years' distinguished service in the NHS

Gareth Wood, winner of the Working Together for Patients Award, at the Trust's WE CARE Staff Awards

PATIENT STORY

The patient suffers with severe asthma, angina and COPD. She had surgery on her right hand so was unable to drive and needed transport to take her to her hospital appointments.

When the transport arrived the patient was advised that she was unable to take her own oxygen equipment (her small cylinder and rollator) that she uses to help her walk and carry the oxygen at the same time. She was advised that she would need to use the oxygen the crew had and they would get her a wheelchair at the hospital. She was unhappy with this as it made her feel more disabled than she was as she did not have need for a wheelchair if she had her oxygen with her.

On occasion she would book a taxi in order to transport herself so that she could keep her oxygen and rollator with her as it is an integral part of her being able to move around independently.

She raised this with Patient Relations and was very happy with the outcome; she was advised that the policy had been changed so that patients who can administer their own oxygen are able to do this. She did however feel she would have preferred to travel by medicar as she feels that having an ambulance to transport her could have been a waste of resources.

PATIENT STORY

In the early hours of 6 October 2016 the patients husband was awoken by his wife's unusual breathing, not knowing the seriousness he called NHS 111.

They were taken through a script and allowed the clinician to listen to his wife's breathing through the telephone, they advised that an ambulance should be sent and one arrived 10 minutes later.

The crew identified that she appeared to have some sort of infection and transported her to hospital where she was taken to intensive care and stayed there for four weeks before recovering.

A few months later the patient was feeling unwell again with symptoms that made them think the sepsis may be returning. They called NHS 111 again and discussed this with the call handler, the call handler asked the patient to leave it with them and they would contact her back shortly. Ten minutes later they were contacted back by the NHS 111 call handler and were advised that an appointment had been made for them on the appropriate ward at the local hospital.

They were very happy with this as an outcome as they were unable to contact the hospital themselves other than going through A&E; they were able to be seen by the doctor and treated appropriately. They would recommend the service to friends and family.

PATIENT FEEDBACK

"Friday night I sat with a 80+ year-old lady in my arms.

She had fallen badly hit her head and suspected broken hip. It took three phone calls to get the ambulance to arrive one and a half hours later.

The staff were great but leaving an old lady laying outside on cold; on stone flags for an hour and a half is very poor."

"The PTS drivers are excellent; they take great care to look after your needs and are very friendly people. They try their utmost to get me to and from dialysis on time. The only issue I have is with "Control", they in my opinion do not understand what the drivers have to go through and they would benefit from going out with the drivers for the experience."

"I had to make three phone calls to 999 to get an ambulance. The first two I was told to wait up to a hour for a phone call; in the meantime nearly passing out from the pain. I was in a lot of pain suffering from severe acute inflammation of the appendix with adhesions. I literally had to tell them I had problems breathing the third time to get medical attention. This is absolutely disgusting."

"Huge thanks to the call taker, emergency responder and two paramedics on the ambulance who came out in response to my call. We waited less than 30 minutes in the early hours of a Saturday morning. The treatment we received was tip-top, these guys all need medals!"

"It would be really beneficial if they could phone ten minutes before arrival to save ambulance men waiting and patients running around. The service is excellent 10 out of 10. Thank you."

"The paramedic was fantastic, couldn't have been more reassuring. It was also brilliant that he was able to do the stitches within the home. To save a trip to the A&E."

Introduction

The following pages contain feedback on the draft Quality Account from our key stakeholders. All of the CCGs, Health and Scrutiny Committees and Healthwatch organisations in the areas covered by the Trust were invited to comment. The replies received are reproduced in full below. Where possible we have acted on suggestions for improvement immediately. Where this has not been appropriate we will ensure that the feedback is reflected in the development of the next Quality Account for the period 2017-18.As ever, we are grateful to all organisations who have engaged with us in discussions of our Quality Account and who have supported its production with their constructive feedback.

Statements from Key Stakeholders

Greater Huddersfield CCG combined response from all the commissioners

Thank you for providing commissioners with the opportunity to review and provide comment on the Yorkshire Ambulance Service (YAS) Quality Account for 2016-17.

Overall the Quality Account provides a fair, accurate and transparent reflection of the quality of services provided by YAS and the activities undertaken throughout 2016-17 demonstrate a continuous drive to improve quality and patient safety.

Overall the document is comprehensive providing a balanced view of the services provided by YAS, and comments throughout the report from staff, relatives and patients offer a realistic balance of both positive and negative feedback.

2016-17 has been another challenging year for YAS, highlighted by the increased demand on services and pressures over the winter period across the Yorkshire and Humber health and social care system. However, the account evidences that YAS strives to deliver safe and effective clinical care and treatment under these difficult circumstances, as demonstrated through performance against the Ambulance Quality Indicators for the myocardial infarction and stroke care bundles.

Commissioners are in agreement with the priorities for 2017-18, particularly that of improving emergency ambulance response times through continued involvement in the National Ambulance Response Programme. However, the National Ambulance Response Programme pilot is still to make a marked difference to the eight minute response time target for high priority calls and the document does not evidence how the pilot is delivering a safer, more beneficial service for the public. Information on any patient harm due to delays and lessons learnt would be a valuable addition to the report. Information on any patient harm due to delays and lessons learnt would be a valuable addition to the report. YAS involvement in the collaborative work to develop a patient centred pathway for patients who have suffered a stroke is vital to prepare YAS services to respond to potential Strategic Transformation Plans (STP) footprint service reconfigurations for stroke services.

Commissioners acknowledge that YAS should be congratulated on the considerable improvements made following the initial CQC inspection in 2015, resulting in an improved overall rating of Good following re-inspection in September 2016, in particular within emergency and urgent care, emergency operations centre and resilience.

The account highlights some of the positive work undertaken by the organisation in 2016-17 including the establishment of the Critical Friends Network, the Bright Ideas process for staff and the growing annual Restart a Heart day which demonstrates YAS's continued commitment to improved engagement with patients, the public and staff. In addition to this,

the aim to develop the Trust's role in care co-ordination across the urgent and emergency care system is welcomed. This should contribute to the integrated working across the whole health and social care economy that is required in order to obtain best outcomes for service users.

The drive for safety is applauded with the reduction in 2016-17 in medicine errors by 50%. In addition it is noted that the incident reporting system is to be reviewed again with a view to streamlining it with a view to improving the data collected. Whilst the implementation of the end to end reviews is acknowledged, it would be helpful to have more detail about the learning from patient feedback, incidents and complaints received and how this has improved services and/or changed practice and been embedded across the whole organisation.

The range of audits and the uptake in certain research projects is also noted as a very positive feature. The Trust is also continuing to develop alternative care pathways in order to achieve "right care, right place" to help target resources more appropriately and this is welcomed. The CCGs will be keen to see the outcome of pilots such as the falls work.

The Quality Account is very comprehensive and covers all elements of the service, namely 999, NHS 111 and Patient Transport Service (PTS). The need to improve the ambulance response times will remain one of the main areas of scrutiny for the foreseeable future, but this shouldn't distract from other key objectives such as improving the rating of the PTS service and contributing to the work to develop and integrated urgent care system.

Healthwatch - Kingston Upon Hull

We are pleased with the amount of consideration given to mental health throughout the report, for both patients and staff alike. Mental Health, according to our own recent public engagement in Hull, is a top public priority.

We are also pleased to note the amount of effort YAS has put into engaging with patients, and the wider community.

Healthwatch - York

Healthwatch York welcomed the opportunity to review and comment on the Yorkshire Ambulance Service (YAS) Quality Accounts 2016-17. We feel that the priorities for improvement reflect a number of the priorities for people living in York.

We particularly welcome the priority to maintain effective patient feedback systems to make sure learning is identified and shared. The development of the role of YAS in working closely with local health and social care partners to deliver the right care in the right place first time is also key.

It is good to see the inclusion of patient stories and feedback about when things went well and when they didn't go so well.

East Riding Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee would like to thank the Trust for the opportunity to comment on its Quality Account 2016-17.

The Sub-Committee found the accounts to be clear in its presentation and informative. The Sub-Committee also welcome the good news stories that the accounts highlight and the participation by the Trust in six national clinical audits and eight research studies.

The Sub-Committee welcome and support the four priorities set for 2017-18, particularly Priority One which is vital for our residents, especially those in the large rural stretches of the East Riding.

The Sub-Committee was extremely pleased to learn of the Trust's rating of 'good' following the CQC's last inspection and commend the Trust and its entire staff for its hard work in achieving this result.

The Sub-Committee welcome the completion and achievements made against three of the four priorities for 2016-17 and hope that the developments made as part of Priority one, whilst still to be completed, can form the bedrock for launching Priority one for 2017-18.

The Sub-Committee look forward to continued engagement and cooperation from the Trust during 2017-18.

Healthwatch - Sheffield

Healthwatch Sheffield welcomes the opportunity to review and comment on Yorkshire Ambulance Service Quality Accounts 2016-17.

We broadly welcome the priorities identified for 2017-18 and agree that these represent the most pressing issues, and that they are striving to improve the involvement of patients and the public in establishing these priorities. However, it may also have been pertinent to include an emphasis on Patient Transport Services (PTS) to mirror the action plan arising from the CQC Report rating of 'Requires improvement' for PTS.

We note that the Trust has made some good progress on its objectives from 2016-17, with three at green "achieved" and three at amber "partially achieved" and therefore being taken forward. Yorkshire Ambulance Service are to be commended on showing improvements despite the current difficult period of change within the health and social care landscape, and also for their CQC Report published in 2017, in which the overall rating has improved from 'Requires improvement' in 2015 to 'Good'.

The Trust is to be commended on working towards more fully involving patients and the public in discussions on quality. However, it would be good if the section on Patient Experience Feedback included a summary analysis, rather than simply a selection of patient comments.

There could be some improvement in the layout of the document to make it easily accessible to patients and the public, with clearer signposting within the report itself. Some explanation of the variation in the Red response times per CCG would be helpful. Due to the nature of the report, it is difficult to see the picture of the service for Sheffield and how the public are served.

Overall, however, we feel that this report is a good representation of the Trust's current position and reflects the fact that it is aware of its strengths and those areas where it needs to improve.

We thank the Yorkshire Ambulance Service for the opportunity to comment on this document and look forward to working with them in future.

Wakefield Council's Adults and Health Overview and Scrutiny Committee

Through the Quality Accounts process the Adults and Health Overview and Scrutiny Committee have engaged with the Trust to review and identify quality themes and issues that members believe should be both current and future priorities. The Trust has sought the views of the Overview and Scrutiny Committee with the opportunity to provide pertinent feedback and comments. This also included a joint session with Wakefield Healthwatch held on the 25 April 2017.

The committee has acknowledged that the priorities for improvement have been reviewed through the expert patient and that the Trust has taken into account issues highlighted in feedback from patients and staff.

On this basis the Committee believes the identified priorities are broadly in line with those of the public.

The Committee believes the layout of the Quality Account provides relevance and clarity to both a professional and public audience.

The Committee welcomes the continued emphasis on patient safety within the Quality Account and the priority to increase awareness amongst clinical staff of the signs and symptoms of sepsis in adults. Early identification is crucial as sepsis can often be treated effectively with intensive medical care including antibiotics and intravenous fluids, saving thousands of lives a year in the UK.

The Committee notes that the sign up to safety work streams all have a focus on incident/complaint analysis and learning. The Quality Account reflects this and illustrates an organisational focus which promotes patient safety by being open and transparent, publishing data and results and celebrating success but learning from errors and mistakes. The Committee welcomes the priority area for improvement in this area by involving patients and developing systems and practice which should ensure learning is shared both internally and externally.

There is compelling evidence that NHS organisations in which staff report they are engaged and valued deliver better quality of care. The Committee supports the emphasis on continued staff engagement in the Quality Account.

The Committee believes that YAS has a key role in care co-ordination across urgent and emergency care, with particular focus on care closer to home and therefore is pleased to see the priority area for improvement in the 2016-17 Quality Account.

Collaborative working with commissioners and partners will help secure this objective and will lead to better co-ordination of services through innovation and new ways of working that will deliver timely emergency and urgent care in the most appropriate setting and will help develop new pathways of care for patients for whom the emergency department is not the most appropriate place for care.

The momentum of improvement has been sustained in the quality of care provided for people who suffer cardiac arrest, stroke and major trauma. The Committee notes the outstanding practice in this area. Members also support the collaborative approach to a patient centred pathway which enables best practice for patients who have suffered a stroke

The Committee welcomes the significant improvement in ambulance turnaround times which hitherto has continued below target, despite increased focus on performance over the last 2 years. The timely handover of care between ambulance services and Accident and Emergency services is essential in order to secure the delivery of high quality patient care. Delays not only indicate inefficiencies within the system, but have the potential to negatively impact on patient outcomes and result in a poor experience of care.

The Committee accepts that Red 1 and Red 2 emergency response standards has presented a significant challenge within the region with unprecedented levels of activity and notes the actions being put in place to address the challenges presented. The Committee particularly welcomes the Trust's involvement in the national Ambulance Response Programme which aims to improve the management of demand, but acknowledges the assurance that YAS will maintain an aim to deliver a safe and responsive service to all patients with different levels of clinical need,

The Committee welcomes the recent CQC inspection findings with the Trust now rated good overall. The Trust recognise progress and examples of good practice but also acknowledge ongoing challenges, specifically maintaining numbers of suitably qualified staff and a further focused improvements in PTS, which will assist in the provision of timely and safe services.

The Committee fully supports the inclusion of mental health nurses within the 999 control room and welcomes the decrease in the number of patients in a mental health crisis who, otherwise would have needed to have been taken to hospital. This better supports the needs of people displaying mental health issues, but also provides efficiencies and increases the availability of ambulance resources for other patients.

Overall the Committee welcomes the Trust's emphasis on collaborative working across the wider health economy and the unique role it can play in the provision of services, both across emergency and urgent care.

Conversely, the Committee would encourage the wider health economy to recognise the major challenges that can arise from hospital and service reconfigurations which can significantly impact on the ambulance service and that the Trust remains fully involved in the widespread changes to the health care system.

The Committee is grateful for the opportunity to comment on the Quality Account and looks forward to working with the Trust in reviewing performance against the quality indicators over the coming year.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee welcomes the opportunity to consider the draft Quality Report.

We are pleased to see the progress that the Trust has made this year, resulting in an improved CQC rating. We are also pleased to see that the Trust has strengthened its approach to patient and public involvement through the establishment of the Critical Friends Network.

We recognise that these are challenging times for health services, and are pleased to see areas included in the quality priorities that have been highlighted as issues of public concern – particularly improving emergency response times and improving co-ordination across urgent and emergency care to relieve pressures on emergency departments. We look forward to seeing continued improvement.

The Committee welcomes the inclusion of improved pathways for stroke as a priority. As part of our joint regional health scrutiny work, we have been looking at the reconfiguration of hyperacute stroke services which involves both YAS and EMAS working across the geographical footprint.

Healthwatch - Wakefield

Healthwatch Wakefield is pleased once again to comment on the Quality Account of the Yorkshire Ambulance Service NHS Trust ('the Trust') for the year 2016/2017. We are pleased to report that the Trust has continued to involve Healthwatch Wakefield on a number of issues.

The opening statement on quality from the Chief Executive, Rod Barnes, reflects on the significant improvements made to the quality of care provided for service users over the course of 2016-17, whilst recognising that the Trust continues to face challenges particularly regarding unprecedented levels of demand. This is a summary that Healthwatch Wakefield are in agreement with, we certainly hear more positive stories than complaints about the Trust, and would take this opportunity to commend the Trust on their continued provision of healthcare services to the people of Wakefield and surrounding area.

Whilst it is encouraging to note the implementation of a transformation programme regarding staff recruitment, Healthwatch Wakefield note that the priority for delivering sustainable improvement in emergency ambulance response performance only partially met national standards in 2016-17. We remain hopeful that intended changes to capacity planning, leadership and management structures will bring about further improvements throughout the next 12 months.

We are pleased to see that the Trust has secured a Health Foundation grant to conduct work around improving responses for frailty and falls across the region, and that good work continues with stakeholders in developing the Trust's role in care co-ordination across the urgent and emergency care system. Healthwatch Wakefield also commends the work the Trust does in relation to palliative care and mental health care services.

Improvement in outcomes for all patients remains a key priority for any healthcare provider, and Healthwatch Wakefield supports the Trust in their efforts to improve this in our region, in particular regarding cardiac arrest and sepsis cases. Work to develop and enhance the level of patient care, particularly in rural areas, is welcomed, as is the collaboration with Emergency Department consultants across Yorkshire in developing a Pre-Hospital Screening Tool. It is heartening to see improvements in the use of new technology, for example the introduction of defibrillator data downloads, being implemented quickly and beneficially.

We welcome the continued involvement with the 'Sign up to Safety' programme and the three work streams established to reduce harm to patients: it is pleasing to note that all three are generating positive results. Engagement with Emergency Department staff is paramount and it is pleasing to see steps taken to achieve this, including the Critical Friends Network.

Healthwatch Wakefield are disappointed to note that targets relating to improving the experience for children were only partially met. However, encouraging work continues in this area, including collaborations with external providers to innovate and improve the care delivered to paediatric patients.

It is encouraging to see strong performances in relation to infection control, safeguarding, and clinical quality ("Right Care, Right Place"), and look forward to seeing these translate into effective service improvements and patient outcomes throughout 2017-18.

The partnership between YAS and the Yorkshire Air Ambulance charity continues to develop and grow, and this undoubtedly brings benefits to the service our patients receive, a partnership which we welcome. However we are concerned to see ongoing poor performances with the NHS 111 service, particularly regarding metrics in relation to 'Warm Transferred and Call Back in 10 minutes' and 'Call Back in 2 hours'. We note that 2017-18 marks the final year of the contract and feel that the opportunity needs to be taken to make significant improvements in this service to ensure patient needs are efficiently met to ease transition into the next phase of the service, whatever that may be post re-procurement.

Priorities for Improvement 2017-18

Healthwatch Wakefield welcomes the fact that, given performance against all 2016-17 priorities has not been completely successful, same priorities are being rolled over into next year:

Emergency ambulance response times

This is a key priority and Healthwatch Wakefield will be keen to see how ongoing involvement in the national ARP translates into ongoing improvements for patients.

Trust's role in care coordination

We feel that delivering the right care at the right time in the right place is crucial to improving patient outcomes, and this can only be achieved via effective collaboration with other healthcare providers.

Patient feedback systems

Developing methodology to ensure robust analysis of adverse events, along with a system to ensure this is transformed into effective learning is undoubtedly important. We would, however, like to see an accessible, ongoing, clear and easy to understand metric presented that can demonstrate how this particular priority is being monitored and measured.

Patient-centred stroke pathway

This is a commendable priority related to a condition where timeliness is of utmost importance, and we look forward to seeing significant improvements for our patients in this area over 2017-18. However, we would urge YAS staff and stakeholders to remember that 'patient-centred' requires a mindset to put the patient at the centre of the entire process, not just the portions that YAS are responsible for.

Overall Summary

The draft document that was presented for review is comprehensive and extensive. We particularly like the use of patient stories, along with comments and quotes from staff and stakeholders.

There is evidence of strong performance against most of the priorities the Trust set for itself, and although some of the targets were narrowly missed, we are encouraged by efforts already made, the future plans, and the dedication of the team to continue driving through improvements despite the continuing challenges in the healthcare macro- and micro-environments.

Healthwatch Wakefield commends the Trust on its performance in delivering quality healthcare services to the people of Wakefield and surrounds, and we look forward to continuing to support and work with the Trust to help ensure continuous improvements are sustained.

Statement of Directors' Responsibilities for the Quality Report

Directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013-14;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - *Board minutes and papers for the period April 2016 to March 2017*
  - *papers relating to quality reported to the Board over the period April 2016 to March 2017*
  - *feedback from commissioners dated 30 April 2017*
  - *feedback from local Healthwatch organisations dated 30 April 2017*
  - *feedback from Overview and Scrutiny Committee dated 30 April 2017*
  - *the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009*
  - *national patient survey - N/A to ambulance sector*
  - *national staff survey*
  - *the head of internal audit's annual opinion over the Trust's control environment*
  - *CQC Intelligent Monitor Report (N/A to ambulance service)*
- the quality report presents a balanced picture of the NHS Trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Kathryn Lavery
Chairman
30 May 2017

Rod Barnes
Chief Executive
30 May 2017

Financial Accounts

2016-17

Annual Governance Statement

1. Scope of responsibility

1.1 The Board is accountable for internal control. As Accountable Officer, and Chief Executive on 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.

1.2 I am supported in my role as Accountable Officer by a clearly defined management structure and governance arrangements, as described in the Trust's Integrated Business Plan. The Executive Director Portfolios and associated management structures were refined during 2015-16, to ensure effective strategic and operational leadership and to provide greater clarity on accountability across all areas of Trust business.

1.3 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 the processes and monitoring arrangements for managing risk, is reviewed and updated on a two-yearly basis. The strategy describes the Trust risk management system and the mechanisms for providing the Trust Board with assurance that risks are managed efficiently and effectively.

1.4 The Trust has met with the NHS Improvement and our lead Clinical Commissioning Groups for 2016-17 on a regular basis to provide assurance that both the national and local targets are being met and that risks are mitigated to tolerable levels. The Trust works with its partners through membership of clinical networks across Yorkshire, contractual arrangements with other NHS providers, membership of Resilience Forums and active liaison with local scrutiny committees and local Healthwatch organisations. The Trust has also engaged extensively with individual clinical commissioning groups, and other local health economy forums such as STPs and A&E Delivery Boards.

2. The governance framework of the organisation

2.1 The Trust Board has reviewed its practice to ensure alignment with available corporate governance guidance and best practice. The Board recognises its accountabilities and provides leadership within a framework of prudent and effective controls which enables risk to be assessed and managed.

2.2 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 Public meeting on the principal risks and associated actions as detailed in the Trust's Board Assurance Framework, through a combination of risk management reports and reports from the Board sub-committees.

2.3 The Trust Board meets on a two monthly basis and currently consists of; the Chairman and 5 other Non-Executive Directors (NEDs), the Chief Executive Officer and 5 other Executive Directors (4 voting and 1 non-voting). There are also 2 other Directors that attend the Board meetings, the Director of Planned and Urgent Care, and the Director of Planning and Development. Two non- voting Non-Executive Director (designate) also attend Board meetings. In addition, the Board functions are co-ordinated and supported by the 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
- Engagement with internal and external stakeholders to support delivery of Trust aims and objectives.
- Supporting and ensuring the financial balance of the organisation.

2.4 During the year there have been changes to Board personnel, mainly as a result of 2015-16 full Executive and senior management portfolio review. This will strengthen management capacity and capability in a number of key areas, including planned and urgent care, A&E operations, estates and facilities, business development and performance management.

The Executive Director of Finance role has been permanently appointed as of March 2017, and prior to that an Interim Director of Finance was in post.

Additionally we have in place a Director of Estates and Facilities, a Director of Planning and Development, and a Director of Planned and Urgent Care. We also now have in place an Associate Director of Performance, Assurance and Risk.

The Director of People and Engagement left the Trust in September 2015 and an Interim Director of Workforce and Organisational Development has been in place since February 2016.

There have been changes to Non-Executive Director personnel during 2016-17. We have appointed a new Chair who joined us in July 2016. Additionally one of the substantive Non-Executive Directors stood down and the designate Non-Executive Director was confirmed into post as a full Non- Executive Director. Recruitment was also completed to the vacated Non- Executive Director Designate role.

2.5 Over the year, the Trust Board has continued to assess its own effectiveness whilst leading through a period of change, and to develop its ability to focus on strategic issues whilst assuring itself of the performance of the whole organisation. It has achieved this by the following:

- A co-ordinated work plan across the Board and its sub-committees, to ensure a focus on key decisions and governance dates during the year
- Regular Board Strategic Development Sessions, to cover key strategic and development issues which have included:

a. The Trust's 5-year integrated business plan and Operating Plan

b. Strategic Development of the Trust including staff and stakeholder engagement, A&E, PTS and service transformation, and the A&E workforce plan

c. Development of suitable Transformation governance arrangements in the context of the emerging Urgent Care agenda.

d. Approaches to collaborative working across the Northern Ambulance sector through the establishment of the Northern Ambulance Alliance and national Director level work streams.

e. Financial Priorities, Performance and Planning

f. Quality governance including consideration of core Health and Safety requirements across the trust and the new CQC Inspection regime and compliance expectations.

g. Board governance and committee arrangements

h. Risk management including the Board Assurance Framework and risk appetite

i. Governance across organisational boundaries and the governance and strategy of the West Yorkshire urgent care Vanguard programme.

2.6 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 nominated associate director attends. Attendance at Board meetings is monitored by the Trust Secretary on behalf of the Chairman. During the year no notable exceptions warranted action by the Chairman or Chief Executive as appropriate.

2.7 During 2015-16 the Trust commissioned external assessments in relation to its quality governance arrangements. A further assessment conducted by the Internal Audit service was completed to provide an independent review of the Trust committees and Executive Group effectiveness using the Well-Led framework. Recommendations from this review informed the development of an action plan which will be followed up as part of our Internal Audit Programme in 17/18.

2.8 The Trust arrangements for quality governance are fully aligned to ensure compliance with the CQC Fundamental Standards and Well-Led framework.

2.9 During the year representatives of NHSI have met regularly with Executive Directors and with the Trust Chairman, to gain assurance on the rigour of Trust governance processes.

Key areas of financial and quality governance have also been subject to NHSI review and the Trust has acted on the feedback received as a result of these exercises. No significant concerns were highlighted as a result of these exercises and feedback has been used alongside the Board's ongoing self- assessment of its effectiveness to inform future development.

2.10 A Clinical Quality Strategy which covers a three year period from April 2015 - 18 describes the priorities for clinical quality and is underpinned by an annual implementation plan covering the key work streams. A full review of the Clinical Quality Strategy will take place in 17/18 with extensive consultation with staff and will further support a real focus on clinical recruitment and retention in coming years.

2.11 Quality is a central element of all Board meetings. The Integrated Performance Report, which has been updated and substantially refined over 2016-17, 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. Patient stories are used in each meeting of the Board, to ensure that the focus on quality of patient care remains at the heart of all Board activity.

2.12 The Board and Quality Committee regularly review issues, learning and action arising from Serious Incidents, other incidents and near misses, complaints and concerns, serious case reviews, claims and coroners' inquests. During the year no nationally defined 'Never Events' have occurred as a result of Trust care or services.

2.13 The Trust Quality Account is developed through a process of extensive consultation both internally and with external stakeholders. The Quality Account for 2016-17 has been reviewed by the Trust Executive Group, the Board and its committees. The final document has also been subject to External Audit scrutiny in line with Monitor guidance.

2.14 A regular commissioner/provider Joint Quality Board has now been established to support ongoing communication on quality governance issues involving the YAS Executive Director of Quality, Governance and Performance Assurance and Executive Medical Director and their equivalents in the three designated sub-regional lead commissioning organisations.

During the year the Executive team has also engaged in a number of positive meetings with individual CCG governing bodies and with Local Authority Scrutiny Committees, to allow an opportunity to consider performance, quality and safety issues in greater depth.

2.15 The Trust Board has been underpinned throughout 2016-17 by five key committees/management groups:

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

In addition, the Remuneration and Terms of Service Committee advises the Trust Board about appropriate remuneration, terms of service, contractual arrangements and performance evaluation for the Chief Executive and other Executive Directors. The Charitable Funds Committee also supports the Board in discharging its responsibilities as trustees of the Trust charitable funds.

2.16 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 formal committee of the Trust Board and is chaired by a Non-Executive Director. The Committee includes three Non-Executive Directors, the Executive Director of Finance, the Chief Executive, the Executive Director of Workforce and OD and senior managers. The Committee undertakes objective scrutiny of the Trust's financial plans, investment policy and major investment decisions, and as such plays a pivotal role in financial risk management. It reviews proposals for major business cases and reports on the commercial activities of the Trust, and also scrutinises the content and delivery of the Trust cost improvement programme.

2.17 The Quality Committee was introduced as a committee of the Board in March 2012 following a comprehensive review of corporate governance arrangements. The Quality Committee consists of three Non-Executive Directors, the Executive Director of Quality, Governance and Performance Assurance, Executive Medical Director, Executive Director of Workforce and OD and senior managers. The Committee undertakes objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from adverse events and infection prevention and control. A key element of this work is scrutiny of the quality impact assessment of cost improvement plans and other service developments. The Committee also supports the Board in scrutinising and gaining assurance on risk management, workforce governance, health and safety and information governance issues. It also provides scrutiny in relation to the actions required as a result of the Hillsborough Inquest findings.

2.18 During 2016-17 the Board further reviewed the function of its committees, in addition to the independent review undertaken by the Internal Audit Service, to ensure rigorous scrutiny of the management of key risks in the Board Assurance Framework and Corporate Risk Register, and the effective flow of information on key risks between the committees and Board.

2.19 In 2016-17 the Board Development Sessions facilitated review of the major Cost Improvement Schemes and other key areas of business from both a finance and quality perspective. This exercise will be repeated on a six-monthly basis during 2017-18.

2.20 In 2015 the Board Committees completed detailed reviews of their effectiveness, through an independent review facilitated by the Internal Audit service based on the Well-Led framework. The exercise concluded that the Board Committees are fulfilling their duties effectively. The reviews also identified a number of recommendations for change to terms of reference or working practices which were implemented during 2016-17 to further strengthen the Board and Committee functions.

2.21 In 2016-17 the Internal Audit service completed a review of the Trust's 'risk management maturity'. The exercise concluded that the Trust had in place a sound risk management strategy and policy which was communicated throughout the organisation, and that risks and risk appetite were effectively defined and described. The review identified a number of areas where there was potential for further development in relation to culture and these will inform the risk management plan and role of the Risk and Assurance Group for 2017-18. This has included and will continue to include focused board discussions on the Board Assurance Framework and Risk appetite, to inform future strategy and risk management decisions. During 2016 the Trust was also inspected under the new regime, by the Care Quality Commission. (See section 5.11 for further detail.)

2.22 The Trust Executive Group (TEG) meets weekly and has 4 key functions that it is responsible for; Strategy and Planning, Systems of Management Control, Assurance and Performance and Risk. This specifically includes the following responsibilities:

- Develop Strategy, Business and Operating Plans for approval of the Board;
- Oversee the day-to-day management of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities, both clinical and non-clinical, which also supports the achievement of the Trust's objectives and compliance with relevant regulatory, legal and code of conduct requirements;
- Review key areas of governance and risk highlighted through the Performance Management Framework;
- Develop and embed the policies, processes and systems required to support Trust wide delivery of the strategy, ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements;
- Deliver all risk and control related disclosure statements, in particular the Annual Governance Statement and declarations of compliance with the Essential Standards of Quality and Safety, prior to endorsement by the Board;
- Manage all significant risks, incidents and events, ensuring effective action to mitigate future risk.

The Chief Executive Officer, as Accountable Officer, presents a progress report from the TEG to each meeting of the Trust Board.

2.23 The Trust Management Group (TMG) reports to Trust Board via TEG, and consists of the Executive Directors and Associate Directors and is chaired by the Chief Executive. The TMG provides TEG with assurances on governance and compliance on areas of delegated responsibility, including; monitoring and review of performance in relation to operational, quality, workforce and financial objectives, identification and management of key risks, including review of the Board Assurance Framework and Corporate Risk Register, action to address key risks to delivery and on operational issues and problems, overseeing delivery of the Trust service transformation programme and cost improvement programme, Internal Audit Plan progress and annual planning process and contributing to the development of strategy and policy including the Operational Plan development and Business Planning Development.

2.24 In 2016-17 a new work plan and standard agenda were produced which ensure the Group is routinely provided with risk and performance management information and assurance from:

- Operational management groups in the Accident and Emergency, Patient Transport and NHS 111 services.
- Risk and Assurance Group (including Information Governance)
- Health and Safety Committee
- Clinical Governance Group (including IP&C)
- Vehicle and Equipment Group
- Capital planning

Membership and function of the group was further strengthened in 2016-17 in line with the Portfolio review and Trust Performance Management Framework, as follows:-

- More focus on performance management deep dives and on oversight of delivery across our transformation programmes, including improved reporting mechanisms in line with the Intelligent Board principles.
- Improved exception reporting from both operational service lines and key organisation support services.
- Increased openness and transparency of reporting and improved richness of conversation and challenge.

- Improved outward focussed and system impact management in relation to fundamental Acute Service Reconfigurations across the patch and its impact on performance and ongoing safety of care, and impacts and risks in relation to increasing Turnaround issues at A&E Depts. across a growing number of Trusts in Yorkshire.

2.25 To support the management of key Trust change programmes and projects aligned to the 5-year business plan, the Trust has an established Service Transformation Programme, with Executive leadership and regular assurance to the wider Board and Committees. The focus and governance of the Service Transformation Programmes were subject to significant review at the close of 2015-16, in order to ensure clarity of purpose. This refined the priority deliverables and benefits aligned to Trust Strategy and Operating Plan objectives for 2016-17, clarified programme accountability and established new Project Management Office arrangements for 2016-17. The PMO office has further supported the drive for increased transparency of reporting in 2016-17 and will support the Board and Trust in aligning the governance arrangements in relation to both internal and external system reconfiguration and transformations for 2017-18. Going into next year an appreciation of and alignment to wider system developments will be a key focus.

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

2.27 The Executive Director of Quality, Governance and Performance Assurance 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.

2.28 The Executive Director of Finance 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 Trust Management Group on an on-going 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.

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

2.30 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.

2.31 The Quality, Governance and Performance Assurance directorate has established 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. A programme of internal 'Inspections for Improvement' provides objective assurance and support for department managers on key areas including health and safety, infection prevention and control and information governance.

2.32 Arrangements are in place through Board and committee review to confirm that the Trust discharges its statutory functions. The Trust is satisfied that it has been compliant with these functions during 2016-17.

3. Risk assessment

3.1 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 pro-active approach and one which reviews risks retrospectively. Therefore Trust risk assessment is a dynamic process.

3.2 Risks are identified proactively by the Board and senior management team as part of the 5-year and annual business planning cycles. As part of this process the Board assesses its overall risk profile, taking into account the key business risks, Trust capacity and capability to address these, and the Board's appetite for risk including the target residual risk. The Board agrees an annual risk appetite statement. This information informs the Board Assurance Framework and its use during the year by the Board and its Committees. The Board Assurance Framework goes through an annual cycle of strategic review lead at Board Level. The focus of board discussions are in relation to strategic risks to YAS in line with our Strategy and Business Plan.

3.3 Additionally we encourage and expect that risks are identified on a daily basis throughout the Trust by any employee. During 2016-17 the Trust has developed new processes to support staff in raising concerns about quality and safety in line with the national Freedom to Speak Up recommendations. 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 on-going risk assessment, described in the Trust Risk Escalation and Reporting Procedure.

3.4 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. Impact and Likelihood are rated on a 5x5 scale, to give an overall risk rating of 1-25. When evaluating risks; consideration is given to any existing controls for that risk and importantly the adequacy and effectiveness of those controls. All risks and associated risk treatment plans are recorded and regularly updated in the Datix risk management system.

This is used as the basis for monthly review of existing and emerging risks involving all departments, via the Risk and Assurance Group for moderation and discussion in relation to mitigations in place. The Chair of RAG report into the Trust Management Group, where a monthly report on the corporate level risks are provided.

3.5 Risks that cannot be managed through TMG are passed up through the line of management, to the Trust Executive Group and ultimately to the Trust Board, which is notified of all risks with a rating of 12 or above 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.

3.6 The organisation's major risks are identified at a corporate level. 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.

3.7 The most significant risks to the strategic objectives identified in 2016-17 were:

- Inability to deliver performance targets and clinical quality standards
- Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes
- Insufficient alignment and responsiveness of corporate services to operational service requirements
- Deficit against planned financial outturn e.g. due to contract target penalties and non-delivery of CQUIN scheme.

- Adverse impact on clinical outcomes and operational performance due to inability to deliver the A&E workforce plan and associated recruitment.
- Challenge to the delivery of key objectives due to ineffective staff engagement
- Impact on delivery of strategic objectives and performance delivery due to external system pressure and changes.

Other risks recorded in the Board Assurance Framework 2016-17 were:

- Inability to implement PTS transformation programme resulting in loss of income due to failure to secure/retain service contracts.
- Lack of compliance with key regulatory requirements (CQC, HSE, IGT, NHSI) due to inconsistent application across the Trust.
- Failure to learn from patient and staff experience and adverse events within the Trust or externally
- Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity.

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.

3.8 Monthly iterations of the Board Assurance Framework are supported by separate risk movement and assurance movement reports. These reports provide detail on the actions taken to mitigate the strategic risks and any reports received that could provide the Trust Board with assurance. The Board and its committees also receive reports on the corporate risk register, to enable a deeper review of emerging risks and of the flow of risk information between operational departments and the Board. We report on the quarterly position of management of the risks in relation to the BAF through TMG, TEG and Board.

3.9 A number of new or developing 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:

- In year, the ongoing challenge relating to delivery of Ambulance response times remained significant. The Trust is now part of the national Ambulance Response Programme Pilot. The challenges remain to response times and this created a potentially increased risk to safety and quality of patient care, which required close monitoring and mitigation. Failure to meet performance targets also increased the risk to the Trust financial position, through the potential application by commissioners of performance fines. The Board and Trust Executive Group have considered the risk in detail and have worked extensively with commissioners during the year to mitigate the risk. An A&E service transformation programme has been in place all year and has successfully resulted in a net increase of 221 fte over 18 months taking into account attrition, all rotas being redesigned in conjunction with staff, improved training, improved employee relations and core policies being updated. This has significantly supported the Trust in absorbing a considerable increase in demand on service without a significant effect on performance. A further phase 2 of this transformation programme is now being scoped and agreed at Executive level and will focus on sustaining the considerable improvements that have been introduced throughout 2016-17, and to help ensure enhanced systems and processes implemented during the year have effectively mitigated the risk to safety and quality. The financial implications have been addressed through collaborative working with commissioners. The achievement of these targets will continue to pose a challenge to the Trust in the coming year despite the investment in the service in 16/17, due to growing demand levels in year of 6%, and the impact of increasing turnaround times at a number of A&E Depts. across Yorkshire, in the context of a contract going into next year that assumes up to 2% increase in demand.

The level of demand and effectiveness of the wider health and social care system will also continue to be a significant contributing factor. Delays in hospital Emergency Department turnaround and changes to ambulance service requirements arising from local service reconfigurations remain significant factors requiring mitigating action.

A key element of mitigation in relation to wider system changes has been the Trust's active participation in the West Yorkshire urgent care Vanguard initiative and the West Yorkshire Accelerator Zone, resulting in the launch of a Clinical Advice Service that aims to reduce conveyance to hospital.

- Recruitment and training of staff was identified as an increasing risk during the year, with a national shortage of trained paramedics creating a specific challenge to delivery of the Trust's five-year workforce plan. During the year, revisions have been made to the workforce plan to increase recruitment and internal training provision and to develop a new clinical career framework and this will remain a key focus across the service lines, and in particular in relation to qualified staff, pending the planned increase in Paramedic and Nurse training nationally over the coming years.

- During the year the pressure on the NHS 111 service increased as demand for the service continued to rise above the levels funded through the contract. Pressures throughout the year impacted on achievement of the national response targets for NHS 111 calls, but internal mitigating action has ensured continued delivery of a safe and effective service to patients. Given the ongoing challenges and significant risks relating to Clinical recruitment in 111 the Trust established in the latter part of the year a formal Improvement Programme focussing on clinical recruitment and retention. This programme is led by an Executive level sponsor.

- Activity in the West Yorkshire Urgent Care service, delivered by Local Care Direct as a part of the NHS111/West Yorkshire Urgent Care contract, did not grow during 2016-17, although management of the existing activity within the available resources remains a significant challenge, impacting on delivery of key performance targets and quality of patient experience During the Easter period in 2016 a serious incident was triggered due to significant Easter Pressures. Mitigating action has been taken by the Trust and Local Care Direct to ensure the maintenance of a safe service to patients. There have been ongoing discussions with commissioners throughout the year with regard to the challenges within the NHS111/West Yorkshire Urgent Care service, including a request in year for a capacity review in relation to the NHS 111 service.
  An independent review of the West Yorkshire Urgent Care provision is underway during 2016-17, which has been jointly sponsored by the Trust and Commissioners to help better understand how we mitigate these risks.

- Employee relations continue to present a key challenge, against a back-drop of a significant change agenda in the A&E service. Positive discussions involving ACAS have helped to move relationships to a more positive footing and the move to a multi-union recognition arrangement from May 2015, created a new platform for constructive working relationships with all of the key unions. This is complemented by a significant focus on wider employee engagement, more robust staff communication and engagement, and the A&E Transformation programme piece which has been collaboratively delivered with staff and staff side.

- PTS is undergoing considerable tendering activity. In 2016-17 it submitted bids for large areas of the geography including Hull, East Riding and the South of the patch. There is real potential risk to this service areas continuity going into next year, with further bid activity expected in the Northern area of the patch. Additionally we lost the Hull element of the contract as a result of the tendering activity which has meant a handover plan has been required to support the safe handover to the new provider, including an analysis of financial and service delivery risks.

- Within Workforce and OD there has been a high level of turnover amongst senior and management roles. While the full senior management team is now in place there are emerging concerns in relation to adoption of appropriate policy and controls for some elements of activity within the directorate. The Executive Director has developed a large scale improvement plan which is overseen by TEG.

- In addition to monitoring by the Trust Board and Audit Committee, progress against risk treatment plans have been routinely discussed in each meeting of the Quality Committee and Finance and Investment Committee.

3.10 All corporate risks subject to on-going risk management plans will be recorded on the 2017-18 iteration of the Board Assurance Framework and will continue to be managed through the Corporate Risk Register.

3.11 The Internal Audit programme was significantly expanded in 2013-14 and this expanded programme was maintained in 2015-16 and 2016-17. In the current year a total of 20 reports were produced with assurance ratings, of which 17 are rated as 'significant assurance' and 3 'limited assurance'. (A number are still in progress).

A number of control issues were highlighted during the year as a result of the Internal Audit programme in aspects of fleet, community first responders, temporary staffing and consultant recruitment processes and elements of HR compliance, and nursing re-validation. These issues have been considered in the relevant management forum and mitigating action agreed to resolve any outstanding issues. The Audit Committee reviews management assurance on completion of related action plans.

3.12 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 Quality, Governance and Performance Assurance, supported by the Trust's Executive Medical Director as the Caldicott Guardian.

During 2016-17 there were two personal data-related incidents that met the Information Governance Serious Incidents Requiring Investigation (IG SIRI) criteria at Level 2 severity or above. Such incidents require reporting to the Information Commissioner's Office, Department of Health and Commissioners. The details of these incidents along with those of a lower (Level 1) severity, which do not meet the criteria for national reporting, can be found in the Trust's Annual Report, Quality Account and Financial Accounts 2016-17.

4. The risk and control framework

4.1 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.

4.2 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, and as such we continue our commitment to working in line with the Risk Maturity Matrix, upon which our Internal Audit of Risk Management this year was based.

4.3 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, and is consistent with available best practice guidance.

4.4 The Board Assurance Framework and Corporate Risk Register enable 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 and Non-Executive review on a quarterly basis.

4.5 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.

4.6 Close liaison between the risk and safety managers and business planning managers has ensured that business planning informs and is informed by risk management. Key business risks and mitigations are captured in the IBP and Operating Plan.

4.7 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. The quality impact assessments and associated early warning indicators are subject to review in each meeting of the Quality Committee.

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

4.9 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.

4.10 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 this organisation's obligations under the Climate Change Act are met.

4.11 The Trust has also this year developed its Policy and approach in relation to the risks associated with Modern Slavery.

4.12 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.

4.13 The Trust has also appointed a "Freedom to Speak up" Guardian to further support a culture of openness and transparency in the management and mitigation of risks across the trust.

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

5.1 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. (See section 5.14)
- 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 key risks to the organisation achieving its principal objectives have been reviewed, which this year coming will be complemented by our strategic Assurance Map.

My review is also informed by:

- Care Quality Commission Fundamental Standards – internal Compliance Assessments
- The Care Quality Commission inspection process where as a Trust we have received an overall Good rating across all service areas of the Trust in 2016-17.

- The NHS Information Governance Toolkit.
- Assessment against NHS Counter Fraud and Security standards
- Peer reviews within the ambulance service sector
- Internal Audit reports
- External audit reports
- External consultancy reports on key aspects of Trust governance.

5.2 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, Finance and Investment Committee and Quality Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

5.3 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
- A two yearly 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 six monthly 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

5.4 The risk assurance infrastructure closely scrutinises assurances on controls to assess their validity and efficiency. A key element of this work is 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. Policy review and updates in line with national guidance are signed off through TMG.

5.5 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 executive committees/management groups as appropriate.

5.6 The Audit Committee consists of all of the Non-Executive Directors, with the exception of the Chairman, with representatives of Internal and External Audit services in attendance. The Executive Director of Finance and Executive Director of Quality, Governance and Performance are in attendance at all meetings, with other Executive Directors attending through the year as part of the Committee work programme. The Committee provides an 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.

5.7 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.

5.8 The Audit Committee primarily utilises the work of internal audit, external audit and other assurance functions, but is not limited to these audit and assurance functions. It also seeks reports and assurances from other Board Committees, directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

5.9 There is a robust process for the flow of information between the Finance and Investment Committee, Quality Committee and Audit Committee to support the assurance process on key risks.

The Quality Committee and Finance and Investment Committee have provided significant assurances to the Audit Committee on risks relevant to their terms of reference, covering all risks contained within the Board Assurance Framework. The Audit Committee completed its annual self-assessment in April 2016 and concluded that the arrangements in place were effective.

5.10 The Trust is required under NHS regulations to prepare a Quality Account for each financial year. The Trust Quality Account for 2016-17 reports on key indicators of quality relating to patient safety, clinical effectiveness and patient experience. The Quality Account includes comments from key stakeholders which are a positive reflection on developments over the year and of the Trust's engagement with partners. The Quality Account has been subject to independent external review by Ernst and Young (who are also the Trust's external auditors) and scrutiny by the Audit Committee and I am satisfied that it presents a balanced and accurate view of quality within the Trust.

5.11 During 2016-17 the Trust received a full inspection from the Care Quality Commission under the revised regime of the Chief Inspector of Hospitals. The inspection took place in September 2016 for A&E and PTS and October for 111. The full report was published in December 2016. The inspection found that the Trust has an overall rating of 'Good' across all domains and highlighted improvements had been made throughout the service lines.

The trust received three "must do's" in the report as follows:

- Ensure there are sufficient numbers of suitably skilled, qualified and experienced staff
- Ensure all PTS ambulances and equipment are appropriately cleaned andIPC procedures followed
- Ensure seating for children is routinely available in ambulance vehicles

An action plan is being implemented to address the issues highlighted, with oversight by the Trust Executive Group and regular assurance on progress to the Board, commissioners and NHSI as appropriate.

There were also a small number of should do's in the report that will also form part of the above action plan. An element related to consistency of delivery across areas of PTS, which will now form a key part of the action plan going forward.

5.12 On final review and closure of the 2016-17 iteration of the Board Assurance Framework, one significant issue was identified relating to continued delivery of the A&E service targets against a backdrop of rising demand for high acuity care likely to be above that contracted for, national paramedic and clinical workforce constraints, wider system changes and service transformation across Yorkshire and increased turnaround pressures at a number of acute A&E Depts. (see Section 6).

5.13 Head of Internal Audit Opinion Introduction

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the Internal Audit work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance subject to the inherent limitations described below.

The purpose of this Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the assessment of the effectiveness of the organisation's system of internal control. This Opinion will assist in the completion of the Annual Governance Statement.

Opinion

My overall opinion is:

Significant Assurance can be given that 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 or inconsistent application of controls put the achievement of particular objectives at risk most notably in the areas of fleet management, community first responders and the level of implementation of required improvements to end of shift overtime management, temporary staffing and consultant recruitment processes and HR process compliance including MARS.

Basis of Forming the Opinion

The basis for forming my opinion is as follows:

Assurance Framework

An Assurance Framework (AF) exists to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. The BAF aligns the Trust's Strategic Objectives and Goals to the principal risks in achieving them. The Trust has continued to ensure the AF is used at Board level, with support from the key governance committees.

Assurance across the organisation's business areas*

(*The assurance areas listed frequently overlap between functional areas.)

The audits for 2016-17 were approved by the Audit Committee in the context of a 3 year plan. The components of the risk-based plan (both assurance and advisory activity) are set out below and include annual audits (including BAF, IGT and core financial systems work) along with other coverage across the Trust's areas of business.

Clinical Quality and Governance	• Clinical Pathways - acute service reconfiguration • Medicines Management • Clinical Governance*
Standards and Governance	• BAF* (including benchmarking) • Risk Management • Corporate governance • IGT • Nursing staff revalidation • Security management • Complaints, Claims and Incident Management*
Workforce and Strategy	• Diversity and Inclusion • Payroll testing and data analysis • MARS follow-up* • Temporary staffing/consultancy recruitment follow-up* • Fit and Proper Persons*
Finance and Performance	• Financial systems (capital, PLICS, management accounts, AP baseline review), • Fleet management • Tariff Validation and Reference Costs • Estates Management • IT - wireless network security, data centre physical and environmental controls, IT project and contract management*, RESWEB follow up, IM&T backup management* • Healthcare contract management
Operations	• End of shift overtime management (follow up) • Community first responders • Medical device management • IM&T CAD general controls • PTS*

** The assurance areas listed frequently overlap between the functional areas.*

Contribution to Governance, Risk Management and Internal Control Enhancements

Wider outcomes from Internal Audit activity are set out below:

- Continued delivery and development of the reshaped internal audit plan following a previous fundamental review of the 'audit universe' alongside Executive Officers and the Audit Committee.
- Effective utilisation of internal audit including in-year communication and changes to the audit plan. The plan has remained flexible and provided capacity to respond to organisational needs - i.e. further work to track developments around previous low assurance audits (including end of shift overtime, temporary staffing and interim management/staff appointments, MARS), data analysis through CAATs, delivery of security management support and wider scope for the IGT review.
- Further contribution to the development of assurance mapping which will help to co-ordinate (and fully utilise) various internal and external assurance mechanisms.
- Involvement and relationship with the organisation e.g. attendance at Audit Committee meetings, Executive Team (TEG and TMG as required) in addition to meeting attendance connected with specific reviews – in particular the risk management group for an interactive workshop.
- Follow-up activity demonstrating progress against recommendations to improve systems and controls, and continued alignment and further development (in redefining a risk-based approach) with the combined follow-up activity by the Trust.
- Delivery of advisory work around Diversity and Inclusion Maturity Matrix, risk management review (including survey) and workshop, BAF benchmarking, data analysis through CAATs.

The Opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its Annual Governance Statement.

Benita Jones
Director of Audit Services
April 2017

5.14 Mitigating action has been taken to address the specific concerns identified in the Head of Internal Audit opinion, 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 2016-17 will be reviewed through the risk management and committee arrangements outlined in section 2 of this statement. This mitigating action includes:

- Detailed risk treatment plans in relation to each of the risks recorded in the BAF.
- Focussed work in relation to the appointment of temporary staff and the development of a new "gate keeping" approach to ensure greater consistency, parity and control around the appointment of temporary staff. This process has been developed and lead by the HR team and was agreed through the Trust Management Group.
- Executive level focus on the reduction of consultancy/agency spend in line with NHSI thresholds. This piece has been sponsored by the Executive Director of Workforce and OD and has been in traction during the second half of 2016-17. The trust is starting to see a reduction in spend levels in relation to agency but this will remain a priority going into 2017-18.
- Targeted project work in relation to recruitment and retention including development of the new clinical career framework and launch of the clinical recruitment and retention programme.
- Commissioning of independent review of Fleet services, to enhance our understanding of issues in fleet, as identified through the internal audit. An action plan has been devised and its implementation is being led by the Director of Estates and Facilities throughout 2017-18.
- Investment into A&E management structures during 2016-17 to strengthen operational capacity to best improve those issues highlighted in relation to end of shift over time. The Executive Director of Operations leads in relation to this, supported by the increased management capacity going into 2017-18.
- In relation to the MARs issue raised Officers are reviewing the operation and business case mechanisms around MARs alongside other process development.
- Review of the Service Transformation Programmes and strengthening of the Programme Management Office arrangements.
- Active engagement with external partners on system wide strategy and development including the West Yorkshire Vanguard, West Yorkshire Accelerator Zone, STPs, A&E Delivery Boards and development of internal arrangements to support cross-organisational governance.

6. Significant Issues

6.1 The 2016-17 review of the Trust's system of internal control has identified a number of significant issues relating to:

- continued delivery of the A&E service targets against a backdrop of rising demand for high acuity care likely to be above that contracted for, national paramedic and clinical workforce constraints, wider system changes and the system wide Acute service reconfiguration across Yorkshire which will have potentially serious impacts on quality of care in relation to ambulance response times, in conjunction with increased turnaround pressures at a number of acutes.

- Service delivery and financial impacts in relation to the volume and scope of re-tendering activity across core areas of the business, including but not limited to PTS and Urgent Care.
- External Acute Service reconfigurations across the patch, which all things being equal, will considerably increase journey times in specific areas and likely impact on the quality and safety of response times for patients.
- Financial performance going into 2017-18 will be a challenge for the Trust in the context of national expectations and the ongoing anticipated demand increase, increased turnaround times across the patch and major A&E and acute service reconfiguration across core parts of Yorkshire.

6.2 The risk relating to delivery of the A&E targets is being addressed through ongoing implementation and embedding of a multi-faceted transformation programme and continued implementation of the 5-year workforce plan. This is underpinned by rigorous diagnostic activity and will be supported by continued strategic engagement with commissioners and other stakeholders, and extensive staff engagement and communication. Employee relations continue to present a challenge during this period of intense change, and are also heavily influenced by the national context in the light of ongoing discussions around national pay settlement and unsocial hours. There is a positive framework for ongoing discussions with unions following the multi- union recognition agreement which was formally put in place in May 2015.

6.3 In terms of impacts of service reconfigurations across acutes this is being managed at Executive level through STPs, liaison with key officers at acute trusts, and ongoing discussion with NHSE and NHSI about a system wide quality summit to bring the system together to support in the mitigation of potential risks to patient care.

6.4 The risk in relation to our financial performance is being addressed through the development of a Strategic 3 year plan aimed at assisting the trust to gain efficiencies and reduce bottom line operating costs, with a focus on back office functions and operational service lines.

The Trust is identifying key areas of delivery where it can further optimise efficiency. The internal trust performance management of our financial position is led by our Executive Director of Finance, through Board, Finance and Investment Committee, Trust Executive Group, TMG and CIP Management Group. Potential quality impacts of all CIPs are reported through to Quality Committee. In terms of opportunities to collaborate across the sector, this work is being led by our Chief Executive and includes focussed collaboration through the Northern Ambulance Alliance Board. The Chief Executives of the 3 trusts are exploring opportunities for economies of scale and collective purchasing power to drive better value across a number of agreed work streams, in line with the proposals of the Lord Carter review.

6.5 Management of this risk will be monitored during 2017-18 through the Trust Executive Group, Finance and Investment Committee, Quality Committee, Audit Committee and Board. Additional monitoring and assurance will be provided through the Trust Service Transformation Programme, to oversee the delivery of key developments aligned to the Trust 5-year business plan.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Yorkshire Ambulance Service 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: **Rod Barnes**
Chief Executive
30 May 2017

Independent Auditor's Statement

Independent auditor's report to the Directors of Yorkshire Ambulance Service NHS Trust

We have audited the financial statements of Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 35. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 46 and 47.
- the table of pension benefits of senior managers and related narrative notes on page 48.
- the table of exit packages on page 54 and 55 and related notes on page 55.
- the analysis of staff numbers and costs and related notes on pages 50 and 52.
- the table of pay multiples and related narrative notes on page 51.

This report is made solely to the Board of Directors of Yorkshire Ambulance Service NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and Auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 151, 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 also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as set out on page 150, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

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 circumstances and have been consistently applied and adequately disclosed
- the reasonableness of significant accounting estimates made by the directors
- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion Issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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.

Opinion on the 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 2017 and of its expenditure and income for the year then ended
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

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

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in these respects

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 Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Hassan Rohimun
for and on behalf of Ernst & Young LLP Manchester
31 May 2017

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

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

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

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

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

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Accountable Officer: **Rod Barnes**
Chief Executive
30 May 2017

Statement of Directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

Chief Executive
30 May 2017

Finance Director
30 May 2017

Financial Accounts

Photo courtesy of David Gardner

Statement of Comprehensive Income for year ended 31 March 2017

	Note	**2016-17 £000**	2015-16 £000
Gross employee benefits	8.1	**(171,116)**	(164,152)
Other operating costs	6	**(79,485)**	(77,283)
Revenue from patient care activities	4	**248,934**	244,411
Other Operating revenue	5	**6,490**	4,554
Operating surplus		**4,823**	7,530
Investment revenue	10	**52**	77
Other gains	11	**180**	173
Finance costs	12	**(231)**	(241)
Surplus for the financial year		**4,824**	7,539
Public dividend capital dividends payable		**(2,111)**	(1,900)
Retained surplus/(deficit) for the year		**2,713**	5,639
Other Comprehensive Income			
Impairments and reversals taken to the revaluation reserve		**0**	(262)
Net gain/(loss) on revaluation of property, plant and equipment		**103**	3,014
Total comprehensive income for the year		**2,816**	8,391
Financial performance for the year			
Retained surplus for the year		**2,713**	5,639
Impairments (excluding IFRIC 12 impairments)		**0**	458
Adjustments in respect of donated gov't grant asset reserve elimination		**6**	6
Adjusted retained surplus		**2,719**	6,103
Less: non recurrent income included in above	35	**0**	(3,653)
Adjusted retained surplus before additional income		**2,719**	2,450

The notes on pages 157 to 185 form part of this account

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets:			
Property, plant and equipment	14	**89,469**	86,061
Intangible assets	15	**1,273**	1,133
Trade and other receivables	19.1	**603**	645
Total non-current assets		**91,345**	87,839
Current assets:			
Inventories	18	**1,299**	1,076
Trade and other receivables	19.1	**9,434**	11,163
Cash and cash equivalents	22	**19,085**	21,469
Sub-total current assets		**29,818**	33,708
Non-current assets held for sale	23	**160**	785
Total current assets		**29,978**	34,493
Total assets		**121,323**	122,332

	Note	31 March 2017 £000	31 March 2016 £000
Current liabilities:			
Trade and other payables	24	**(13,833)**	(18,658)
Provisions	27	**(2,889)**	(1,801)
Borrowings	25	**(823)**	(823)
Total current liabilities		**(17,545)**	(21,282)
Net current assets/(liabilities)		**12,433**	13,211
Total assets less current liabilities		**103,778**	101,050
Non-current liabilities:			
Provisions	27	**(9,575)**	(8,936)
Borrowings	25	**(5,813)**	(6,636)
Total non-current liabilities		**(15,388)**	(15,572)
Total Assets Employed:		**88,390**	85,478
FINANCED BY:			
Public Dividend Capital	35	**75,037**	74,941
Retained earnings		**3,852**	647
Revaluation reserve		**9,501**	9,890
Total Taxpayers' Equity		**88,390**	85,478

The financial statements on pages 153 to 156 were approved by the Board on 30 May 2017 and signed on its behalf by:

Chief Executive
30 May 2017

Statement of Changes in Taxpayers' Equity for the year ending 31 March 2017

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	**Total reserves £000**
Balance at 1 April 2016	74,941	647	9,890	**85,478**
Changes in taxpayers' equity for 2016-17				
Retained surplus for the year		2,713		**2,713**
Net gain on revaluation of property, plant, equipment			103	**103**
Impairments and reversals			0	**0**
Transfers between reserves		492	(492)	**0**
Reclassification Adjustments				
Temporary and permanent PDC received - cash	96			**96**
Net recognised revenue/(expense) for the year	**96**	**3,205**	**(389)**	**2,912**
Balance at 31 March 2017	**75,037**	**3,852**	**9,501**	**88,390**

Balance at 1 April 2015	78,594	(5,071)	7,217	80,740
Changes in taxpayers' equity for the year ended 31 March 2016				
Retained surplus for the year		5,639		5,639
Net gain on revaluation of property, plant, equipment			3,014	3,014
Impairments and reversals			(262)	(262)
Transfers between reserves		79	(79)	0
Reclassification Adjustments				
PDC repaid in year	(3,653)			(3,653)
Net recognised revenue/(expense) for the year	(3,653)	5,718	2,673	4,738
Balance at 31 March 2016	**74,941**	**647**	**9,890**	**85,478**

Information on reserves

1. Public Dividend Capital

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

Details are provided in note 33.2.

2. Retained Earnings Reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

3. Revaluation Reserve

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

Statement of Cash Flows for the Year ended 31 March 2017

	Note	**2016-17 £000**	2015-16 £000
Cash Flows from Operating Activities			
Operating surplus		**4,823**	7,530
Depreciation and amortisation	6	**9,082**	8,994
Impairments and reversals	16	**0**	458
(Increase)/Decrease in Inventories		**(223)**	(171)
(Increase)/Decrease in Trade and Other Receivables		**1,528**	1,892
Increase/(Decrease) in Trade and Other Payables		**(3,476)**	3,539
Provisions utilised		**(1,106)**	(1,497)
Increase/(Decrease) in movement in non cash provisions		**2,718**	231
Net Cash Inflow from Operating Activities		**13,346**	20,976
Cash Flows from Investing Activities			
Interest Received		**52**	77
(Payments) for Property, Plant and Equipment		**(13,737)**	(7,966)
(Payments) for Intangible Assets		**(287)**	(107)
Proceeds of disposal of assets held for sale (PPE)		**953**	178
Net Cash (Outflow) from Investing Activities		**(13,019)**	(7,818)
Net Cash Inflow before Financing		**327**	13,158
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**96**	0
Gross Temporary and Permanent PDC Repaid	35	**0**	(3,653)
Loans received from DH - New Capital Investment Loans		**0**	1,500
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(823)**	(578)
Interest paid		**(116)**	(130)
PDC Dividend (paid)		**(1,868)**	(2,255)
Net Cash Inflow/(Outflow) from Financing Activities		**(2,711)**	(5,116)
NET INCREASE IN CASH AND CASH EQUIVALENTS		**(2,384)**	8,042
Cash and Cash Equivalents (and Bank Overdraft) at beginning of the period		**21,469**	13,427
Cash and Cash Equivalents (and Bank Overdraft) at year end	22	**19,085**	21,469

Notes to the accounts

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health.

The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

Going Concern

These accounts have been prepared on a going concern basis

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

Movement of assets within the DH Group

"Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries."

1.3 Charitable Funds

Following HM Treasury's agreement to apply IAS27 to NHS Charities from 1 April 2013, the Trust has established that as it is the corporate trustee of the Yorkshire Ambulance Charitable Trust Fund, it effectively has the power to exercise control. However the transactions are immaterial in the context of the Trust and therefore the transactions relating to the Charity have not been consolidated. Details of transactions with the charity are included in the related parties note 32.

1.4 Pooled Budgets

The Trust was not part of any pooled budget arrangements during the year ending 31 March 2017

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Revaluation of Land and Buildings: During the year a desktop revaluation of land and buildings was carried out by the District Valuer.

1.5.2 Key sources of estimation uncertainty

Non Current Assets

Values are as disclosed in notes 14, tangible assets, and 15 intangible assets.

Asset lives, with the exception of buildings are set out in note 1.11 with maximum lives being set by reference to the type of asset and its expected useful life in normal use. Building lives are based on the recommendations received from the District Valuer. Land and buildings have been re-valued as at 31 March 2017 and have not been subject to indexation in the year. The results of this are disclosed in note 14.

Provisions

Values are as disclosed in note 27.

These have been estimated based on the best information available at the time of the compilation of the accounts. Estimates of employee's legal claims are made including the advice received from the National Health Service (NHS) Litigation Authority to the size and likely outcome of each individual claim. The Trust's maximum liability regarding each claim is limited to £10k.

We have provided for the costs of reinstating dilapidations to leased and tenancy properties based on a professional evaluation by Dacres Commercial.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

National Employment Savings Trust (NEST)

There are a small number of staff who are not entitled to join the NHS pension scheme, for example:

- Those already in receipt of an NHS pension who have taken benefits from the 1995 section of the scheme;
- Those who work full time at another Trust;
- Those over 75 years of age

The National Employment Savings Trust (NEST) has been set up specifically to help employers to comply with the Pensions Act 2008. Employees who have taken their benefits from the 1995 section of the NHS pension scheme and are under state retirement age are enrolled in the NEST scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST; it is a non- departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP).

In 2016-17 employee contributions to NEST were 0.8% of pensionable pay and employer contributions were also 1.0% of pensionable pay. NEST levies a contribution charge of 1.8% and an annual management charge of 0.3% which is paid for from the employee contributions. There are no separate employer charges levied by NEST and the Trust is not required to enter into a contract to utilise NEST qualifying pension schemes.

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets depreciation commences in the quarter after they are brought into use.

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally- generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating.

Internally- developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

Economic lives of non-current assets at the close of the reporting period were as follows:

Buildings excluding dwellings	4-60 years
Plant and machinery	5-15 years
Vehicles and related equipment	3-7 years
Information Technology	2-7 years
Furniture and fittings	4-10 years

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income.

Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.17 Cash and cash equivalents

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

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

1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it.

The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 35.

1.20 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust.

A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets; and
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.24 Value Added Tax

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

1.25 Foreign currencies

The Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 34 to the accounts.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.28 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.30 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating segments

In accordance with the Requirements of IFRS 8 (Operating Segments), the Trust has considered the need to report as segments. It has considered the criteria for which segmentation should be assessed and concludes that the Trust operates as one segment.

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving a surplus, which is then used in the delivery of patient care.

The Trust does not have any income generation schemes where costs exceed £1m.

4. Revenue from patient care activities

	2016-17 £000	2015-16 £000
NHS Trusts	**103**	114
NHS England	**1,918**	1,320
Clinical Commissioning Groups	**245,183**	236,887
Foundation Trusts	**754**	1,287
Additional income for delivery of healthcare services (note 35)	**0**	3,653
Non-NHS:		
Local Authorities	**0**	64
Private patients	**12**	4
Injury costs recovery	**964**	1,070
Other Non-NHS patient care income	**0**	12
Total Revenue from patient care activities	**248,934**	244,411

5. Other operating revenue

	2016-17 £000	2015-16 £000
Recoveries in respect of employee benefits	**563**	266
Education, training and research	**2,120**	1,770
Sustainability and Transformation Fund Income	**1,140**	0
Income generation (Other fees and charges)	**2,667**	2,418
Other revenue	**0**	100
Total Other Operating Revenue	**6,490**	4,554
Total operating revenue	**255,424**	248,965

6. Other Operating expenses

	2016-17 £000	2015-16 £000
Services from other NHS Trusts	**185**	181
Services from NHS Foundation Trusts	**0**	122
Total Services from NHS bodies*	**185**	303
Purchase of healthcare from non-NHS bodies	**22,137**	20,649
Trust Chair and Non-executive Directors	**68**	59
Supplies and services - clinical	**5,137**	5,174
Supplies and services - general	**1,333**	1,569
Consultancy services	**977**	926
Establishment	**6,173**	5,533
Transport	**17,877**	20,025
Business rates paid to local authorities	**1,291**	1,291
Premises	**6,385**	6,501
Hospitality	**555**	299

6. Other Operating expenses *(continued)*

	2016-17 £000	2015-16 £000
Insurance	**2,289**	2,219
Legal Fees	**244**	871
Impairments and Reversals of Receivables	**29**	(196)
Depreciation	**8,569**	8,564
Amortisation	**513**	430
Impairments and reversals of property, plant and equipment	**0**	458
Internal Audit Fees	**192**	174
Audit fees	**61**	61
Other auditor's remuneration	**30**	30
Clinical negligence	**1,063**	988
Education and Training	**1,505**	893
Change in Discount Rate	**1,015**	(61)
Other	**1,857**	523
Total Operating expenses (excluding employee benefits)	**79,485**	77,283
6.1 Employee Benefits		
Employee benefits excluding Board members	**170,079**	163,404
Board members	**1,037**	748
Total Employee Benefits	**171,116**	164,152
Total Operating Expenses	**250,601**	241,435

**Services from NHS bodies does not include expenditure which falls into a category below*

7. Operating Leases

The Trust's operating lease commitments relate to land, buildings, medical equipment and vehicles.

The vehicle commitments are based on 438 vehicles, of which 149 are due to expire within 1 year and 289 are due to expire between 1 and 5 years.

The commitment on land consists of 2 leases which is for the car parking facility at the Springhill Headquarters and Fleet Unit M which is due to expire between 1 and 5 years. The commitment on land and buildings consists of 41 leases, of which 4 are due to expire after 5 years, 12 will expire between 1 and 5 years, and 25 will expire within 1 year.

7.1 Yorkshire Ambulance Service NHS Trust as lessee

	Land £000	Buildings £000	Vehicles £000	**2016-17 £000**	2015-16 £000
Payments recognised as an expense					
Minimum lease payments				**2,683**	4,061
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**2,683**	4,061
Payable:					
No later than one year	39	678	839	**1,556**	1,915
Between one and five years	22	1,068	1,844	**2,934**	2,357
After five years	0	916	0	**916**	1,293
Total	61	2,662	2,683	**5,406**	5,565
Total future sublease payments expected to be received:				**0**	0

8. Employee benefits

8.1. Employee benefits

	2016-17 Total £000	2015-16 Total £000
Employee Benefits - Gross Expenditure		
Salaries and wages	**141,276**	138,433
Social security costs	**13,247**	9,957
Employer Contributions to NHS BSA - Pensions Division	**16,244**	15,547
Termination benefits	**349**	215
Total employee benefits	**171,116**	164,152

8.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**4**	10
	£000	£000
Total additional pensions liabilities accrued in the year	**168**	676

8.3 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

9. Better Payment Practice Code

9.1. Measure of compliance

	2016-17	2016-17	2015-16	2015-16
	Number	**£000**	Number	£000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**30,869**	**86,721**	30,344	80,733
Total Non-NHS Trade Invoices Paid Within Target	**27,141**	**76,456**	26,550	69,636
Percentage of NHS Trade Invoices Paid Within Target	**87.9%**	**88.2%**	87.5%	86.3%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**551**	**3,292**	618	2,481
Total NHS Trade Invoices Paid Within Target	**447**	**2,806**	488	1,976
Percentage of NHS Trade Invoices Paid Within Target	**81.1%**	**85.2%**	79.0%	79.6%

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

9.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000	2015-16 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	**0**

10. Investment Revenue

	2016-17 £000	2015-16 £000
Bank interest	**52**	77
Other loans and receivables	**0**	0
Total investment revenue	**52**	**77**

11. Other Gains and Losses

	2016-17 £000	2015-16 £000
Gain/(Loss) on disposal of assets	**180**	173

12. Finance Costs

	2016-17 £000	2015-16 £000
Interest on loans and overdrafts	**116**	130
Provisions - unwinding of discount	**115**	111
Total	**231**	**241**

Note: Provisions - unwinding of the discount.

Where provision is made for costs that will arise in future years, the costs involved are discounted to current values. At the end of each year that discount is recalculated as the timing of the expense draws nearer. The cost that results is known as "unwinding the discount".

13. Audit Costs

13.1. Other auditor remuneration

	2016-17 £000	2015-16 £000
Other auditor remuneration paid to the external auditor: Taxation compliance services	**30**	30
Total	**30**	**30**

13.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016-17 or 2015-16.

14.1. Property, plant and equipment 2016-17

2016-17	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation: At 1 April 2016	19,229	35,306	6,112	3,634	56,408	28,353	813	**149,855**
Additions of Assets Under Construction	0	0	5,784	0	0	0	0	**5,784**
Additions Purchased	0	690	0	2,618	2,239	691	0	**6,238**
Reclassifications	0	113	(5,393)	120	3,758	1,402	0	**0**
Disposals other than for sale	(11)	0	0	0	(5,180)	(2)	0	**(5,193)**
Revaluation	(139)	(937)	0	0	0	0	0	**(1,076)**
At 31 March 2017	**19,079**	**35,172**	**6,503**	**6,372**	**57,225**	**30,444**	**813**	**155,608**
Depreciation: At 1 April 2016	0	0	0	2,167	36,998	23,994	635	**63,794**
Disposals other than for sale	0	0	0	0	(5,043)	(2)	0	**(5,045)**
Revaluation	0	(1,179)	0	0	0	0	0	**(1,179)**
Charged During the Year	0	(1,179)	0	330	5,342	1,695	23	**8,569**
At 31 March 2017	**0**	**0**	**0**	**2,497**	**37,297**	**25,687**	**658**	**66,139**
Net Book Value at 31 March 2017	**19,079**	**35,172**	**6,503**	**3,875**	**19,928**	**4,757**	**155**	**89,469**
Asset financing:								
Owned - Purchased	19,079	35,172	6,503	3,875	19,918	4,757	155	**89,459**
Owned - Donated	0	0	0	0	10	0	0	**10**
Total at 31 March 2017	**19,079**	**35,172**	**6,503**	**3,875**	**19,928**	**4,757**	**155**	**89,469**

14.1. Property, plant and equipment 2016-17 - Revaluation Reserve Balance

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	**£000**
At 1 April 2016	2,135	7,478	0	71	204	0	2	**9,890**
Movements (specify)	(567)	242	0	0	(64)	0	0	**(389)**
At 31 March 2017	**1,568**	**7,720**	**0**	**71**	**140**	**0**	**2**	**9,501**
Additions to Assets Under Construction in 2016-17								
Buildings excluding Dwellings	0	0	264	0	0	0	0	
Plant and Machinery	0	0	5,520	0	0	0	0	
Balance as at YTD	**0**	**0**	**5,784**	**0**	**0**	**0**	**0**	

All valuations of Land and buildings are carried out by professionally qualified valuers in accordance with the Royal Chartered Institute of Surveyor Valuation Standards. The Trust's land and buildings valuations were undertaken by the District Valuer Service, part of the Valuation Office Agency of HM Revenue and Customs, during February 2017 and March 2017 with a prospective valuation date of 31 March 2017. There were no impairments arising as a result of the valuation exercise.

14.2. Property, plant and equipment 2015-16

2015-16	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation: At 1 April 2015	19,592	36,851	7,501	2,338	57,389	25,202	712	**149,585**
Additions of Assets Under Construction	0	0	7,261	0	0	0	0	**7,261**
Additions Purchased	0	8	0	369	0	2,622	9	**3,008**
Reclassifications	0	1,285	(8,650)	927	5,105	689	92	**(552)**
Reclassifications as Held for Sale and reversals	(625)	0	0	0	0	0	0	**(625)**
Disposals other than for sale	0	0	0	0	(6,086)	(160)	0	**(6,246)**
Revaluation	288	(2,144)	0	0	0	0	0	**(1,856)**
Impairment/reversals charged to operating expenses	(26)	(432)	0	0	0	0	0	**(458)**
Impairments/reversals charged to reserves	0	(262)	0	0	0	0	0	**(262)**
At 31 March 2016	**19,229**	**35,306**	**6,112**	**3,634**	**56,408**	**28,353**	**813**	**149,855**
Depreciation: At 1 April 2015	147	3,202	0	2,020	37,658	22,698	616	**66,341**
Disposals other than for sale	0	0	0	0	(6,081)	(160)	0	**(6,241)**
Revaluation	(147)	(4,723)	0	0	0	0	0	**(4,870)**
Charged During the Year	0	1,521	0	147	5,421	1,456	19	**8,564**
At 31 March 2016	**0**	**0**	**0**	**2,167**	**36,998**	**23,994**	**635**	**63,794**
Net Book Value at 31 March 2016	**19,229**	**35,306**	**6,112**	**1,467**	**19,410**	**4,359**	**178**	**86,061**
Asset financing:								
Owned - Purchased	19,229	35,306	6,112	1,467	19,394	4,359	178	**86,045**
Owned - Donated	0	0	0	0	16	0	0	**16**
Total at 31 March 2016	**19,229**	**35,306**	**6,112**	**1,467**	**19,410**	**4,359**	**178**	**86,061**

14.3. Property, plant and equipment

The Trust has two donated assets, both are community medical units.

The assets were added to the asset register at NBV at the time of the donation. The asset have been internally assessed to have an expected life of five years.

15. Intangible assets

Intangible non current assets relate to purchased software licences which are valued at purchase cost less accumulated amortisation.

Asset lives range between 3 and 5 years with no asset having an indefinite life given software is constantly being updated.

15.1. Intangible assets

2016-17	Computer Licenses	Intangible Assets Under Construction	Total
	£000	£000	£000
At 1 April 2016	2,917	-	2,917
Additions of Assets Under Construction	0	459	459
Additions Purchased	194	0	194
Reclassifications	248	(248)	0
At 31 March 2017	**3,359**	**211**	**3,570**
Amortisation			
At 1 April 2016	1,784		1,784
Charged During the Year	513		513
At 31 March 2017	**2,297**	**0**	**2,297**
Net Book Value at 31 March 2017	**1,062**	**211**	**1,273**

15.2. Intangible non-current assets prior year

2015-16	Computer Licenses	Intangible Assets Under Construction	Total
	£000	£000	£000
Cost or valuation:			
At 1 April 2015	2,365	0	2,365
Reclassifications	552	0	552
At 31 March 2016	**2,917**	**0**	**2,917**
Amortisation			
At 1 April 2015	1,354	0	1,354
Charged During the Year	430	0	430
At 31 March 2016	**1,784**	0	**1,784**
Net Book Value at 31 March 2016	**1,133**	**0**	**1,133**

16. Analysis of impairments and reversals recognised in 2016-17

There were no impairments or reversals of impairments during the year.

17. Commitments

17.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	2016-17 £000	2015-16 £000
Property, plant and equipment	**153**	227
Intangible assets	**7**	26
Total	**160**	253

18. Inventories

	Drugs £000	Consumables £000	Other £000	**Total** **£000**	Of which held at NRV £000
Balance at 1 April 2016	84	853	139	**1,076**	1,076
Additions	351	6,566	4,861	**11,778**	11,778
Inventories recognised as an expense in the period	(361)	(6,343)	(4,851)	**(11,555)**	(11,555)
Balance at 31 March 2017	**74**	**1,076**	**149**	**1,299**	**1,299**

19.1. Trade and other receivables

	Current		Non-current	
	31 March 2017 **£000**	31 March 2016 £000	**31 March 2017** **£000**	31 March 2016 £000
NHS receivables - revenue	**2,350**	2,066	**0**	0
NHS prepayments and accrued income	**980**	750	**0**	0
Non-NHS receivables - revenue	**419**	575	**0**	0
Non-NHS prepayments and accrued income	**5,458**	7,531	**603**	645
PDC Dividend prepaid to DH	**125**	368	**0**	0
Provision for the impairment of receivables	**(532)**	(505)	**0**	0
VAT	**240**	291	**0**	0
Other receivables	**394**	87	0	0
Total	**9,434**	11,163	**603**	645
Total current and non current	**10,037**	11,808		
Prepaid pension contributions: Included in NHS receivables	0	0		

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care, no credit scoring of them is considered necessary.

19.2. Receivables past their due date but not impaired

	31 March 2017 £000	31 March 2016 £000
By up to three months	**1,602**	1,826
By three to six months	**418**	103
By more than six months	**909**	93
Total	**2,929**	**2,022**

19.3. Provision for impairment of receivables

	2016-17 £000	2015-16 £000
Balance at 1 April 2016	**(505)**	(739)
Amount written off during the year	**2**	38
(Increase)/decrease in receivables impaired	**(29)**	196
Balance at 31 March 2017	**(532)**	**(505)**

21. Other current assets

There are no other relevant assets.

22. Cash and Cash Equivalents

	31 March 2017 £000	31 March 2016 £000
Opening balance	**21,469**	13,427
Net change in year	**(2,384)**	8,042
Closing balance	**19,085**	21,469
Made up of:		
Cash with Government Banking Service	**19,042**	21,438
Commercial banks	**37**	23
Cash in hand	**6**	8
Cash and cash equivalents as in statement of financial position	**19,085**	21,469
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**19,085**	21,469

23. Non-current assets held for sale

Non-current assets classed as held for sale are valued at the lower of carrying value and fair value less costs to sell, in accordance with IFRS 5.

	Land
	£000
Balance at 1 April 2016	785
Plus assets classified as held for sale in the year	0
Less assets sold in the year	(625)
Less impairment of assets held for sale	0
Plus reversal of impairment of assets held for sale	0
Balance at 31 March 2017	**160**
Liabilities associated with assets held for sale at 31 March 2017	**0**
Balance at 1 April 2015	160
Plus assets classified as held for sale in the year	625
Less assets sold in the year	0
Balance at 31 March 2016	785
Liabilities associated with assets held for sale at 31 March 2016	0

The assets held for sale in year were Bramham, a former ambulance station, and Gildersome Ambulance Station.

The former is part of a tri-party multi agency disposal event which is expected within the first quarter of 2017-18. The latter was approved for disposal by Trust Board in 2016-17 and thereafter marketed for sale.

The sale of Gildersome completed in June 2016. There was no loss or gain realised on disposal as the receipt of £625,000 was consistent with the fair value of the asset.

24. Trade and other payables

	Current		Non-current	
	31 March 2017 £000	31 March 2016 £000	**31 March 2017 £000**	31 March 2016 £000
NHS payables - revenue	**281**	297	**0**	0
NHS accruals and deferred income	**32**	204	**0**	0
Non-NHS payables - revenue	**1,938**	3,205	**0**	0
Non-NHS payables - capital	**1,895**	3,243	**0**	0
Non-NHS accruals and deferred income	**7,331**	9,663	**0**	0
Accrued Interest on DH Loans	**6**	7	**0**	0
Tax	**201**	0	**0**	0
Other	**2,149**	2,039	**0**	0
Total	**13,833**	18,658	**0**	0
Total payables (current and non-current)	**13,833**	18,658		
Included above:				
to buy out the liability for early retirements over five years	**0**	0		
number of cases involved (number)	**0**	0		
outstanding pension contributions at the year end	**2,149**	2,039		

25. Borrowings

	Current		Non-current	
	31 March 2017 £000	31 March 2016 £000	**31 March 2017 £000**	31 March 2016 £000
Loans from Department of Health	**823**	823	**5,813**	6,636
Total	**823**	823	**5,813**	6,636
Total other liabilities (current and non-current)	**6,636**	7,459		

Borrowings / Loans - repayment of principal falling due in:	**Total £000**
0-1 Years	**823**
1-2 Years	**823**
2-5 Years	**1,491**
Over 5 Years	**3,499**
Total	**6,636**

Loans are in respect of the acquisition of the Springhill site and the Electronic Patient Record system.

26. Deferred income

	Current		Non-current	
	31 March 2017 £000	31 March 2016 £000	**31 March 2017 £000**	31 March 2016 £000
Opening balance at 1 April 2016	**206**	183	**0**	0
Deferred revenue addition	**12**	23	**0**	0
Transfer of deferred revenue	**(40)**	0	**0**	0
Current deferred Income at 31 March 2017	**178**	206	**0**	0
Total deferred income (current and non-current)	**178**	206		

27. Provisions

	Total	Early Departure Costs	Legal Claims	Restructuring	Other
	£000	£000	£000	£000	£000
Balance at 1 April 2016	**10,737**	8,395	667	0	1,675
Arising during the year	**1,927**	248	479	358	842
Utilised during the year	**(1,106)**	(547)	(439)	0	(120)
Reversed unused	**(224)**	(110)	(112)	0	(2)
Unwinding of discount	**115**	115	0	0	0
Change in discount rate	**1,015**	1,015	0	0	0
Balance at 31 March 2017	**12,464**	**9,116**	**595**	**358**	**2,395**
Expected Timing of Cash Flows:					
No Later than One Year	**2,889**	533	595	358	1,404
Later than One Year and not later than Five Years	**2,483**	2,119	0	0	364
Later than Five Years	**7,092**	6,464	0	0	627
Subtotal over one year	**9,575**	8,583	0	0	991
Total	**12,464**	**9,116**	**595**	**358**	**2,395**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2017	**6,764**
As at 31 March 2016	11,188

Restructuring provisions have been made in respect of reorganisations within the 111 service and Patient Transport Service. 'Other' provisions comprise:

Potential costs relating to the East Coast Audit Consortium (ECAC);

Provision for staff costs including 'Frozen Leave' costs, debts outstanding on the Salary Sacrifice Scheme for Cars, and holiday pay; and provision for anticipated dilapidation costs of leased buildings based on an independent assessment by Dacres Commercial.

28. Contingencies

	31 March 2017 £000	31 March 2016 £000
Contingent liabilities		
NHS Litigation Authority legal claims	**(389)**	(390)
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Net value of contingent liabilities	**(389)**	(390)

29. Financial Instruments

29.1. Financial risk management

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

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust's Management Board.

Treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

29.2. Financial Assets

	Loans and receivables £000	Total £000
Receivables - NHS	**2,350**	**2,350**
Receivables - non-NHS	**419**	**419**
Cash at bank and in hand	**19,085**	**19,085**
Total at 31 March 2017	**21,854**	**21,854**
Receivables - NHS	2,066	2,066
Receivables - non-NHS	575	575
Cash at bank and in hand	21,469	21,469
Total at 31 March 2016	24,110	24,110

29.3. Financial Liabilities

	Payables and Borrowings £000	Total £000
NHS payables	**281**	**281**
Non-NHS payables	**5,982**	**5,982**
Loans from Department of Health	**6,636**	**6,636**
Total at 31 March 2017	**12,899**	**12,899**
NHS payables	297	297
Non-NHS payables	6,448	6,448
Loans from Department of Health	7,459	7,459
Total at 31 March 2016	14,204	14,204

The figures for 2015-16 in the above table have been restated to include £7.459m loans from the Department of Health and to adjust payables values to include amounts contractually due.

30. Events after the end of the reporting period

There were no events after the reporting period which would require an adjustment to the account or other disclosure.

31. Related party transactions

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

The Department of Health is regarded as a related party. During the year Yorkshire Ambulance Service NHS Trust has had a significant number of material transactions with the Department (defined as constituting over 5% of turnover), and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Sheffield CCG	21,952	0	108	0
NHS Wakefield CCG	21,446	0	431	0
NHS Bradford Districts CCG	16,867	0	57	0
NHS Vale Of York CCG	16,299	0	39	0
NHS Leeds South And East CCG	16,192	0	49	0
NHS Leeds West CCG	15,062	0	33	0
NHS East Riding Of Yorkshire CCG	14,620	0	335	0
NHS Greater Huddersfield CCG	12,471	10	81	0
NHS Pension Scheme	0	16,244	0	0

No Trust board members had any interest in any of these organisations during the financial year.

No Trust board member has declared an interest in any other organisation with which the Trust does business.

The Trust works with the Yorkshire Air Ambulance charity and provides medical staff for that service.

Dr David Macklin works as Medical Director for that charity.

The Trust Board is the Corporate Trustee of the Yorkshire Ambulance Service NHS Charitable Trust Charity No. 1114106.

Transactions between the Charity and the Trust during the year were not material.

32. Losses and special payments

	Total Value of Cases £	Total Number of Cases
Losses	**5,516**	**27**
Special payments	**519,840**	**89**
Total losses and special payments and gifts	**525,356**	**116**

The total number of losses cases in 2015-16 and their total value was as follows:	Total Value of Cases £	Total Number of Cases
Losses	39,357	12
Special payments	310,778	78
Total losses and special payments	350,135	90

Details of cases individually over £300,000

The Trust did not incur any losses which individually exceeded this amount during the year.

Current year losses and special payments include all non-clinical payments made in accordance with the NHSLA Property Expenses Scheme (PES) and Liabilities to Third Parties Scheme (LTPS) to the extent of the Trust's liability i.e. the net cost to the Trust. This is normally limited to the value of the applicable excess.

33. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

33.1. Breakeven performance

	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	2011-12 £000	2012-13 £000	2013-14 £000	2014-15 £000	2015-16 £000	**2016-17 £000**
Turnover	144,639	155,010	186,710	197,910	195,228	200,333	209,772	233,384	241,328	248,965	**255,424**
Retained surplus/(deficit) for the year	(4,467)	251	151	(6,439)	(1,644)	20	512	2,771	2,537	5,639	**2,713**
Adjustment for: Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	**0**
Prior Period Adjustments	7,566	0	0	0	0	0	0	0	0	0	**0**
Adjustments for impairments	0	0	0	6,957	1,881	408	1,711	(110)	449	458	**0**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	0	(28)	5	6	**6**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	0	**0**
Absorption accounting adjustment	0	0	0	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0	**0**
Break-even in-year position	3,099	251	151	518	237	428	2,223	2,633	2,991	6,103	**2,719**
Break-even cumulative position	**3,099**	**3,350**	**3,501**	**4,019**	**4,256**	**4,684**	**6,907**	**9,540**	**12,531**	**18,634**	**21,353**

** Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.*

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	**2016-17 %**
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	2.14	0.16	0.08	0.26	0.12	0.21	1.06	1.13	1.24	2.45	**1.06**
Break-even cumulative position as a percentage of turnover	2.14	2.16	1.88	2.03	2.18	2.34	3.29	4.09	5.19	7.48	**8.36**

The amounts in the above tables in respect of financial years 2006-07 to 2008-09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

33.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

33.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000	2015-16 £000
External financing limit (EFL)	**2,042**	(3,953)
Cash flow financing	**1,657**	(10,773)
Other capital receipts	**0**	0
External financing requirement	**1,657**	(10,773)
Under spend against EFL	**385**	**6,820**

The External Financing Limit is a control over cash expenditure by NHS trusts. It encompasses all sources of financing available to an NHS trust, whether internal, external or from the Department of Health. An underspend demonstrates that this control has been met.

33.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

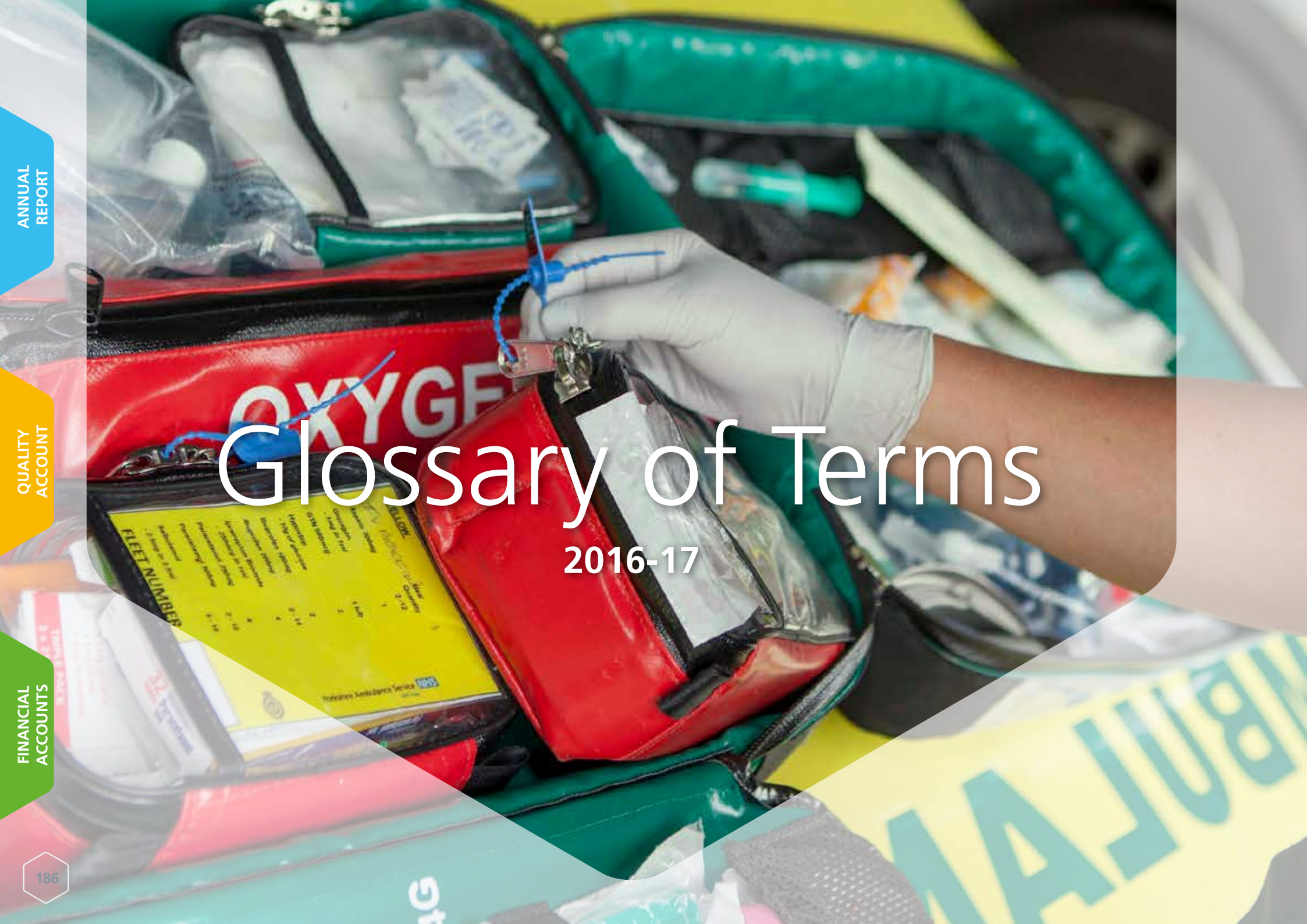
	2016-17 £000	2015-16 £000
Gross capital expenditure	**12,675**	10,268
Less: book value of assets disposed of	**(774)**	(5)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current	**0**	0
Charge against the capital resource limit	**11,901**	10,263
Capital resource limit	**12,126**	10,388
Underspend against the capital resource limit	**225**	**125**

34. Third party assets

The Trust does not hold any third party assets.

35. Non recurrent income

In 2015-16 the Trust received £3.653m from the Department of Health as part of an agreement to defer capital expenditure into 2016-17. This is shown as non-recurrent income. As part of that agreement the Trust repaid £3.653m Public Dividend Capital in 2015-16.



Glossary of Terms

2016-17

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.
Algorithm	A self-contained step-by-step set of operations to be performed. Algorithms exist that perform calculation, data processing and automated reasoning.
Advanced Life Support (ALS)	ALS is a set of life-saving protocols and skills that extend Basic Life Support (BLS) to further support the circulation and provide an open airway and adequate ventilation (breathing).
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 and 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.
Automated External Defibrillator (AED)	A portable device that delivers an electric shock through the chest to the heart. The shock can then stop an irregular rhythm and allow a normal rhythm to resume in a heart in sudden cardiac arrest.
Bare Below the Elbows (BBE)	An NHS dress code to help with infection prevention and control.
Basic Life Support (BLS)	When a patient has a cardiac arrest and their heart stops beating they can be provided with basic life support to help their chance of survival. Essentially chest compressions are provided to pump blood from the heart and around the body, ensuring the tissues and the brain maintain an oxygen supply.
Being Open	The process of having open and honest communication with patients and families when things go wrong.
Better Payment Practice Code (BPPC)	The BPPC was established to promote a better payment culture within the UK and urges all organisations to adopt a responsible attitude to paying on time. The target is to pay all invoices within 30 days of receipt.
Board Assurance Framework (BAF)	Provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their strategic objectives.

Term/Abbreviation	*Definition/Explanation*
British Association for Immediate Care (BASICS)	A 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 services, 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.
Cardio-pulmonary Resuscitation (CPR)	A procedure used to help resuscitate a patient when their heart stops beating and breathing stops.
Care transfer	Keeping patients safe when they transfer between care providers.
Care Bundle	A group of interventions (practices) related to a disease process that, when carried out 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.
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.
Chronic Obstructive Pulmonary Disease (COPD)	COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.
Clinical Commissioning Group (CCG)	Groups of clinicians who commission healthcare services for their communities. They replaced primary care trusts (PCTs).
Clinical Governance Group (CGG)	Internal regulatory group that agrees and approves all clinical decisions.
Clinical Hub	A team of clinical advisors based within the Emergency Operations Centre providing support for patients with non life-threatening conditions.
Clinical Pathways	The standardisation of care practices to reduce variability and improve outcomes for patients.

Term/Abbreviation	*Definition/Explanation*
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 Quality Strategy	A framework for the management of quality within YAS.
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.
Dashboards	Summary of progress against Key Performance Indicators for review by managers or committees.
Dataset	A collection of data, usually presented in tabular form.
DATIX	Patient safety software for healthcare risk management, incident and adverse event reporting.
Department of Health (DH)	The government department which provides strategic leadership for public health, the NHS and social care in England.
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR)	For a small number of people who are approaching the last days of life, cardio-pulmonary resuscitation (CPR) would be futile or not a viable option. In these circumstances DNACPR forms are completed to avoid aggressive, undignified and futile actions to resuscitate a patient, and to allow a natural, dignified death in line with the patient's wishes.
Duty of Candour	Regulation that ensures providers are open and transparent with people who use their services.
Electrocardiogram (ECG)	An interpretation of the electrical activity of the heart. This is done by attaching electrodes onto the patient which record the activity of the different sections of the heart.
Emergency Care Assistant (ECA)	Emergency Care Assistants work with clinicians responding to emergency calls. They work alongside a more qualified member of the ambulance team, giving support and help to enable them to provide patients with potentially life-saving care at the scene and transporting patients to hospital.

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 on an emergency ambulance to provide the care, treatment and safe transport of patients.
Emergency Operations Centre (EOC)	The department which handles all our 999 emergency and routine calls and deploys the most appropriate response. The two EOCs are based in Wakefield and York.
Epidemiology	Is the study and analysis of the patterns, causes and effects of health and disease conditions in defined populations.
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.
Expert Patient	Independent person who works with YAS and offers a patient perspective to the Trust.
Face, Arm, Speech Test (FAST)	A brief test used to help determine whether or not someone has suffered a stroke.
Foundation Trust (FT)	NHS organisations which operate more independently under a different governance and financial framework.
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.
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.
Health Overview and Scrutiny Committees (HOSCs)	Local authority-run committees which scrutinise matters relating to local health services and contribute to the development of policy to improve health and reduce health inequalities.
Healthwatch	Healthwatch England is the independent consumer champion for health and social care in England. Local Healthwatch organisations have also been set up. Local Healthwatch organisations are a network of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. Healthwatch organisations started to replace LINks (Local Involvement Networks) from October 2012.

Term/Abbreviation	*Definition/Explanation*
Human Resources (HR)	A function with responsibility for implementing strategies and policies relating to the management of individuals.
Immediate Life Support (ILS)	ILS training is for healthcare personnel to learn cardio-pulmonary resuscitation (CPR), simple airway management and safe defibrillation (manual and/or AED), enabling them to manage patients in cardiac arrest until arrival of a cardiac arrest team.
Incident	Any unplanned event which has given rise to actual personal injury, patient dissatisfaction, property loss or damage, or damage to the financial standing or reputation of the Trust.
Information Asset Owner (IAO)	An IAO is an individual within an organisation that has been given formal responsibility for the security of an information asset (or assets) in their particular work area.
Information, Communication and Technology (ICT)	The directorate responsible for the development and maintenance of all ICT systems and processes across Yorkshire Ambulance Service.
Information Governance (IG)	Allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.
Integrated Business Plan (IBP)	Sets out an organisation's vision and its plans to achieve that vision in the future.
Joint Decision Model (JDM)	A national information and intelligence model that gathers information around patient/location/threat to aid a safer response.
Joint Royal Colleges Ambulance Liaison Committee (JRCALC)	Its role is to provide robust clinical speciality advice to ambulance services within the UK and it publishes regularly updated clinical guidelines.
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 Education and Training Board (LETB)	Responsible for the training and education of NHS staff, both clinical and non-clinical, within their area.

Term/Abbreviation	*Definition/Explanation*
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 centres throughout the UK, specialising in treating patients who suffer from major trauma.
Mental Capacity Act (MCA)	Legislation designed to protect people who can't make decisions for themselves or lack the mental capacity to do so.
Myocardial Infarction (MI)	Commonly known as a heart attack, an MI is the interruption of blood supply to part of the heart, causing heart cells to die.
National Ambulance Non-conveyance Audit (NANA)	National indicator for re-contact rates within 24 hours for patients treated and discharged at scene by ambulance services.
National Early Warning Score (NEWS)	The NEWS is a simple physiological scoring system that can be calculated at the patient's side, using agreed parameters which are measured in unwell patients. It is a tool which alerts healthcare practitioners to abnormal physiological parameters and triggers an escalation of care and review of an unwell patient.
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 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 Reporting and Learning System (NRLS)	The NRLS is managed by NHS Improvement. The system enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.
Near-miss	Any occurrence, which does not result in injury, damage or loss, but has the potential to do so. Investigation of individual incidents allows us to address the immediate issues, whilst aggregation of data ensures wider themes and trends are identified across the organisation. Triangulation of data from multiple sources such as incidents, complaints, claims, coroners' inquiries and safeguarding cases provides us with a valuable opportunity for organisational learning that utilises both the staff and patient perspective.
NHS 111	NHS 111 is an urgent care service for people to call when they need medical help fast but it's not a 999 emergency. Calls are free from landlines and mobile phones.

Term/Abbreviation	*Definition/Explanation*
NHS England	NHS England is responsible for Clinical Commissioning Groups (CCGs), working collaboratively with partners and encouraging patient and public participation in the NHS.
NHS Improvement	Provides leadership and support to the non-Foundation Trust sector of NHS providers.
Non-conveyance	Non-transportation of patients to hospital.
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.
Paramedic	Senior ambulance service healthcare professionals at an accident or medical emergency. Working alone or with colleagues, 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 Group Directives (PGDs)	Good practice recommendations for individual people and organisations, aiming to ensure patients receive safe and appropriate care and timely access to medicines, in line with legislation.
Patient Report Form (PRF)	A comprehensive record of the care provided to patients.
Patient Safety Alerts	Incidents identified by NHS England reporting system that spots emerging patterns at a national level, so that appropriate guidance can be developed and issued to protect patients from harm.
Patient Transport Service (PTS)	A non-emergency medical transport service, for example, to and from outpatient appointments.
Peer Review	The evaluation of work by one or more people of similar competence to the producers of the work. It constitutes a form of self-regulation by qualified members of a profession within the relevant field.
Personal Development Reviews (PDRs)	The PDR process provides a framework for identifying staff development and training needs and agreeing objectives.
Personal Digital Assistants (PDAs)	Small computer units which help to capture more accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.
Pharmacological agents	A biologically active substance applied to the body for its therapeutic effects on one or more tissues or organs.
PREVENT	Prevent is part of counter-terrorism strategy. Its aim is to stop people becoming terrorists or supporting terrorism.

Term/Abbreviation	*Definition/Explanation*
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.
Quality Governance Framework	A process to ensure that YAS is able to monitor and progress quality indicators from both internal and external sources.
Quality Strategy	Framework for the management of quality within Yorkshire Ambulance Service.
Qualitative research	Is primarily exploratory research. It is used to gain an understanding of underlying reasons, opinions, and motivations.
Quantitative research	Is used to quantify the problem by way of generating numerical data or data that can be transformed into useable statistics.
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.
Resilience	The ability of a system or organisation to recover from a catastrophic failure.
Return of Spontaneous Circulation (ROSC)	ROSC is resumption of sustained perfusing cardiac activity associated with significant respiratory effort after cardiac arrest.
Safeguarding	Processes and systems for the protection of vulnerable adults, children and young people.
Safeguarding Referral	Yorkshire Ambulance Service staff are given information to help them identify warning signs of abuse or neglect and to report this via our Clinical Hub, to social care. Social care will follow up each referral to ensure that the vulnerable adult or child involved is safe.
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.
Sepsis	Is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs.
Serious Incidents (SIs)	Serious Incidents include any event which causes death or serious injury, involves a hazard to the public, causes serious disruption to services, involves fraud or has the potential to cause significant reputation damage.
Stakeholders	All those who may use the service, be affected by or who should be involved in its operation.

Term/Abbreviation	*Definition/Explanation*
ST Elevation Myocardial Infarction (STEMI)	A type of heart attack.
Transient Ischaemic Attack (TIA)	A mini-stroke.
Urgent Care Practitioner (UCP)	Has enhanced skills in medical assessment and extra clinical skills over and above those of a paramedic.
Volunteer Car Service (VCS)	Volunteers using their own cars to support our non-emergency Patient Transport Service by transporting patients to their outpatient and clinic appointments.
Year to Date (YTD)	The period from the start of a financial year to the current time.
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 Trust

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