NHS
Yorkshire
Ambulance Service
NHS Trust

Yorkshire Ambulance Service Annual Report and Accounts 2024-25

FINAL – 26 June 2025

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Annual Report

Part 1 - Overview

Chair's Foreword

In my second year at Yorkshire Ambulance Service (YAS), it continues to be a privilege to serve as Chair of the Trust. I remain full of pride about the caring and compassionate approach that staff and volunteers make to patients every day and the high-quality treatment they provide when people are at their most vulnerable. It's at the very heart of everything we do as a vital part of the NHS's emergency and urgent care provision.

Leadership changes
During 2024-25 there were a number of changes to Non-Executive Director (NED) positions. Jeremy Pease left us in January 2025 when his term of office came to an end after six years as a NED at the Trust; we thank him for his valued contribution.

Saghir Alam OBE joined the Trust as NED in February 2025; he has a legal and business background and is very experienced through his work as a Rotherham MBC councillor and former NED at The Rotherham NHS Trust. We have also appointed three Associate Non-Executive Directors. Katherine Lees, Tabitha Arulampalam, and Rebecca Randell commenced as Associate Non-Executive Directors in February 2025.

In addition, there were some changes to Executive Director positions during the year. Marc Thomas joined us as Deputy Chief Executive in April 2024, and Dr Julian Mark retired from his role as Executive Medical Director. We thank Julian for his many years' service with the Trust and the positive influence he has had nationally to help give the work of the ambulance service and pre-hospital care a stronger voice.

YAS Strategy
We have progressed the business plan priorities earmarked for the first year of our 2024-29 strategy - **Great Care, Great People, Great Partner**. These included improving our 999 and 111 call response times, with particular emphasis on the category 2 ambulance response times, and further investing in integrated clinical assessment across the 999 and 111 services. Meeting the 30-minute category 2 response target has continued to be a challenge, as have hospital handover times. However, significant progress has been made in introducing a maximum 45-minute transfer of care (handover) time at Hull Royal Infirmary during December 2024 which has been sustained due to excellent partnership working between the two trusts and the leadership shown in both organisations. This has had a real impact on patient safety and experience.

In terms of our workforce, we remain committed to improving the health, wellbeing and safety of staff, and driving further improvements in the organisation's culture.

Our STARS Awards took place in November 2024, when we celebrated some of the exceptional achievements of our staff and volunteers. The awards centred around our five **YAS Together** pillars - Care Together, Lead Together, Grow Together, Excel Together, and Everyone Together – and identified colleagues who inspire others, deliver beyond expectations, and are shining examples of all that is excellent about YAS. The nominations all reflected individuals who live and work by the Trust's values - Kindness, Respect, Teamwork and Improvement. Our values underpin everything we do as an organisation and they highlight the behaviours we expect from everyone.

We have further embedded partnership working and system collaboration for the benefit of patients. In addition, an over-arching aim has been to use our resources effectively, efficiently and provide value for money, particularly in financially challenging times.

Tackling health inequalities is an important focus for the Trust and our commitment to close partnership working will help to support the reduction of disparities between outcomes for our communities.

As part of our strategy, we set ourselves four bold ambitions to drive our actions and outcomes over the five years of the strategy - Our patients, Our people, Our partners, Our planet and pounds. Throughout this report you will see reference to all of these, and evidence of the progress being made.

Supporting equality and providing excellent patient care
We remain committed to supporting equality and ensuring our workforce is diverse and inclusive so that it reflects the communities we serve. In addition, we regularly engage with our communities to raise awareness of the services we provide and teach important first aid and life-saving skills. This helps people to build trust in us as an organisation and provides an opportunity for us to learn about how we can improve access to our services and those provided by health and social care partners.

Providing excellent patient care is central to what we do every day and during 2024-25 our staff and volunteers have continued to do fantastic job, often in very difficult environments and circumstances. I'm tremendously proud of their commitment to patients and each other, and I'd like to thank everyone for their unwavering dedication.

I am pleased to present the 2024-25 Annual Report which, as well as our statutory obligations, showcases the achievements of the Trust in the last year. We look forward to progressing the opportunities that present themselves in 2025-26 and overcoming any challenges that lie ahead for the Trust.

We do hope what you read is both interesting and positive.

Martin Havenhand

Our Strategy 2024-29

The Trust's 2024-29 strategy recognises that the Trust operates in a dynamic world, which has changed significantly in just a few years. It represents a major step change in how YAS is delivering deliver services fit for the future.

Our vision is **Great Care, Great People, Great Partner**. By 2029, we will be best known for delivering great care, being a great place to work and being a great partner to work with.

To achieve this, we have set ourselves four bold ambitions that will drive our actions and outcomes over the five-year period, centred around:

Our patients: our ambition is to deliver exceptional patient-centred out-of-hospital emergency, urgent and non-emergency care, which is safe, kind and responsive, seamlessly integrating services and utilising technology to deliver a high-quality patient experience.

Our people: our ambition is to be a diverse and inclusive organisation with a culture of continuous improvement, where everyone feels valued, included, proud to work and can thrive.

Our partners: our ambition is to be a collaborative, integral and influential partner across a joined-up health and social care network that works preventatively, reduces inequality and improves population health outcomes, supporting all our communities.

Our planet and pounds: our ambition is to be a responsible and sustainable organisation in the use of our financial and physical resources, reducing our environmental impact and ensuring the most effective use of all our resources.

In developing our strategy, we engaged extensively with our people, partners and communities to ensure that their views are represented and our plans meet the needs of those we serve and work with.

You can read more about the 2024-29 strategy on the Trust's website (www.yas.nhs.uk)

Our Purpose, Vision and Values

Our Purpose

To provide and co-ordinate safe, effective, responsive and patient-centred out-of-hospital emergency, urgent and non-emergency care, so all our patients can have the best possible experience and outcomes.

Our Vision

Great Care, Great People, Great Partner

Our Values

Our values underpin everything we do and how we do it.

They reflect the behaviours our patients, colleagues, volunteers, partners and others can expect from us all.

Kindness

As a Trust, we believe kindness is shown by caring as we would care for our loved ones.

- We will care for others as we would want to be cared for.
- We will be compassionate, courteous and helpful at all times.
- We will be calm, professional and considerate at all times.

Respect

As a Trust, we believe respect is having due regard for the feelings, contribution and achievements of others, adhering to the highest professional standards, even in the most challenging of circumstances.

- We will be open and honest and do what we say.
- We will celebrate and appreciate the successes of others.
- We will actively listen to, respect and involve others, valuing diversity and taking the time to understand personal and cultural viewpoints.

Teamwork

As a Trust, we believe teamwork is working collaboratively and openly with colleagues, patients, volunteers and partners, striving to achieve an exceptional standard in everything we do.

- We will work positively and openly with all.
- We will celebrate success together and be there for each other through both good and difficult times.

- We will work together to deliver exemplary care and services.

Improvement

As a Trust, we believe improvement is a commitment to learning, developing and implementing best practice to deliver better care and services.

- We will strive to do the best for patients, colleagues, staff and partners by continually seeking to learn, develop and deliver better care and services.
- We will create a culture in which all staff and volunteers are empowered to pioneer new and better ways of working across the Trust to improve patient care and services.
- We will pursue excellence by taking personal responsibility for learning and improving.

YAS Together

YAS Together is our approach to cultural improvement at the Trust and explains what we believe and what we prioritise. YAS Together supports us to achieve our vision of Great Care, Great People, Great Partner and is built around five key themes – the Pillars of YAS Together.

The YAS Together Pillars describe what is important for us, and they set the direction for how to deliver our vision. Each pillar is based on a key theme, which describes what it means and acts as a core principle to summarise how this will be lived at YAS.

Strategic Achievements

During 2024-25 the Trust made good progress in implementing the first year of its 2024-29 strategy. The Trust delivered many of its business plan priorities, demonstrating continued commitment, resilience, and adaptability to improving patient responses and experience, operational performance, staff engagement and organisational development, despite high demand and ongoing system pressures.

The Trust delivered tangible progress towards delivering key elements of its bold ambitions for Our Patients, Our People, Our Partners, and Our Planet and Pounds. In doing so the Trust maintained financial balance and delivered many improvements to efficiency, service performance, care standards and both patient and staff experience, all despite ongoing operational pressures and system-wide challenges.

The Trust also took forward important work that lays the foundations for continued improvements in 2025-26 to support successful achievement of the YAS Strategy by 2029.

Our Patients

Improving Responses, Care and Experience
The Trust continued to improve patient care, quality and safety through being a clinically led, patient-centred organisation, prioritising care closer to home and enhanced decision-making at the point of contact to ensure patients receive the right care at the earliest point in their journey. The Trust continued to improve how patients access and experience care:

- More patients than ever received the right care in their own home and closer to home through improved Hear and Treat, access to appropriate pathways and services and reduced inappropriate conveyance.
- While 999 response performance remains challenged due to increased demand and handover delays, alternative care pathways and urgent care integration activities have delivered more appropriate responses for patients at the earliest point.
- Clinical leadership has been strengthened, with a clearer focus on clinical supervision, quality improvement and continuous learning and improvement.

Our People

Supporting and Developing Our Workforce
The Trust continued to be a values-driven, inclusive, supportive, and resilient employer, supporting staff health, safety and wellbeing, aligned with NHS People Plan values. 2024-25 saw the Trust continue to invest in workforce wellbeing, inclusion, and organisational development and culture work, essential for workforce sustainability in an increasingly complex health system:

- The YAS Together Organisational Development Programme has continued to deliver planned improvements across the organisational culture with a focus on leadership, reflected in positive outcomes in the National Staff Survey results.
- Leadership development and staff health and wellbeing support has been expanded to meet both operational and individual staff needs.
- Recruitment has stabilised in key areas of the organisation via the achievement of recruitment plans for critical staff groups; however, challenges remain in retention and sickness absence which will require ongoing focus during 2025-26.

Our Partners

System Collaboration and Integration
The Trust is increasingly recognised as an integrated system leader and strategic partner, through effective collaboration with ICBs and local providers. The Trust is helping to lead regional efforts to deliver the right care, in the right place, at the right time and supporting addressing health inequalities and population health management. The Trust's role in the Integrated Care System (ICS) has evolved significantly during 2024-25:

- The Trust is a proactive contributor to place-based urgent care redesigns and population health strategies.
- There have been significant improvements in supporting access to and availability of appropriate patient pathways to support right care.
- Collaboration with ICBs, acute and community providers, and mental health services has enhanced the Trust's strategic voice and influence.

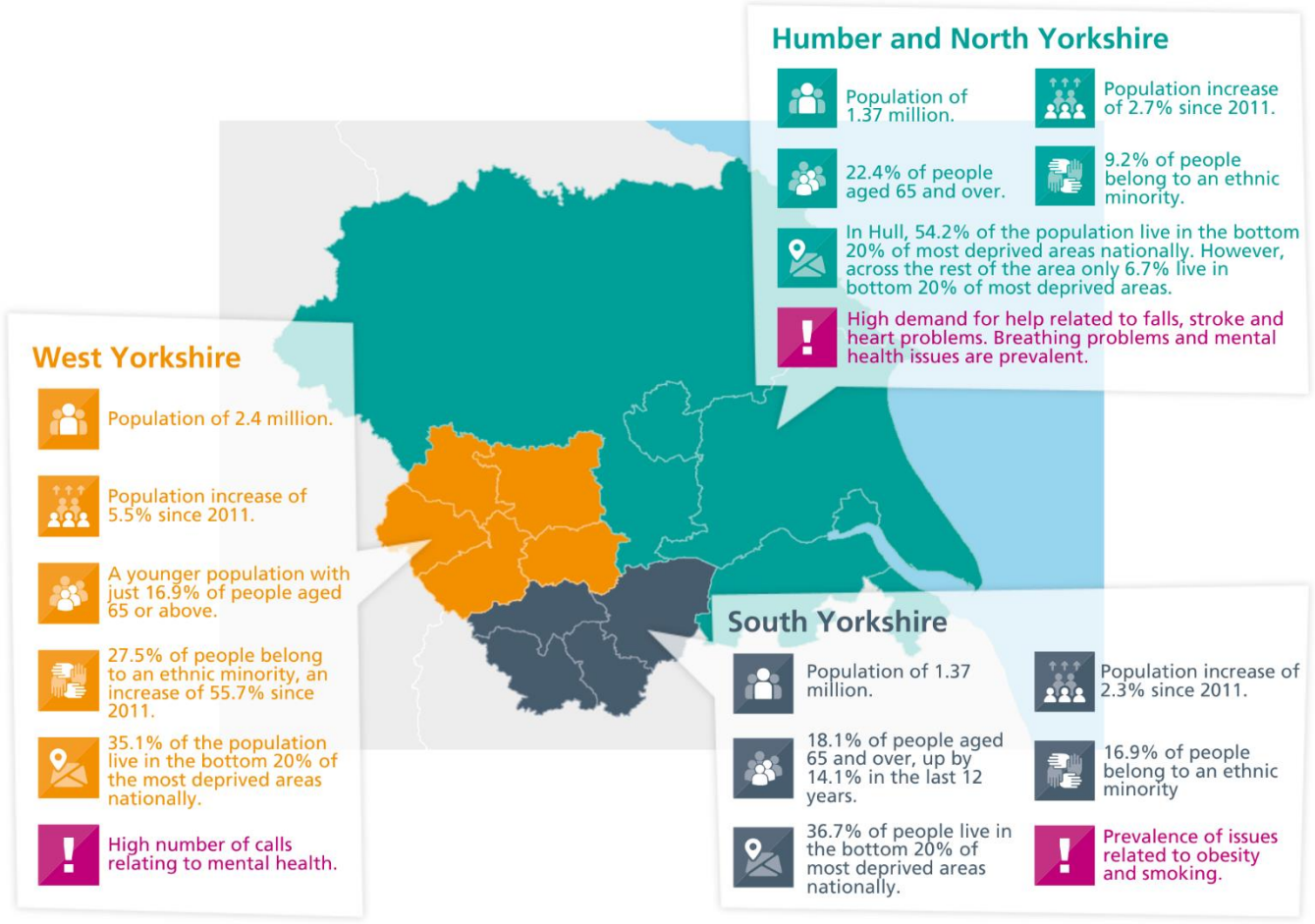
Our Planet and Pounds

Sustainability and Innovation
The Trust achieved a financial break-even position for 2024-25 and delivered on the significant efficiency and cost improvement programme requirements whilst improving service performance and quality. The Trust is moving into 2025-26 on a strong foundation of financial balance, improved governance and performance management, to support transformation and delivery of efficiencies in an increasingly challenging environment. Despite a difficult economic environment in 2024-25, the Trust delivered:

- A breakeven financial position and achieved the cost improvement programme and efficiency plan.
- Improved fleet availability to support operational performance.
- Sound foundations for strategic technical and infrastructure projects: NHS Pathways, the Hull hub.

Our Partnerships

Yorkshire Ambulance Service forms an important part of health services across Yorkshire and the Humber and is an integral partner to three Integrated Care Boards – West Yorkshire, South Yorkshire, Humber and North Yorkshire. Our local partners include 13 acute hospital trusts, 7 community and mental health trusts, 15 local authorities, 4 police services, 4 fire and rescue services, and many community interest companies and voluntary organisations involved in health and social care.



During 2024-25 we continued to work closely with colleagues in the three ICBs to develop relationships with commissioners and providers of healthcare services and place-based initiatives. Throughout this annual report you will find examples of partnership working at ICB, Place and local community level that has improved service delivery and patient experience.

Yorkshire Ambulance Service is a member of the Northern Ambulance Alliance (NAA) which is a partnership arrangement between four ambulance services covering the North of England and East Midlands - North East (NEAS), North West (NWAS), East Midlands (EMAS) and Yorkshire (YAS).

The aim of the alliance is to create a collaborative approach of working together to improve health outcomes for patients and deliver greater benefits for the populations it collectively serves. The main principles of the Northern Ambulance Alliance are to improve the quality and service delivery for all patients, to maximise opportunities for standardisation across the North of England, and reduce the overall costs of the collective budgets of the four services.

YAS is also a member of the Association of Ambulance Chief Executives (AACE), which provides the UK's statutory ambulance services with support in the implementation of nationally agreed policy and work programmes and acts as an interface at a national level.

Both the NAA and AACE help to share best practice in ambulance service operations and patient care as well as providing strong, collective voices.

As a key member of the three main emergency services, Yorkshire Ambulance Service works closely with police and fire and rescue services in responding to serious incidents across the region.

Part 2 – Performance Report

Performance Overview

The purpose of this overview is to provide a summary of the Trust's main operational services and other activities, its purpose, the key risks to the achievement of its objectives, and how the Trust performed during 2024-25.

Statement from the Chief Executive

In my second year at Yorkshire Ambulance Service NHS Trust (YAS), I remain very proud to lead this organisation whose fantastic staff and volunteers respond to thousands of emergency and urgent care needs from patients across our region every day.

We have continued to focus on providing the very best care to patients during the 2024-25 year despite operational pressures and tighter financial constraints. We have nurtured the strong links we have with our partners, and ensured the health and wellbeing of colleagues remains a priority.

Operational Review

Like other ambulance services across the country, our core frontline operations have remained busy, and all have seen increased activity during the year. Despite this we have seen some improvements in response times.

A&E Operations
In our A&E Operations service (999) in 2024-25, the average response time for a category 1 incident (for the most seriously ill or injured patients) was eight minutes and one second; an improvement of 25 seconds on the year before, but still not achieving the national standard of seven minutes. The other performance measure is to reach at least nine out of 10 patients (the 90th percentile) within 15 minutes and we achieved 13 minutes and 59 seconds (14 minutes and 39 seconds in 2023-24).

For category 2 incidents, our average response time in 2024-25 was 31 minutes and 57 seconds (32 minutes and 32 seconds in 2023-24) against the standard of 30 minutes. The 90th percentile response time was 72 minutes and two seconds (73 minutes and 28 seconds in 2023-24), against the standard of 40 minutes.

In terms of the challenge of hospital handover delays, we have piloted a new 'transfer of care' process in a move to improve patient safety. The Trust has established a structured, safe, and timely process for transferring patient care from YAS staff to acute trust colleagues, which is aligned to practices observed by some other ambulance services across other regions in England. A Standard Operating Procedure (SOP) has been developed to ensure patient handover takes place within a maximum of 45 minutes and it was first rolled out, in a phased way, at Hull Royal Infirmary in mid-December 2024. It is already helping to support timely patient handovers, which in turn supports rapid ambulance turnaround and preserves emergency response capacity.

The overarching aim is to reduce the risk to patients waiting for a 999 response in our communities, therefore improving response times and maximising patient safety and experience. We are continuing to roll out this new process across the region during 2025-26.

National NHS ambulance priorities for 2025-26
The planning guidance for the NHS for 2025-26 has been issued, with a number of national priorities for ambulance services. These are identified as:

- Category 2 ambulance response times should average no more than 30 minutes across 2025-26.

To support delivery of this priority, ambulance services are required to maximise opportunities for managing patients without the need for conveyance to emergency departments. This includes increasing clinical capacity in Emergency Operations Centres to enhance 'hear and treat', 'see and treat', and ‘call before convey’ activities. Improving availability and access to urgent care services at home or in the community, such as Urgent Community Response and Virtual Ward/Hospital at Home services, is crucial. The guidance requires systems to position Single Points of Access as a cornerstone for streaming urgent care pathways and reducing avoidable conveyance. This will ensure that emergency ambulances are prioritised for the sickest patients and patients who do not need an ambulance can be referred into alternative services.

Emergency Operations Centre
In our Emergency Operations Centre (EOC), we achieved an average answer time of 4 seconds for a 999 call, which is 6 seconds quicker than in 2023-24. The proportion of 999 calls answered within 5 seconds increased from 83.6% in 2023-24 to 90.3% in 2024-25. This improved call-handling performance was achieved against a backdrop of a 4.8% increase in calls received (1.23 million emergency and routine calls).

More detailed information on frontline A&E Operations activity is provided in this section of the annual report. Whilst response times remain an important measure, the compassionate care provided by our staff and volunteers to patients, day in and day out, remains paramount, and we all owe an enormous gratitude to the tireless job they do.

Later in 2025, BBC viewers will get the opportunity to see our emergency operations centre and A&E Operations staff in action as part of the popular *Ambulance* programme. Filming began with production company Dragonfly TV in February 2025 for a three-month period and we are excited for the tremendous work of our colleagues to be showcased in front of a national TV audience.

Integrated Urgent Care
In our Integrated Urgent Care service (NHS 111) our performance also improved, in some part due to increased staffing capacity. NHS 111 calls were answered in an average of 26 seconds, shaving 1 minute and 38 seconds off the 2023-24 average. The proportion of the 1.8 million calls we received being answered within 60 seconds increased to just under 90%.

With demand for mental health support at an all-time high, people of all ages can now access support through NHS 111, by selecting the mental health option and speaking directly to a trained mental health professional in a local service provided by our partners.

As part of our strategy for 2024-29, we set out our ambition to integrate our services for the benefit of patients and, as part of this, we will be introducing the NHS Pathways clinical triage system into our EOCs during 2025-26, aligning with the tool already used in our NHS 111 call

centres.

Patient Transport Service
Our non-emergency Patient Transport Service (PTS) also saw increased activity with over 978,000 journeys made during the year, a 5.6% increase from the same period in 2023-24, including higher demand from patients with more complex needs.

From April 2025, YAS started the phased implementation of national eligibility changes to our non-emergency PTS, which is commissioned through our three Integrated Commissioning Boards (ICBs). NHS England led this work by setting out a new national framework to ensure patient transport services are consistently more responsive, fair and sustainable. This has resulted in revised national eligibility criteria for PTS aimed at preserving the service for those whose medical conditions make independent travel to and from healthcare settings unsafe or impossible.

Quality Improvement
During the year, the Trust approved a new Quality Improvement (QI) Enabling Plan, covering 2024-29 which sets out how the organisation will embed QI into everything we do. Based on the four themes of learn, engage, analyse and network, the plan will develop the capacity and capability of our people, to foster behaviours and a culture that will bring about improvement for our patients and colleagues.

The Trust appointed three Patient Safety Partners (PSP), who are supporting our work to improve outcomes for patients, the work of the Quality Committee and our recruitment activities.

Research activity
A refreshed research strategy for the YAS Research Institute was approved at Clinical Governance Group in May 2024. The 2024-27 strategy, with accompanying workplan, lays out the next steps for the Trust to maintain and develop its prominence as a leader in ambulance-sector research.

It seeks to capitalise on the success of the YAS Research Institute following its launch in 2023, to set the direction for ambulance research, and be trusted to deliver high quality projects that create impact for the improvement of ambulance care.

Celebration of 10 years' certification to the international standard for business continuity
YAS has successfully passed its 10-year audit of certification to the ISO 22301 standard for Business Continuity and Societal Security, having started this journey back in 2014. This is a significant achievement as YAS remains the only UK ambulance service and one of a handful of NHS organisations to have achieved certification to ISO 22301.

Our fleet and estates
Our vehicles drive over 40 million miles per year and under the NHS England Net Zero travel and transport strategy we have some set targets to reduce carbon emissions through our fleet. The NHS will have fully decarbonised its fleet by 2035, with ambulances following in 2040.

Over the past year, our Estates team has been busy installing 109 EV charging points across the Trust ready for the arrival of our new electric vehicles with more EV points being fitted in the next few months.

We have taken delivery of the first of 35 new electric Patient Transport Service vehicles and also started to introduce electric mental health vehicles and two all-electric emergency ambulances will be delivered in 2025.

Workforce and Leadership

During 2024-25 our leadership team was enhanced with a newly introduced role of Deputy Chief Executive. Marc Thomas joined us in April 2024 from NHS England where he was the national lead for ambulance and 111 services. In addition to the extra senior capacity at Board and executive level, Marc has been integral to embedding the Trust's revised operating model and strategy and overseeing corporate services, communications and engagement and ICT.

We also welcomed Sam Robinson who joined the Trust in summer 2024 as our Chief Digital Information Officer to lead our information technology and business intelligence teams.

We bid farewell to our Executive Medical Director, Dr Julian Mark QAM, who retired from the Trust at the beginning of April 2025. He has made an excellent contribution to YAS and the ambulance sector nationally over many years, including developing clinical programmes for the Hazardous Area Response Team, chairing the National Ambulance Services Medical Directors' Group, and coordinating efforts during the COVID-19 pandemic, as well as championing the creation of the YAS Research Institute. Dr Steven Dykes, Deputy Medical Director, is our Acting Medical Director while recruitment is underway.

NHS Staff Survey results show continued improvement
The NHS Staff Survey 2024 results showed year-on-year improvement, with progress since 2023 in all key themes. The survey questions and results are aligned to the seven NHS People Promise themes plus two additional themes of staff engagement and morale.

YAS is currently benchmarking as best in sector, or very close to best, in six of the nine themes. Significant progress was evident in the areas of health and safety, working flexibly and morale.

We also saw an increase in the number of staff who recommend YAS as a place to work, up 2.7% from last year to 57.6%. Whilst this is a step in the right direction, there is still more to do and our cultural improvement programme, YAS Together, along with a range of other initiatives is helping ensure our colleagues are happy and healthy at work and have equal opportunities to develop and progress.

The survey has also highlighted that we need to continue our focus on creating a safe workplace and providing colleagues with the right support and protection from physical violence, harassment, bullying or abuse at work. Too many colleagues are experiencing this and it is not acceptable. We will be focusing on what more we can do to support colleagues and help prevent this from happening. We have also continued to advocate for sexual safety in the workplace through our continued embedding of the sexual safety charter, the launch of the 'Let's Talk Sexual Safety' campaign and other associated work.

We continue to look closely at what our staff have told us and how we can make sure we are prioritising the support and compassion all our colleagues need.

Top 100 Apprenticeship Employers 2024 success
We are proud to have retained our Top 100 Apprenticeship Employer status in the 2024 rankings, which celebrates England's outstanding apprenticeship employers. The Trust has placed 23rd overall – a significant rise from 36th place in 2023.

The rankings are produced annually by the Department for Education, in partnership with High Fliers Research, who independently assess and rank the nation's top apprenticeship employers.

The Trust was recognised for its commitment to creating new apprenticeships, the diversity of our apprentices, and the number of apprentices who successfully achieve their apprenticeships.

Gold TIDE Award for commitment to diversity and inclusion
Out of 185 entries, YAS was one of 25 organisations to receive the Gold TIDE Award in 2024 for its commitment to diversity and inclusion.

Talent Inclusion and Diversity Evaluation (TIDE) is the diversity and inclusion self-assessment evaluation and benchmarking tool developed by the Employers Network for Equality and Inclusion (ENEI). It measures an organisation's approach and progress on diversity and inclusion across eight key areas, including strategy and plan, leadership and accountability, recruitment and attraction, and training and development.

YAS staff recognised in King's Birthday Honours list
Two YAS colleagues were recognised in the in the 2024 King's Birthday Honours list.

Ola Zahran, the Trust's Chief Technology Officer, was awarded the King's Ambulance Medal for Distinguished Service (KAM). During her career, Ola has played a key role in the development of the digital agenda and healthcare technologies at the Trust, both regionally and nationally.

Jason Carlyon, Community Engagement Manager and Paramedic, was awarded an MBE in recognition of his services to resuscitation. Jason has been a driving force behind the local, national and international roll-out of the multi-award-winning Restart a Heart campaign which provides life-saving cardio-pulmonary resuscitation (CPR) training to members of the public.

National award – Volunteer of the Year
Dave Fenwick, one of our Community First Responders (CFRs) in Doncaster, was recognised nationally by the Association of Ambulance Chief Executives at the Ambulance Leadership Forum in Leeds in March 2025, for his exceptional commitment to volunteering.

The award was an acknowledgement of Dave's outstanding contribution as a CFR and his dedication to the Trust. Dave has been a responder in his local community for the last nine years and he regularly gives over 100 hours a month on call, having clocked up an impressive 9,000 hours to date. He has responded to numerous patients and was recognised for his involvement in cardiac arrests that have resulted in eight successful resuscitations because of his intervention.

Conclusion
As the region's emergency and urgent care provider, we continue to do all that we can to deliver the highest quality services across Yorkshire and the Humber, and are committed to providing safe, responsive and appropriate care to everyone who needs it.

On behalf of the Trust, sincere thanks go to all colleagues and volunteers for their resilience, dedication and compassion in caring for our patients, and to our partners and communities across Yorkshire for their support of the work we do.

Peter Reading
Chief Executive

About Yorkshire Ambulance Service – our purpose and activities

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 around 7,682 staff, who together with just over 1,000 volunteers, enable us to provide a vital 24-hour, seven-days-a-week, emergency and healthcare service.

Our main focus is to:

- 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 Integrated Urgent Care (IUC) service which includes the NHS 111 urgent medical help and advice line
- take eligible patients to and from their hospital appointments and treatments with our non-emergency Patient Transport Service (PTS).

In addition, we:

- have a Resilience and Special Operations 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
- provide vehicles and drivers for the specialist Embrace transport service for critically ill infants and children in Yorkshire and the Humber
- provide clinical cover at major sporting events and music festivals
- provide first aid training to 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, and we have volunteer car drivers who support the delivery of our PTS.

In 2024-25 we were led by a Board of Directors which met in public quarterly and comprised the Trust Chair, five non-executive directors, three associate non-executive directors, five executive directors, including the Chief Executive, and two other non-voting executive directors.

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, integrated care systems and other emergency services.

Principal Risks to the Delivery of Trust Strategy

The principal risks to the delivery of the Trust's strategy are set out in the Board Assurance Framework and organised under the Trust's four bold ambitions as follows:

Our Patients

1. Ability to respond in a timely manner to patients.
2. Ability to provide patients with appropriate access to care.
3. Ability to support patient flow across the health and care system.
4. Ability to strengthen quality governance and medicines management.
5. Ability to develop and maintain effective emergency preparedness, resilience and response arrangements.

Our People

6. Ability to develop and sustain an open and positive workplace culture.
7. Ability to support staff health and well-being effectively.
8. Ability to deliver and sustain improvements in recruitment and retention.
9. Ability to deliver and sustain improvements in leadership and staff development.

Our Partners

10. Ability to act as a collaborative, integral, and influential system partner.
11. Ability to collaborate effectively to improve population health and reduce health inequalities.

Our Planet and Pounds

12. Ability to secure sufficient levels of revenue resource and use this well.
13. Ability to secure sufficient levels of capital resource and use this well.
14. Ability to deliver safe and effective digital technology and cyber security developments.
15. Ability to respond responsibly and effectively to climate change.

These risks were managed via the Board Assurance Framework and associated processes. More information about this is found elsewhere in this report: in the Trust's Risk Profile and in the Annual Governance Statement.

Going Concern Disclosure

The Directors are responsible for the preparation of the financial statements and for being satisfied that these statements give a true and fair view in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual for 2024-25.

The directors have a reasonable expectation that the services provided by the Yorkshire Ambulance Service NHS Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Performance Review

The purpose of this section is to describe how well the Trust responds and delivers services to its patients against a number of key national measures. The relevant details are provided in the service-line sections.

Accident and Emergency / 999 Services

Demand for our services
In 2024-25, our Emergency Operations Centre (EOC) received 1,233,697 emergency and routine calls, an average of 3,381 calls a day. This this was a 4.8% increase from the 1,176,634 calls received in 2023-24.

The Trust responded to a total of 908,378 emergency incidents through either a vehicle arriving on scene or by telephone advice. This was an increase from 876,043 emergency incident responses during 2023-24.

Clinicians and call handlers based in our Clinical Hub, which operates within the EOC, triaged and helped 170,069 callers with their healthcare needs over the telephone. This was an increase from 140,824 in 2023-24.

Performance against national targets

Ambulance Response Programme Standards

The Ambulance Response Programme (ARP) was introduced in 2017 as a means of categorising emergency calls to ensure that patients receive the clinical response that is most appropriate to their needs. The table below explains the various categories and the expected response times standards.

Response Category		Description	Average Response Time	90th Percentile Response
1	Life-threatening	A time critical life-threatening event requiring immediate intervention or resuscitation.	7 mins	15 mins
2	Emergency	Potentially serious conditions that may require rapid assessment and urgent on-scene intervention and/or urgent transport.	18 mins (currently 30 mins)	40 mins
3	Urgent	An urgent problem (not immediately life-threatening) that needs treatment to relieve suffering and transport or assessment and management at the scene with referral where needed within a clinically appropriate timeframe.	60 mins	2 hours
4	Less Urgent	An urgent problem (not immediately life-threatening) that needs treatment to relieve suffering and transport or assessment and management at the scene with referral where needed within a clinically appropriate timeframe.	None	3 hours

The Trust's performance against these national standards in 2024-25 was as follows:

Mean Response Time

Response Category	Standard we aim to achieve	Mean Response Time: 2023-24	Mean Response Time 2024-25	Direction of Travel
Category 1	7 mins	8 mins 26 secs	8 mins 01 sec	Improved
Category 2	30 mins	32 mins 32 secs	31 mins 57 secs	Improved
Category 3	60 mins	1 hr 37 mins 43 secs	1 hr 31 mins 39 secs	Improved
Category 4	Not applicable	Not applicable	Not applicable	Not applicable

90th Percentile Response Time

Response Category	Standard we aim to achieve	90th Percentile Time 2023-24	90th Percentile Time 2024-25	Direction of Travel
Category 1	15 mins	14 mins 39 secs	13 mins 59 secs	Improved
Category 2	40 mins	1 hr 13 mins 28 secs	1 hr 12mins 02 secs	Improved
Category 3	2 hours	3 hrs 41 mins 15 secs	3 hrs 31 mins 41 secs	Improved
Category 4	3 hours	4 hrs 58 mins 26 secs	3 hrs 43 mins 48 secs	Improved

During 2024-25 improvements in response times across all categories has continued to be a significant focus for the Trust, with business plan priority work programmes in place to target reduce demand, increase capacity, and improving efficiency. Despite demand, all categories of response time have improved.

The Trust has taken the following actions to improve the mean and 90th percentile compliance to protect the quality of its services:

- Specific quality improvement work to reduce handover (the transfer of professional responsibility and accountability for some or all aspects of care for a patient) delays has continued in this year to ensure we have as many crews working in our communities as possible. We have worked with our Emergency Department colleagues, using rapid process improvement workshops, to review flow into hospitals and streamline handovers.

- We have worked with local clinical hubs in each Clinical Business Unit (CBU) to support with Hear and Treat. We also have been referring patients to the Urgent Care Response teams (UCRTs) instead of sending an ambulance response.

- Recruitment has continued to be an operational priority throughout 2024-25. Increasing the number of clinicians in our Emergency Operations Centre (EOC) has helped in providing additional call handling capacity. This combined with the significant work to increase the number of calls that can be dealt with by phone as part of the hear and treat initiative (when a person does not require an ambulance but a clinician is able to provide

treatment and advice over the phone), has led to safer and more sustainable call answering services, ensuring patients get the right care, at the right time.

- In A&E Operations the increase in staffing has enabled us to put out more ambulances to respond to the increased call volume. In addition, our Capacity we have realigned operational rosters at some stations. These new rosters support response times to patients and improve staff wellbeing.

- Operational managers remain focused on reducing sickness absence rates in both EOC and A&E Operations.

- In 2024-25 the EOC continues its focus on the health and well-being of our staff, aiming to reduce staff absence and to ensure we create a positive environment for our people, so they in turn can look after the population of Yorkshire and the Humber.

Hospital Handover

Handover delays improved across the region compared to 2023-24, which has supported improvements in response time performance. Despite improvements, hospital handover times were over 5 minutes above planned levels, impacting on crew availability, response times, and patients. However, the Transfer of Care procedure implemented in Hull in December significantly improved the handover position, reducing handover times at Hull Royal Infirmary from an average of 50 minutes in March 2024 to 26 minutes in March 2025.

It is important to recognise that handover delays are a systemic issue and not confined to the ambulance service. The Trust continues to work with Integrated Care Boards, acute trusts and social care partners across integrated care systems to develop long-term sustainable solutions. This includes the implementation of new operating procedures to place time limits on handover delays at each emergency department.

PROFILE: HOSPITAL HANDOVER IMPROVEMENTS AT HULL ROYAL INFIRMARY

Delays in patient handovers at hospitals have been a longstanding issue within the urgent and emergency care system. These delays create serious operational challenges for ambulance services, often resulting in ambulances and paramedics being unavailable for new emergency calls for extended periods. This leads to delays in responding to emergency situations, heightening the risk of harm to patients and, in some cases, resulting in catastrophic outcomes. The impact of handover delays on patient safety is profound, as these delays contribute to a higher likelihood of adverse events and complications during care delivery. For some years the potential for patient harm and catastrophic outcomes caused by handover delays was the greatest area of operational risk faced by the Trust.

Hull Royal Infirmary, like many other hospitals across the country, has been significantly affected by these delays and was frequently losing over 100 hours of ambulance time per day due to delayed patient handovers.

Addressing this problem was crucial to ensure the safety and well-being of patients, to improve the efficiency of ambulance services, and to minimise the risk of harm to the community. Immediate and sustained action was necessary to improve the handover processes at hospitals like Hull Royal Infirmary, as well as across the wider healthcare system, to safeguard patient care and prevent further harm.

To address the problem, a new operating procedure was developed and introduced under the title "Transfer of Care". The primary objective of this procedure was to reduce handover delays

and ensure that no ambulance would wait longer than 45 minutes to transfer a patient to the care of the hospital. By setting a clear and enforceable time limit for patient handovers, the Transfer of Care procedure aimed to streamline the process and reduce the negative impacts of delays on both ambulance availability and patient safety.

The implementation of Transfer of Care at Hull Royal Infirmary began in December 2024 through a phased approach. This phased rollout was designed to allow for careful monitoring, feedback, and adjustments as the procedure was integrated into the hospital's existing systems and processes. It was essential that both Yorkshire Ambulance Service and the Emergency Department at Hull Royal Infirmary worked collaboratively to achieve the goals outlined in the new approach. This required clear communication, alignment of resources, and a shared commitment to improving patient care.

The success of the Transfer of Care procedure depended on the cooperative efforts of all stakeholders involved, as effective handover processes could only be realised through coordinated action between the ambulance service and the hospital's staff. By ensuring that ambulances were able to promptly transfer patients into hospital care, it was anticipated that the overall efficiency of emergency services would improve, leading to faster response times for subsequent patients and a reduction in the risk of harm caused by delays.

The introduction of the Transfer of Care at Hull Royal Infirmary was a critical step toward mitigating handover delays. Its success relied heavily on the seamless cooperation between Yorkshire Ambulance Service and the Emergency Department to ensure that the 45-minute handover window was consistently met, ultimately improving patient care and reducing operational strain on ambulance services.

The introduction of the Transfer of Care (ToC) Standard Operating Procedure (SOP) at Hull Royal Infirmary was a resounding success: its impact was noticeable almost immediately and handover times at Hull Royal Infirmary reduced from an average of 50 minutes in March 2024 to 26 minutes in March 2025. By reducing handover delays to no longer than 45 minutes, the procedure resulted in safer patient care, as patients were transferred promptly to hospital care, reducing the risk of harm associated with prolonged ambulance waits. This improvement in patient care not only enhanced patient safety but also contributed to better staff wellbeing, as ambulance crews were able to complete handovers more efficiently, leading to reduced stress and pressure on emergency services personnel.

The positive outcomes observed at Hull Royal Infirmary underscored the effectiveness of the phased approach, and improvements continue to be made as the policy is refined and adapted to further optimise its implementation. The collaboration between the staff of both trusts has proven to be a key factor in the success of the Transfer of Care procedure, with both teams working closely together to meet the 45-minute handover target consistently.

Encouraged by the success at Hull Royal Infirmary, plans are now underway to roll out similar Transfer of Care procedures across the entire operational footprint of the Trust. The aim is to replicate the positive results seen at Hull Royal Infirmary in other hospitals, further improving the efficiency of handovers, enhancing patient care, and supporting staff wellbeing across the region. The continued progress of this initiative is expected to drive further improvements in ambulance service response times and contribute to a safer, more efficient healthcare system overall.

Managing Operational Risk: Seasonal Plans

A key means to maintaining good performance levels and managing risk is the ability to identify and response to anticipated changes to demands on our services and/or our capacity to respond. To support this, the Trust develops and implements two seasonal plans: a summer plan and a winter plan.

<u>Summer Plan</u>

The summer plan covered the period April to September inclusive. A key feature of the summer plan was a set of tactical plans to manage the Easter period which typically presents increased risk to service delivery due to high demand and wider system pressures due to the public holiday.

The most significant operational issue identified during the summer plan period related to the weather (heat wave). The rest of the period operated as business as usual.

During the period of the summer plan the following areas of risk were identified and managed by operational services:

- Impacts on Operational performance
- Workforce capacity in all service lines
- Hospital handover monitoring
- Clinical Capacity NHS 111/IUC
- Culture / retention in NHS 111
- Unable to recruit Health Advisors
- Commencement of the Collective Action by General Practitioners
- Risk of wider Industrial Actions across the NHS
- Non-Covid YAS Sickness Absence
- C1 Driver training for recruits
- Right Care, Right Person: Demand.

Winter Plan

The winter plan covered the period October to March inclusive. Risk exposures during the winter period are typically higher and more prolonged than during summer, and severe spikes of demand can occur. In addition, multiple other system pressures and related risks impact on operational services during the winter months, such as delays in hospitals, increased prevalence of chest and respiratory conditions, and seasonal infections such as norovirus.

For this period all operational services produced tactical plans and implemented actions to mitigate risks. The development and execution of tactical plans was coordinated through the Operational Resilience Oversight Group (OROG), with escalations and outputs reported to Trust Executive Group. During the period of greatest operational pressures, from early December to the end of January, the Trust moved into an enhanced 'response' phase in which OROG increased its intensity and a formal Commander Cell was established co-ordinate activity across the organisation.

During the period of the winter plan the following areas of risk were identified and managed by operational services:

- Excessive response times due to attending to patient acuity.
- Hospital handover delays- region wide
- Out of hours GP access often impacted and result in increased calls to 111
- Clinical Capacity NHS 111 / IUC
- Culture / retention in NHS 111
- Unable to recruit Health Advisors
- Workforce capacity in all service lines
- Ongoing Collective action by General Practitioners
- Risks to fleet being repaired in a timely way.

Ambulance Station Developments

In South Yorkshire, the Ambulance Vehicle Preparation (AVP) model has been introduced at Rotherham, Middlewood, and Longley stations. This is more timely and efficient way of ensuring that ambulances are ready for deployment at the start of a shift. The Trust has also undertaken extensive ambulance station improvement works, including new portakabins to increase space and enhance the operating environment at Middlewood and Rotherham stations. The Trust is taking forward a project to relocate Wath Ambulance Station into the Callflex facility.

In East Yorkshire, the focus during 2024-25 has been the planning and mobilisation of a strategic infrastructure project to develop new large and multi-functional hub in Hull which will accommodate multiple Trust services. It was also incorporate the AVP service.

System Working

As an anchor organisation across the urgent and emergency the Trust works closely with partners across the three integrated care systems present in our operational footprint.

PROFILE: PARTNERSHIP WORKING IN A&E OPERATIONS – CLINICAL PATHWAYS

A&E/999 operational response is delivered through a devolved geographical operating model, allowing for the provision of services that align with patient needs and demand within local communities. In addition to traditional ambulance response models, the Trust's commitment to excellence is reflected in our strategic initiatives aimed at optimising the use of clinical pathways to ensure that patients receive the most appropriate care in the most clinically appropriate setting. In short: patients can be referred directly to the most appropriate service to meet their needs rather than taking them first to the local emergency department.

This was achieved by leveraging Business Intelligence (BI) dashboard data to identify areas for improvement and decisive actions to enhance clinical pathway utilisation. This data-driven approach facilitated informed discussions with system partners, focusing on reducing missed opportunities to refer patients directly into their services and comprehending the underlying factors that influenced conveyances to A&E departments.

In aligning with our operational objectives, substantial efforts were directed towards the enhancement of the Push /early response model across all three integrated care system areas. Emphasis was placed on increasing both the utilisation and acceptance rates of this model. We orchestrated site visits and convened external sessions with partners to cultivate robust relationships and foster a collaborative understanding. Our goal was to optimise access to alternative pathways, including 'hear and treat' and 'see and treat' modalities, thereby augmenting operational availability and ensuring timely emergency care for patients.

There was an improvement of 1.4% in 'hear and treat' rates over the course of 2024-25, along with a slight reduction in see, treat and refer percentages. This outcome is expected because the early response model ensures more patients receive appropriate care initially, reducing the need for further treatment or referral upon arrival. See, Treat and Convey rates improved by 4%, from 62.9% in 23-24 to 58.9% in 2024-25.

Furthermore, we adopted a diversified strategy in influencing the development of Single Point of Access (SPoA) across each of the ICB systems, requiring engagement at place level as well as ICB level. By systematically testing different models, we aimed to provide comprehensive feedback on their efficacy, which informed the development of a uniform and well-informed approach to SPoA at Trust level. This iterative process was pivotal in enhancing system engagement and ensuring a cohesive and effective implementation.

PROFILE: YAS AS A PARTNER IN THE WEST YORKSHIRE COMMUNITY SERVICES PROVIDER COLLABORATIVE

West Yorkshire Integrated Care Board established a Community Services Provider Collaborative to bring together providers of community services, and to support the NHS priority of moving more care into the community. This unique collaborative initiative, one of only a few such arrangements nationally, is further strengthened by the inclusion of the Yorkshire Ambulance Service (YAS) as a formal member. Traditionally associated with hospital and acute care, the membership of YAS has provided a fresh perspective, emphasising the importance of community-based services.

The following benefits and opportunities are as a direct result of YAS involvement in this collaborative.

- Enhanced Visibility: YAS has effectively influenced senior leaders, showcasing the crucial role paramedics play in urgent care response and preventing unnecessary hospital admissions and the importance of paramedics in transitioning to community-focused services.

- Great System Partner: Other partner members have noted the contributions and value of YAS's membership, emphasising the importance of including paramedic expertise in the community-focused healthcare approach. YAS Director of Partnerships and Operations for West Yorkshire served as the Senior Responsible Owner (SRO) for a workstream focused on urgent care response and the establishment of the Single Point of Access, acknowledging their leadership and YAS as a reliable partner. This also supported by ensuring the perspectives of YAS and the roles of paramedics, remote clinicians, and patient response were central to the discussions.

- Service Delivery opportunities: The opportunity to see, treat, and refer patients to community services has been enhanced, through shared information, presenting opportunities to avoid unnecessary conveyance to hospitals to ensure patients receive appropriate care in the community. A particular area of focus has been to highlight opportunities for patients who have fallen.

- Development of Business Case: Following YAS's data sharing on the opportunity, a business case is being produced to improve falls service provision and reduce unnecessary hospital visits. This will enhance Yorkshire Ambulance Service's ability to direct patients to community falls services, supporting community-based care.

- Funding to evaluate service models and concepts: The Integrated Care Board (ICB) delegated service development funding to the collaborative that allowed the West area 999 operations team to trial two pilot areas to test core principles of Single Point of Access (SPoA). One pilot aligned Specialist Paramedics Urgent Care (SPUC) clinicians with Bradford Urgent Community Response (UCR) for pre-dispatch case reviews, strengthening decision-making through clinical discussions. The second pilot involved crews contacting a senior clinical decision-maker on scene to find alternative pathways for care home patients. The models will continue to evolve to support stronger integration with place-based services and Single Points of Access across West Yorkshire.

    - During the Bradford pilot program, a review of 287 patients was conducted, resulting in 115 receiving an alternative response. Refining eligibility criteria is essential to minimise inappropriate referrals. Although 60% of cases were rejected after review, many received care from our SPUCs, ensuring they were referred to the appropriate clinical team or professional for optimal care. Staff appreciated direct communication with senior clinicians but questioned the benefit versus resource commitment overall.

    - The call-before-convey model remains active, showing promising initial outcomes with most patients receiving alternative care to ED. Senior clinicians from the acute hospital highly commended paramedic decision-making and professionalism. Efforts are ongoing to scale up the concept given its success on a smaller scale.

These efforts underscore the collaborative's commitment to improving patient care by supporting the shift towards community-focused services and recognising the instrumental role of paramedics and the ambulance service in making this transition successful.

Working with Place Partners

The Trust works closely with partners across the three integrated care systems present in our operational footprint. For example, the urgent crisis response teams in each area have further enhanced our 'push model' to allow patients to receive the right care without attending hospital. In addition, several Integrated Care Coordination Services have been implemented in which partners work together to operate streamlined single points of access to care and signposting.

The following are further examples partnership working and developments in each of our three integrated care system areas.

West Yorkshire

Early Intervention Pathways
Partnership work focused significantly on early intervention pathways such as the Push Model, which aims to identify patients who may benefit from an alternative response earlier in their journey. This allows patients to receive quicker and more appropriate care. Work has particularly concentrated on falls, which generate considerable demand for both the Trust and acute partners.

Partnership Collaboration and Data Insight
The Trust has worked with system partners to develop data insights which identify opportunities for improved care pathways. Key areas of focus include respiratory pathways and HCP calls. Data-led discussions have driven significant engagement between partners, although further levels of implementation are dependent on funding.

Single Point of Access (SPoA)
The Trust has worked with system partners to develop a pilot project to integrate a Specialist Paramedic in Urgent Care (SPUC) into the Bradford Intermediate Care Hub. This aims to provide on-scene and EOC-based support, fostering deeper collaboration between care providers and better outcomes for patients.

Winter 'HALO' Support Initiative
Over the winter period, West Yorkshire introduced Hospital Ambulance Liaison Officers (HALOs) at acute hospital emergency departments to improve patient flow and assist crew clear times. This initiative was well-received by system partners and had a positive impact on alleviating system pressures.

Deep Dive Work: Understanding Handover
The Trust has undertaken deep dive work in collaboration with the West Yorkshire Association of Acute Trusts (WYAAT) group to ensure that handover times are captured as accurately as possible for the acute trusts. This allows acute trusts to better understand factors that contribute to handover delays and to identify effective solutions. This work has focused on reviewing processes, exploring technological improvements, and ensuring robust validation.

South Yorkshire Area

Partnership Collaboration
Partnership working has been strengthened across multiple areas. Our close working with system partners has resulted in the development of a Joint Escalation Action Plan to be used across South Yorkshire. Another collaboration has included working with South Yorkshire Police on the introduction of the Right Care, Right Person National Policing Policy which endeavours to send the most appropriate response to an incident involving mental health factors.

Acute Trust Initiative
The Trust's relationship with the Northern General Hospital in Sheffield supported the introduction of the 'Streaming Sister' role which helps with patient flow.

Pathways Development
Enhancement of the Mental Health Push from EOC to all place partners has resulted in a reduction in the need for ambulance responses to some patients. This is now established as a 24/7 service.

The Trust has worked with community teams in Rotherham to initiate pilots to identify and develop better ways of meeting patient needs. Similarly, the Trust has worked with RightCare Barnsley to undertake a trial which directs patients to a multi-disciplinary team which identifies the best response for them, thereby reducing unnecessary ambulance responses.

Other pathways work developed with partners in South Yorkshire include the first specialist respiratory pathway as part of the Push model, and the sickle cell tertiary centre pathway, which will be shared with centres in other integrated care system areas.

North And East Yorkshire

During 2024-25 the Trust continued to work closely with the Humber and North Yorkshire Integrated Care Board (ICB) and other system partners under the admissions avoidance workstream of the ICB's urgent and emergency care recovery programme. This programme included a focus on community frailty, alternative care pathways, virtual wards, and streaming and redirection activities within hospital emergency departments.

As described above, the Trust's operational colleagues have worked in partnership with acute trust colleagues to introduce the Transfer of Care operating procedure which aims to reduce handover delays within emergency departments. Successfully implemented in December 2024 at Hull Royal Infirmary, work is now underway to roll out similar approaches across other acute trusts across the region.

Clinical Pathways
Within the North and East area the Trust has dedicated Clinical Pathways Managers in place to support the continued utilisation of existing clinical pathways in collaboration with other partner agencies. Additional clinical pathways have been introduced, accessed both by clinicians in the Trust's Emergency Operations Centre and by crews on scene at an incident.

Pathways developments have included the introduction of the "Push" model to community urgent response teams in the Hambleton and Richmondshire areas, and in for falls in Harrogate. A new pathway to provide access to the virtual respiratory ward beds in the East area has been established. Work continues to support implementation of the stroke video triage project and other improvements in accessing stroke services.

The increased utilisation of the frailty hub operated by Nimbuscare for patients in the York area has been a notable success. The new “call before convey” model (in which crews contact the hub for advice and guidance where frailty is suspected) has seen a significant increase in usage and the service has expanded its availability and geographical coverage.

Care Coordination

In partnership with the Humber and North Yorkshire ICB, the Trust has introduced two hubs; one covering North Yorkshire and York and the other covering East Riding and Hull. Each hub has access to the Trust’s ambulance stack and can appropriately ‘push’ patients into care pathways that are deemed low acuity with complex needs (typically calls in categories 3, 4 and 5).

The hubs focus on “pre-dispatch” and “pre-conveyance” activity which enables the referral of more patients to alternative pathways at the point of call. This reserves emergency ambulance resources for the most urgent patients and ensures that conveyance to hospital is only applied to patients who require secondary care intervention.

Working in this helps to make more effective and efficient use of ambulance and paramedic resources and supports more appropriate patient care and better patient experience. It also enables enhanced oversight of demand entering the system via the 999 service, insight into which patients require an alternative response, and helps to capture intelligence that can be analysed to support future commissioning intentions.

The hubs were initially established until the end of March 2025, pending a full evaluation and confirmation of business planning priorities for the urgent and emergency care system for 2025-26 and beyond.

A Clinical Perspective

The Trust's main statement of performance and assurance regarding clinical effectiveness, patient care and patient experience is found in a separate publication, the Quality Account, available on the Trust's website (www.yas.nhs.uk). The following are examples of clinical developments progressed by the Trust during 2024-25.

Clinical Improvements
The Trust progressed work to improve airway management across the area, based on reviews and education in response to a coronial inquiry. This learning has been shared across the organisation.

The Trust has evaluated the positioning of defibrillator pads and made changes to improve efficacy of defibrillation through better pad placement.

Clinical care to paediatric patients has been improved in response to learning from reviews and educational packages.

Quality Improvement Work on Crew Clear
Quality Improvement methodology has been applied to improve the efficiency of handover and crew clear procedures. Process mapping exercises involving all levels have staff identified key improvement areas.

Controlled Drugs and Medicines Compliance
During 2024-25 the Trust concentrated on improving compliance with medicines management and controlled drugs processes and regulations. To support this, the Trust developed better processes and systems, including commencement of the phased implementation of a medicines management app. Compliance has improved in most areas and audits indicated that 100% compliance has been achieved in some areas.

Urgent Care
In West Yorkshire there has been a focus on targeting Category 2 details with the potential to downgrade to a Category 3 to make it appropriate for a Specialist Paramedics Urgent care (SPUC) to attend. There are now significant Paramedics Urgent Care (PUC) / SPUC trained on remote care, with others awaiting training. This has ensured the Urgent Care Hub (UCH) is covered 0600-0200. These staff also support the Single Point of Access (SPA) which will be trialled at the 2 different UCH (Wakefield, Manor Mill and Keighley).

North, East and South Yorkshire have also now recruited to Paramedics Urgent Care via the apprenticeship model at Sheffield Hallam University and commenced their 2-year training. Advanced Paramedics Urgent Care have also been recruited to support the Urgent Care workforce.

The Advanced Paramedic Clinical Lead (APCL) is a new role within YAS. We have recruited these across the patch. They role is to offer clinical support, embedding clinical supervision, implementing learning from themes and trends in incident reporting via Datix.

Mental Health Response Vehicles (MHRVs)
During 2024-25 the Trust introduced more mental health response vehicles, which provide enhanced support for mental health patients. The Trust now has 8 mental health response vehicles in operation across its geographic footprint. As a direct impact of these vehicles, the majority of mental health patients are either treated on scene or diverted to local mental health

pathways. This has resulted in fewer mental health patients being conveyed to hospital emergency departments.

We have also been successful in recruiting a further 10 Specialist Paramedics in Mental Health (SPMHs) as part of our Cohort 2 to commence MHRV duties. This takes us up to 25 SPMHs in total out of the 30 that are required.

Clinical Governance

The Trust's clinical staff have continued to support the implementation of the national Patient Safety Incident Response Framework (PSIRF) process and other patient safety measures in all our areas. As part of this, the Trust has continued to develop a devolved approach to incident management and other learning mechanisms to analyse excessive responses and instances of patient harm. Evidence of successful learning from patient harm incidents, leading to changes within pathways has been seen.

The Trust has continued to develop its clinical supervision model, including the delivery of clinical supervision sessions with crews waiting to hand over patients at emergency departments. This has supported improved patient flow at emergency departments. Clinical supervision has also been used effectively to raise awareness and utilisation of alternative clinical pathways.

Individual clinical dashboards have been rolled out across all areas.

Remote Patient Care

Remote Patient Care
There are two service lines which make up Remote Patient Care: Integrated Urgent Care (IUC) and the Emergency Operations Centre (EOC). These two services merged to become one directorate in February 2024.

The Trust monitors several national and local metrics in respect of our call-handling services. These metrics include 999 and 111 call answering performance, timeliness of 111 clinician call-backs, and the percentage of 111 calls receiving a revalidation from a clinician, which are within an agreed set of measures we report to our commissioners and NHS England.

Emergency Operations Centre

Accident and Emergency / 999 Call Handling
Our 999 call handling services delivered significant improvements during 2024-25 supported by successful recruitment campaigns to boost staffing capacity. This additional capacity, along with a series of other improvements and developments, has supported stronger 999 call taking performance.

The average time taken for 999 calls to be answered improved in 2024-25 from 10 seconds to 4 seconds. The proportion of 999 calls answered within 5 seconds increased from 83.6% in 2023-24 to 90.3% in 2024-25.

This improved call-handling performance was achieved in the context of higher demand. In 2024-25 the Emergency Operations Centre received 1,233,697 emergency and routine calls, an average of 3,381 calls a day. This this was a 4.8% increase from the 1,176,634 calls received in 2023-24.

Demand and Performance Metrics

Activity / Performance Measures	2023-24	2024-25	Direction of Travel
Number of calls received	1,176,634	1,233,697	Increased
Average call answer time	10 seconds	4 seconds	Improved
Calls answered within 5 seconds	83.6%	90.3%	Improved

Accident and Emergency/999 Call Handling Developments
During 2024-25 the EOC has implemented many continuous improvement initiatives to support efficient, productive and effective delivery. These include:

- Process improvements, such as the ‘PUSH’ model to utilise alternative pathways and better use of segmentation to manage Category 2 calls more effectively.
- Clinical developments, including deployment of general practitioners into EOC which has encouraged a coaching environment and improved the clinical decision-making confidence of colleagues, and introduction of the clinical calibration process which is a bi-monthly opportunity for all clinicians to present complex cases they have encountered, encouraging discussion for shared learning.

- Technical developments, including improvements to call routing systems, new radio terminals for dispatchers, a text messaging service to improve communications with patients waiting for a response, and the introduction of the Ordnance Survey Places Gazetteer solution to improve the identification of caller location.

- Staffing developments, including a restructure of leadership and management roles and the embedding of Clinical Navigator roles that help the Trust to maximise opportunities to utilise alternative pathways.

PROFILE: LEADERSHIP IMPROVEMENTS IN THE EMERGENCY OPERATIONS CENTRE

In 2024-25, the EOC undertook a leadership re-structure. This was designed to strengthen 'on day' leadership within the EOC and strategic leadership for the service.

The Performance Challenge
There were challenges within the EOC management structure and establishing key management responsibilities and accountabilities across both the Wakefield and York sites and ensuring the management of EOC was robust to effectively manage a significantly increased staff profile was essential.

There was a need to restructure the EOC function, teams and roles to deliver continuous and sustainable improvements which would positively impact on the experiences of EOC staff and patients, improve and sustain levels of performance, and deliver high quality outcomes.

The Improvement Plan
The objectives of introducing a new EOC management and operational teams' restructure were:

- To deliver a transformational change in the leadership culture of EOC through the introduction of a number of new roles to ensure our EOC workforce felt engaged, supported and valued and were able to contribute to improving patient care.
- To provide a supportive structure that enabled managers and staff to have regular and meaningful conversations around performance, learning, staff welfare, health and wellbeing and career progression, which would have a positive impact on patient safety, patient care and patient experience.
- To introduce enhanced career structure and development and provide senior managers within EOC the time to recognise and implement required changes to working practices to improve EOC productivity including reduced sickness absence and improved staff retention through a reduction in attrition.
- To provide greater opportunities for health and wellbeing activities and priorities to be implemented, ensuring staff are supported and able to stay in work.
- To enable a visible and consistent management presence at York.

The Impact
A number of metrics are being monitored to demonstrate the impact of the restructure. Examples include:

- Improved patient care by reducing the average call answer time and achieving the key performance indicator standards. The average call answer time for 2023-24 was 10 seconds, and by the end of 2024-25 this had improved to 4 seconds.

- Increased EOC management capacity at York – this was achieved once all duty manager positions were filled.
- Improved performance by reducing sickness absence in EOC by 0.5%. Whilst this target was not fully met in 2024-25, wider staff welfare benefits have achieved.

Integrated Urgent Care (NHS 111)

The Trust's Integrated Urgent Care / NHS 111 service delivered significant performance improvements during 2024-25, supported by changes in the way the service operates and successful recruitment campaigns to boost capacity, particularly in clinical roles. This additional capacity has supported improvements in the time taken to answer calls to the NHS 111 service, and improvements in decision-making and advice provided by the service.

The average time taken for NHS 111 calls to be answered improved in 2024-25, from 2 minutes 4 seconds to 26 seconds, and call abandonment rates have dropped from 10.9% to 6.2%. The proportion of calls answered within 60 seconds increased from 63.4% in 2023-24 to 89.2% in 2024-25.

This improved performance was achieved in the context of higher demand. In 2024-25 the Trust's NHS 111 service received 1,803,834 calls, an increase from the 1,786,561 calls received in 2023-24. Through the national contingency plan, the Trust answered an average of 316 calls per month on behalf of other NHS 111 providers.

Demand and Performance Metrics

Activity / Performance Measures	2023-24	2024-25	Direction of Travel
Calls received	1,786,561	1,803,834	Increased
Patient calls answered	1,591,620	1,691,748	Increased
Calls abandoned	10.9%	6.2%	Improved
Calls answered within 60 seconds	63.4%	89.2%	Improved
Average call answer speed	2 mins 4 seconds	26 seconds	Improved
Clinical call-backs within one hour (target 60%)	47.2%	47.2%	Static
Core clinical advice provided (target 30%)	21.5%	24.4%	Improved
Emergency Department validations (target 50%)	42.5%	56.7%	Improved
999 Validations (target 95%)	99.5%	99.6%	Improved

PROFILE: DELIVERING THE CASE FOR CHANGE IMPROVEMENTS IN INTEGRATED AND URGENT CARE

The Performance Challenge

During recent years in IUC there have been consistent workforce challenges, particularly relating to call-handling roles (known as health advisors). This has led to a reliance on recruitment through agencies, which creates operational costs and inefficiencies. This has resulted in IUC needing to recruit as many as 30 new starters every month via multiple agencies in order to maintain call handling performance.

This led to several adverse impacts on service performance. IUC has seen high levels of turnover during and immediately after training courses, and then also during post-training coaching periods (typically the first six months in role). This challenged our ability to maintain the required performance levels and delivery standards.

There were also other impacts on the training delivery and financial implications for the high levels of recruitment and staff turnover.

The overall result of this has meant organisational inefficiencies and a poor staff experience as well as a waste in valuable resources in a constant cycle of recruitment and training.

The Improvement Plan: Case For Change

As part of a wider Case for Change to improve the way IUC operates, the service leadership team co-produced a plan for 2024-25 that focused on reducing and stopping agency recruitment. Activities to deliver this included:

- Review recruitment processes and integrate the two services' recruitment plans.
- Updated the recruitment and selection day, with the aim of preparing potential recruits for the role and ensure the most appropriate candidates.
- Reviewed and updated advertisements, focusing on career pathways in the NHS.
- Set clear substantive recruitment targets with monthly oversight/governance processes.
- Gave notice to agencies around our intent.
- Communicated with our staff and trade union representatives to ensure all staff were informed.
- Reviewed our training 'offer' in IUC. Resulted in integration of training teams across Remote Patient Care in Q3 2024-25.
- Roll-out of updated rota across IUC.
- Made improvement trajectories to reduce turnover by 5%.
- We would achieve this by implementing 'stay conversations' and listening sessions.
- Utilise updated electronic 1-1 'app' in IUC.
- Implemented IUC team leader apprentice training and development programme. Aimed to ensure compassionate and inclusive leadership.

The Impact

- Delivered the ceasing of agency call-taking recruitment completely by Q4.
- Overachieved substantive recruitment from Q2.
- Call handling performance maintained all year as one of the best nationally and overachieved on the full-year plan.
- Full year reduction in turnover 5.4% in IUC.
- IUC turnover now back to 2023 figures, with further plans to improve.
- Staff survey improvements, across all domains in IUC.

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Patient Transport Service

The Trust's Non-Emergency Patient Transport Service (PTS) provides NHS-funded transport for eligible people, who are unable to travel to their healthcare appointments by other means, due to their medical condition or mobility needs.

2024-25 was a challenging year, with high levels of demand for PTS provision. Despite this increased demand PTS performance and quality has remained consistently high.

Between April 2024 and March 2025, the PTS operated 978,407 journeys, a 5.6% increase from the same period in 2023-24. Throughout the first half of 2024-25 monthly demand levels were more than 10% higher than the previous year, although activity began to stabilise from November onwards.

During 2024-25 PTS experienced an increase in demand from patients with higher and more complex needs. For example, around 313,000 journeys required a multi-handed vehicle in 2024-25, which was a 12.5% increase to the previous year.

The PTS reservations team took 536,672 telephone calls in 2024-25, an 8.6% increase from the previous year. The number of call handlers in PTS reservations increased during 2024-25, resulting in improved performance. 79.8% of calls were answered within 3 minutes, an increase of 28.1% increase from the same period in 2023-24.

PROFILE: EFFICIENCY AND PRODUCTIVITY GAINS - INCREASING THE NUMBER OF PATIENTS PER VEHICLE

Since the COVID-19 pandemic the number of patients travelling alone in PTS vehicles increased considerably. There are various reasons why patients may not be able to travel with others: they might be immunocompromised or carrying a contagious infection. However, conveying patients on their own in our non-emergency vehicles reduces the timeliness, efficiency and availability of transport to other patients, which results in more late arrivals or missed appointments.

During 2024-25 the Trust focused on increasing the number of patients per vehicle by strengthening processes for reviewing travel alone requests and by reviewing scheduling priorities and on-day decision-making. Best practice examples and expertise from across our planning and control teams was shared to ensure that limited resources were maximised. To maintain momentum, results were shared on leaderboards around the control room – an approach that was embraced by our teams.

As a result of the new processes, the number of patients travelling alone has reduced and the average number of patients transported per vehicle has increased.

PTS STRATEGIC AND TRANSFORMATIONAL PRIORITIES

Patient Eligibility Criteria

This programme aims to implement common eligibility criteria so that PTS provision is delivered on a consistent, fair and sustainable basis across the Trust's footprint. During 2024-25 the Trust worked with its three ICBs to standardise patient access to PTS for West Yorkshire, South

Yorkshire and Bassetlaw, and North Yorkshire and Humber. The new approach went live from April 2025.

PTS Electric Vehicle Implementation

During 2024-25 the Trust introduced 35 new electric vehicles for PTS. This is the largest mobilization of ambulance-sized electric vehicles by any NHS ambulance service to date.

Throughout 2024-25, the electrical charging infrastructure has been fully installed at seven identified ambulance stations: Bramley, Barnsley, Bradford, Doncaster, Hull, Scunthorpe and Wakefield.

The first PTS crew to use a PTS electric vehicle said: *"We are really enjoying the new electric vehicles – they're great to drive and run very quietly, which makes it easier to have meaningful conversations with patients. The electric vehicles have been generating a lot of interest and compliments from patients, hospital staff, and the general public. Patients are also enjoying the new vehicles and keep telling us how smooth their journeys feel."*

Alternative Resources

The Trust's PTS is supported by a framework of quality-assured 'alternative resource' (organisations from outside the Trust that help to provide patient transport services). This benefits the local business economy, supports employment within the region, and ensures that the Trust can offer the "best of both" with high quality NHS service levels and the flexibility and value for taxpayer money with our commercial and community transport partners.

The flexibility of having other transport providers on our framework also allows us to respond quickly, and dynamically to ever-changing situations, from extreme weather conditions to the provision of additional support during periods of industrial action.

During the 2024-25 financial year, our private providers (including taxi providers) undertook 51.1% of all PTS journeys.

The framework is currently made up of 29 active providers:

- 13 private ambulance providers
- Three community transport providers
- 13 taxi companies.

KEY ACTIVITY AND DEVELOPMENTS WITHIN PTS THROUGHOUT 2024-25

During 2024-25 a number of improvement developments have been progressed in PTS, including:

- A PTS Local Incident Review Group has been established to review and act upon patient incidents and complaints. Related, PTS produces a monthly safety thermometer, a short, visual document, that highlights positive and negative themes and trends taken from analysing that month's PTS incidents, complaints, compliments, concerns and comments.

- 2024-25 also saw the introduction of a direct phone line for healthcare staff to make ‘on day’ journey bookings on behalf of their patients. This enables journeys to be booked more quickly and supports patient flow across the wider system by supporting quicker and more efficient discharges from hospital.

- PTS brought in a SMS cancellation service in May 2024. This service sends a reminder text to patients the day before they are due to be travelling, with the option to reply “no” to the text if they no longer require transport. Since its inception 3,207 text cancellations have been received. Without the SMS cancellation service, these texts would previously have been phone calls into PTS reservations, and in some cases wasted journeys.

PTS Volunteers
The Trust’s PTS could not operate without the support of its volunteer workforce,

During 2024-25 the PTS Volunteer Team was a key part in the Trust’s re-accreditation of the Investing in Volunteers Award

Looking forward to next year, the Trust will be focusing on recruitment and retention of volunteers. Do you have friends or family that enjoy driving, like meeting new people, and might have some time to spare? Please share our details with them: Phone: 0330 678 4003 Email: yas.vcsrecruitment@nhs.net

Further information on becoming a volunteer is available at: https://www.yas.nhs.uk/get-involved/patient-transport-service-volunteers/

Monitoring Performance

In addition to the Ambulance Response Programme performance standards and other indicators referred to above, the Trust uses a range of other metrics, indicators and processes to monitor performance on a daily, weekly, and monthly basis. Many of these are reported in the monthly Integrated Performance Report published on the Trust website.

During 2024-25 the Trust developed and implemented a new performance management framework. The purpose of this framework is to:

- Support a culture of systematic, continuous improvement to ensure the effective delivery of Trust strategic ambitions, objectives and development priorities set out in the Trust strategy, enabling plans, annual business plan, and other service and project plans, including delivery of relevant national standards and local contractual targets.
- Strengthen accountability for performance providing assurance and evidence to the Board, internal and external stakeholders, and the wider public that the organisation has effective systems in place and is committed to achieving high standards of quality, safety and value for money as part of the Trust's wider governance framework.
- Facilitate excellence in operational and support functions at all levels of the organisation, ensuring a clear line of sight from Trust strategy and ambitions to the contribution of all directorates, teams and individual members of staff.
- Set out clear, consistent and effective lines of accountability for delivery, from the Board to service level, teams and individuals.
- Ensure a values-led approach to collectively identifying, reporting and escalating performance issues, and to planning and delivering recovery actions in response to performance issues through supportive discussions.
- Enable visibility and sharing of good practice.

The performance management framework ensures the effective delivery of the Trust's strategic objectives, business plan priorities, and key performance measures. The framework sets out the processes, values and culture of the organisation that need to be embedded to support people and teams to take positive ownership and accountability for improvement.

The framework is shaped by the:

- The Trust's vision and strategy, supported by objectives, performance measures and accountability.
- The Trust's values and behavioural framework. •
- Strategic and annual business planning processes aligned to the annual NHSE planning guidance and Integrated Care Board Joint Forward Plans and local Place priorities. •
- The Trust's Board Assurance Framework.

Accountability

The Trust's performance management framework presents a hierarchy of consistent and linked performance management arrangements - the golden thread from the Board through to services, teams, managers and individual members of staff.

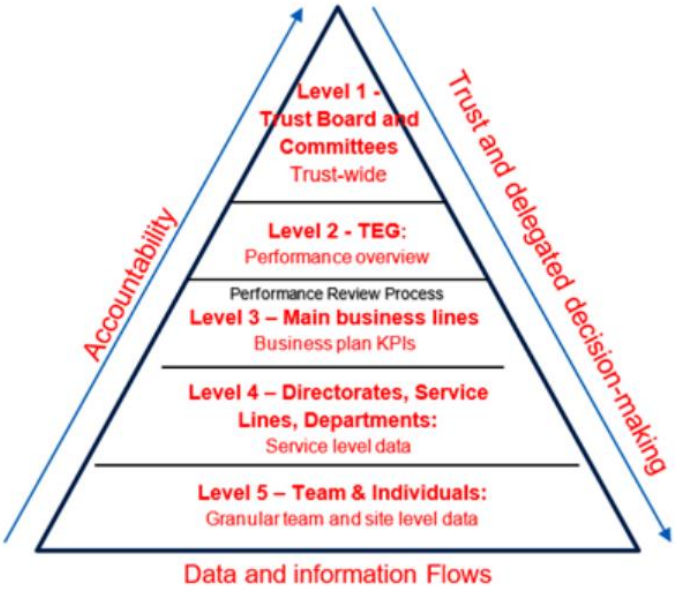
The performance management hierarchy sets out how different levels of the organisation:

- Monitors and report performance information.
- Identifies performance challenges and improvement opportunities.

- Implements recovery / remedial actions to address performance challenges.

To ensure accountability, roles and responsibilities are clearly defined at all levels, utilising consistent reporting, to ensure that performance goals are met and sustained.

Performance Management Framework



The **Board of Directors** (and Board Assurance Committees) are accountable to NHS England for meeting performance targets. The Trust Board:

- Sets the level of ambition and communicates these goals widely.
- Understands which services are performing well and which require improvement.
- Creates an environment of appropriate challenge and holding to account.
- Understands current and future challenges and plans for those.

The **Trust Executive Group** (TEG) is accountable to the Board for meeting clinical, quality and performance targets. TEG is formally designated as the Trust's senior operational decision-making body. TEG oversees the delivery of the Trust's clinical, operational, workforce and financial objectives.

Each of the main operational service lines is accountable for performance in their areas, particularly the delivery of their elements of the Trust's annual business plan as well as national, local and contractual standards and targets. In addition, each of the main corporate and support functions is accountable for delivering their elements of the business plan and supporting and enabling the operational performance. Performance is assured through Performance Review and Improvement meetings and reported to TEG, Board Assurance Committees and to the Board.

Other directorates, department and teams are responsible for the delivery of, or contribution to, national, local and contractual standards and targets. They are accountable to the relevant Trust management group.

All staff have clearly defined roles and objectives linked to the organisational goals. Regular feedback and appraisals ensure individual performance aligns with these objectives.

Financial Review

Strategic Context
In 2024-25, at national level, there was a focus on reducing staffing levels that had increased during the COVID-19 pandemic, and a drive to increase efficiency and productivity savings. By contrast, the ambulance sector was being asked to continue investing in frontline services to improve performance of Category 2 mean response times. Handover delays at hospital Emergency Departments remain the single biggest driver of increased resource requirements.

Specifically, 2024-25 funding arrangements reflected:

- Net cost uplift factor (CUF) of 0.6% (*1.7% gross with 1.1% efficiency*).
- Growth funding of 0.6%.
- A convergence adjustment (reduction) of 0.97% (applicable only to the West Yorkshire ICB element of the contract) to move funding towards a fair share target.
- UEC capacity funding was provided recurrently (£13.55m).

As in previous years, commissioners agreed a consolidated global sum payment to cover all service contracts. The CQUIN Quality Incentive Schemes were paused for a further year, removing the risk associated with 1.25% of the contract value.

The detailed Trust position for 2024-25 is set out below.

2024-25 Financial Regime
The Trust set a break-even financial plan and set budgets within the parameters of this plan. The challenging national financial position meant that the 2024-25 planning process extended into Q1 with final plans being submitted to NHSE and approved by Trust Board in June.

Plans were initially based on an assumed 2% inflationary uplift. The pay award was subsequently confirmed at 5.5% and included an additional incremental uplift for bands 8 and 9. The backdated pay award was transacted in October 2024 and funded through an additional CUF of 3.3% to the contract value.

The budgets included a £21.7m efficiency/cost reduction target, incorporating a vacancy factor of £6.5m and an ‘unidentified’ element of £4.1m for which there were no plans developed.

The Trust started the year with an underlying deficit of £8.4m. This had reduced to £7.2m by the year-end, due to additional recurrent income.

Income and Expenditure

The Trust delivered a £92k surplus in 2024-25 against a breakeven plan.

	2024/2025	
Income & Expenditure	**Plan**	**Actual**
	£000s	
Operating Income & Expenditure		
Income	(447,859)	(447,761)
Pay	352,291	346,226
Non pay	95,881	101,012
Finance Costs		
Finance Income	(3,800)	(2,815)
Finance Costs	365	687
PDC Dividend	3,122	3,365
Other (gains)/losses	-	(311)
(Surplus)/Deficit	-	403
Remove impact of I&E Impairment	-	(495)
Reported (Surplus)/Deficit	**0**	**(92)**

Income

The Trust received total operating income of £447.8m; of which, £411m was contract income from NHS commissioners for the provision of 999/PTS and 111 services. Included within the contract was an additional £2m to cover increased depreciation charges, in accordance with changes to national guidance.

The Trust also recognises £21.2m of notional funding from NHSE to cover the increased staff pension contributions (at 9.4%).

£1.8m of additional NHSE funding was allocated to support improved performance in Category 2 response times.

YAS received additional Patient Care income from the Embrace contract for neonatal services, from Primary Care Networks for rotational paramedics and from the National Ambulance Resilience Unit (NARU).

Non-patient care income (£9.3m) included Education and Training, Research and Development, digital funding and the apprenticeship levy.

Finance income (£2.8m) is from interest receivable on the Trust's bank account; this was lower than planned due to falling interest rates and lower average cash balances.

Total income to the Trust was £450.6m.

	2024/25		2023/24
Income	**£m**	**%**	**£m**
Patient Care Income*	£ 438.43	97%	£395.2
Non-Patient Care Income	£ 9.34	2%	£10.3
Finance Income	£ 2.82	1%	£3.9
Total Income	**£ 450.58**	**100%**	**£409.4**

**of which, NHSE notional pension income £21.2m (£12.5m in 23/24)*

Expenditure

Operating expenditure in 2023-24 was £447.2m, which is summarised below:

	2024/25		2023/24
Expenditure	**£m**	**%**	**£m**
Pay Costs*	£346.2	77%	£306.1
Non Pay Costs	£81.6	18%	£84.9
Depreciation (incl. amortisation)	£19.4	4%	£15.1
Total Expenditure	**£447.2**	**100%**	**£406.1**

**of which, NHSE notional pension income £21.2m (£12.5m in 23/24)*

Pay costs increased by 13% from the previous year, due to:

i) 5.5% inflationary uplift and the inclusion of a 2nd year increment for bands 8a and above in the 2024-25 pay award.

ii) Increased employers pension rate to 23.78%, of which 9.4% is paid centrally by NHSE (*previously 20.68% with 6.3% being paid centrally*)

iii) Ongoing recruitment and improved retention throughout the Trust, but most notably in A&E Operations and 111.

Non-pay expenditure decreased by £3.3m due to reduced reliance on private sector support in our operational services, because of successful recruitment to substantive vacancies.

The depreciation charges increased due to higher levels of capital expenditure (made possible through the availability of additional funds in-year and slippage at system level) and inflationary price increases across estates, fleet and medical devices. Increased depreciation costs (above a baseline determined by the 2024-25 plan) are now funded by NHSE via the host commissioner.

Quality and Efficiency Savings

The Trust had an efficiency target of £21.7m during 2024-25. The vacancy factor was achieved, there were savings on retendered contracts, and the insurance rebate was higher than expected.

Fleet Telematics and the Procurement Buyer Function did not deliver savings in year due to delayed implementation and recruitment, however, are in place for 2025-26.

An executive-led Non-Pay Review panel was introduced mid-year that informed changes in procurement process and led the cultural shift to an efficiency mind-set.

Overall, shortfalls in the efficiency programme were offset by pay underspends.

The focus on efficiencies and productivity gains intensifies as we move into 2025-26 with requirements to reduce corporate cost growth by 50%. The Trust continues to evaluate and develop initiatives to improve efficiency and reduce waste through its Organisational Efficiency and Quality Improvement Groups.

Capital Expenditure
The Trust had an opening capital allocation of £27.8m; £15.8m for purchased assets and £12m for leased (right of use) assets.

Initially, funds were ring-fenced for purchased and leased assets separately but were merged towards the end of the financial year. This gave the Trust greater flexibility in managing overall capital expenditure.

The Trust took advantage of additional capital funds resulting from system slippage and received monies for National Energy Efficiency Funds (NEEF) and cyber security. The final total of capital funds was £33.5m.

Capital Expenditure for 2024-25 is summarised in the table below.

Capital Expenditure Analysis 2024-25	Plan	Actual
	£000s	
Estates	3,900	8,687
Fleet	11,156	12,033
ICT	685	2,261
Sub Total - Purchased Assets	**15,741**	**22,981**
Estates	1,099	1,608
Fleet	10,960	6,659
ICT	-	1,528
Procurement	-	121
Sub Total - Leased Assets	**12,059**	**9,916**
TOTAL CAPITAL EXPENDITURE	**27,800**	**32,897**

There were two significant capital decisions taken within the year that required reconfiguration of the capital plan.

- The Trust approved the re-platforming of the electronic patient record (ePR) and the replacement of current GETAC devices with personal issue iPads. These were procured via a three-year lease.
- The Trust approved the purchase and refurbishment of a new site for Hull Ambulance Station. This will enable the consolidation of four existing stations, PTS, training facilities and fleet workshop into one site and will deliver increased capacity, operational efficiencies and maximise clinical resource. The project will be completed across three financial years.

Thirsk Ambulance Station was badly damaged by a fallen tree during the winter storms; the Trust opted to demolish and replace with a modern equivalent station rather than proceed with a planned refurbishment to the old station.

Completed capital projects within the year include:

- Purchase of the Hull (Clough Road) site and the lease of additional car parking.
- Remodelling of the vacant area within Springhill 2 (Wakefield HQ) to provide on-site training facilities for EOC.

- Installation of the Fleet Telematics system.
- Operational fleet replacement; DCAs, specialist HART vehicles, PTS vehicles and Team Leader cars.

The Trust was also able to accelerate a few projects from the 2025-26 capital plan, including voice recorder refresh, the replacement of support vehicles and some smaller estates projects.

Final capital expenditure was £32.9m.

The Trust's Risk Profile

The Trust's risk profile is shaped by internal and external factors affecting the organisation and its wider operating environment. These factors include demand and capacity, response and patient flow, workforce capacity, well-being and culture, and financial constraints affecting revenue budgets and investment capital.

The Trust's strategic risks are set out in the Board Assurance Framework and organised under the Trust's four strategic ambitions. These risks were managed via the Trust's risk management and assurance strategic framework and associated processes. During 2024-25 three of the Trust's strategic risks were subject to heightened risk exposures above the forecast risk trajectory:

- Strategic Risk 3: Patient Flow
  Hospital handover times deteriorated markedly during the autumn. Mitigations included focused work with partners, including the implementation of operational / clinical protocols ('Transfer of Care') relating to handover time limits. Implementation of these protocols had a notable positive impact, resulting in clear reductions in handover delays and associated improvements in ambulance response times.
- Strategic Risk 8. Recruitment and Retention
  This risk was forecast for reduction from high risk to moderate risk during the year, based on the planned improvement in both recruitment and retention levels. The Trust did achieve high levels of recruitment across most service areas, although modest variances have affected some staff groups. However, retention remained more challenging and although some improvements were evident the People Committee advised that it would be premature to reduce the risk.
- Strategic Risk 12. Revenue Resources
  The Trust's revenue position carried significant risk during much of the year, derived from internal and external factors. Mitigations included a series of 'grip and control' measures and budget reviews introduced by the Trust to reduce discretionary expenditure, as well as enacting technical adjustments. The impact of these and other measures meant that the Trust achieved a break-even position for 2024-25.

Future risk outlook
The Trust's strategic risk outlook for 2025-26 is informed by routine review of corporate risks and the Board Assurance Framework combined with analysis of ongoing developments and changes affecting the organisation and the wider health and care system.

The urgent and emergency care system is expected to continue to experience stress during 2025-26, characterised by demand and capacity pressures, response and patient flow issues, workforce capacity, well-being and culture issues, and financial constraints affecting operational budgets, efficiency requirements, and capital investment in vehicles, buildings, technology, and environmental sustainability.

For the 2025-26 the main areas of strategic risk to the Trust remain as set out in the Board Assurance Framework. Within that context, however, particular elements of risk are likely to be significant. Examples include:

- Operating with available revenue finances during 2025-26, including the need to identify and deliver significant cost reductions and productivity gains.

- The impact of national and system-level restructuring and cost reduction programmes (NHS England, Integrated Care Boards)
- Implementation of major infrastructure schemes such as NHS Pathways and the Hull hub.

The Trust's main approaches to mitigating the most significant risks during 2025-26 are set out in its five-year strategy for 2024-29 and its annual business plan for 2025-26, with relevant actions linked directly to the Board Assurance Framework. These mitigations include:

- Actions to reduce risk relating to demand, patient flow and response times, particularly Category 2 ambulance response. This includes strengthening staffing and vehicle availability and deployment, streamlining triage and care navigation processes to ensure patients get the most appropriate care at the earliest point in their journey, working with hospitals to reduce handover times, working with local partners on clinical pathways, and delivering more care remotely, in people's own homes and closer to home.
- Actions to reduce risk relating to quality and safety. This includes strengthening medicines management, strengthening the Patient Safety Incident Response Framework (PSIRF), further developing the Clinical Supervision model, delivering a step-change in approaches to Quality Improvement.
- Actions to reduce risk relating to workforce capacity, well-being and culture. This includes further improvements in recruitment, retention, training, staff support and sickness management, improving the health, wellbeing and safety of staff, and improving the culture of the organisation with a particular focus on leadership development, improving equality, diversity and inclusion, and creating a more open culture.
- Actions to reduce financial risk, both revenue and capital. This includes the development of balanced break-even financial plans supported by a drive to make more effective use of resources through a greater productivity, a cost improvement programme, and delivery of external expectations regarding the reduction of corporate costs.
- Actions to reduce risk relating to fleet availability. This includes ongoing development of the ambulance fleet and support services, increasing the numbers of ambulances on the road and reducing the average age of vehicles, and reducing the environmental impact of vehicles through telematics systems.

The Annual Governance Statement provides further information on the Trust's risk profile and its approach to risk management and risk assurance as part of a wider system of governance, risk management and internal control.

Environmental and Sustainability Matters

Task Force on Climate-related Financial Disclosures (TCFD) report for Yorkshire Ambulance Service
Since 2010 the Trust has had in place plans for carbon reduction, sustainable development, and subsequently a Green Plan. In addition, a climate change adaptation plan was developed in 2022 and supports this annual report disclosure.

Governance
During 2024-25 the Trust established a new senior level management group to oversee environmental, sustainability and associated matters. This Environmental and Sustainability Oversight Group oversees the implementation of the Trust's Green plan, including the identification and mitigation of risks, the development and delivery of plans and initiatives, and the co-ordination of resources.

The following governance structure supports the green agenda within YAS.

- Net Zero Board Lead and Board Level SRO – Kathryn Vause (Director of Finance)
- Senior Responsible Officer – Glen Adams (Director of Fleet and Estates)
- Net Zero Lead – Alexis Percival
- Environmental and Sustainability Oversight Group
- Environmental and Sustainability Delivery Group

Strategy for Assessing Climate Risk
Climate change poses risks to the Trust's operations and patients. The Trust's staff, patients, fleet and estate are already being impacted by climate change. In recent years extreme weather including floods and flash flooding, storms, droughts, wildfires and heatwaves have affected our organisation and our ability to respond to emergencies.

The Green Plan outlines the Trust's strategy to reduce its impact on the environment whilst ensuring that, as an organisation and first responder, we are prepared for the impacts of the climate change. A new Green Plan will be launched during 2025-26.

Climate change risks are identified, managed and reported as part of the Trust's established risk management and assurance frameworks and processes. Strategic climate change risk is captured in the Trust's Board Assurance Framework as one of the highest risks to the organisation's strategic objectives. Operational climate change risks are identified and managed via the Trust's corporate risk registers and other local risk registers. Management of these risks receives assurance and oversight via the Trust Executive Group and the Finance and Performance Committee. This ensures that there is visibility of climate change risk at Board level.

Documents have been developed to support the knowledge sharing of the risks. An overarching Climate Adaptation Plan has been developed to highlight the risks to the Trust from climate impacts through flood risk assessments at organisational and location levels.

Reporting and escalation mechanisms are in place that provide further information relating to the impacts of climate change on the Trust and our communities. These include climate-specific mechanisms relating to the Climate Adaptation Plan, Flood Risk Assessment and Green Plan, a as well as links to other Trust resilience and business continuity processes such as the Major Incident Plan, the Resource Escalation Plan, the Business Continuity Plan, the Transport Plan and the Adverse Weather Plan.

The Trust's response to climatic events is embedded in EPRR and Business Continuity arrangements. Through departmental green strategies (for example, green ICT strategy,

sustainable procurement plan etc) individual departments carry out an assessment of the climate risks in their area of operation.

The Trust is currently developing processes by which the relevant management structures are informed about climate related issues and how those structures monitor climate-related issues.

Framework

The predicted impacts of climate change will be – and already are - felt differently across the Yorkshire region. On the coast there is significant shoreline erosion. Storm surges have brought flooding events further inland than previously experienced. Low-lying urban areas and city centres have seen an increase in the frequency and severity of flooding. Drought and moorland fires are becoming more prevalent in rural areas. Areas of large populations are also suffering from the 'urban heat island effect' due to the concentration of buildings in one place.

These changes are having an impact on individuals, services and society as a whole. This is a key concern to YAS and the delivery of its services, which is why the preparation of a climate change adaptation plan will ensure the Trust is designing the future use of its assets, estate and supply chain, for resilience against the effects of climate change.

Adaptation planning is an opportunity to ensure a cohesive approach to future planning. The process of developing the plan should integrate with the development and refinement of emergency preparedness and business continuity plans.

The NHS, health and social care organisations must adapt to a range of scenarios so they can be prepared for future climate change. The UK CCRA 2012 and UKCP18 have highlighted several key health risks from climate change including:

- Heat (increased summer temperatures / heat wave events)
- Cold (reduced deaths and illness but with continued risk from cold 'snaps')
- Increase in extreme weather events
- Increase in wildfires and droughts
- Ground level ozone
- Flooding and storms (resilience and continuity of health and social care services, mental health impacts and injuries)
- Rising sea levels and sea inundation
- Changing patterns of disease and air quality
- Food shortages
- Incidence and exposure to marine and freshwater pathogens
- Sunlight (UV risk)
- Population increase and migration.

The YAS Climate Adaptation Plan 2024-2029 lays out the challenges that our region and service face with each of these risks. The unpredictability of these climatic events needs to be factored in to present day operations, estate and fleet.

Climate Risk Management

The YAS Climate Adaptation Plan 2024-29 lays out the challenges that our region and service face with each of these risks. The unpredictability of these climatic events needs to be factored into present day operations, estate and fleet.

The Trust is developing a method to make decisions to mitigate, transfer, accept or control risks

as well as to assess and prioritise out risks. The Trust is working with national and regional NHS organisations to devise climate risk assessments relevant to our service.

The Trust is working with local resilience forms, other NHS partners and regional organisations, to identify the most effective means to minimise the impact of climate change on the health and care system across Yorkshire.

Through a staff awareness and education programme the Trust hopes to raise awareness of climate risks and their potential impact. Mandatory training for staff includes an e-learning module on Net Zero.

Metrics

The Trust tracks its carbon reduction through Green Plan metrics and has been tracking carbon reduction trajectories for over 15 years. The Trust has been tracing Scope 1 and Scope 2 carbon emissions since 2007 and recently conducted an assessment for Scope 3 to complete the full analysis of carbon impact. We use national carbon factors to track our carbon emissions as well as aligning the Greener NHS's reporting metrics.

Over the past 15 years our Scope 1 and 2 emissions have been reducing although not as fast as required to achieve our required reductions in line with the Net Zero targets.

All new projects to reduce carbon emissions we include quantifiable baselines to ensure that carbon reduction and climate mitigation can be monitored and reported throughout the process. These metrics form the basis of the Trust's carbon reduction programme, allowing us to see the impact of our carbon journey.

Targets

The Trust is aligned to the NHS's target to eliminate carbon emissions through the Greener NHS targets of ambition to reach an 80% reduction by 2028–32 and complete decarbonisation by 2040 for decarbonisation of Scope 1 and 2 emissions (NHS Carbon Footprint) and for an extended set of emissions including those that can be influenced in the supply chain, ambition to reach an 80% reduction by 2036–39 achieving Net Zero for all emissions by 2045. The YAS baseline assessment year is 2011 for Scope 1 and 2 and 2021 for Scope 3 emissions.

To date the Trust has achieved reductions in carbon emissions based on our baseline year (2011) for Scope 1 and 2.

We work nationally with the Greener NHS team and wider NHS to ensure that we align with the carbon factors and reduction requirements.

We do not undertake internal carbon pricing.

We are currently creating a new Green Plan which will lay out targets for the next three years and will extend to a 2035 plan. KPIs from this new plan will be reported as metrics and targets to the Senior Sustainability Group. These KPIs will include percentage assessment of items like solar or heat decarbonisation programmes i.e. we wish to achieve 20% of the estate to have solar panels on the roof by a specified date. This will enable us to visualise the programme of decarbonising works. We are developing a Scope 3 reduction programme under the new Green Plan.

Emergency Preparedness, Resilience and Response

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care.

EPPR Core Standards
Under the Civil Contingencies Act (2004), NHS organisations must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. NHS England sets the minimum standards that NHS organisations must meet. These are known as the Core Standards for the Emergency Preparedness, Resilience and Response (EPRR). The Trust is required to assess itself against these core standards each year.

For 2024-25 the performance of the Trust against the NHS England Core Standards for EPRR was 93%, an improvement from 71% the previous year. This means the Trust achieved 'substantial compliance' (compared to 'partial compliance' previously. This self-assessment was validated and confirmed by the West Yorkshire Integrated Care Board.

In addition, the Trust demonstrated a high level of compliance against the following standards for EPRR 'Interoperable Capabilities':

- Command and Control.
- Hazardous Area Response Team.
- Marauding Terrorist Attack Response.
- Chemical, Biological, Radiological and Nuclear (CBRN) Response.
- Mass Casualty Response.
- Joint Emergency Services Interoperability Principles.

Business Continuity
During 2024-25 the Trust underwent an external assessment of compliance with the business continuity standard, ISO 22301. This concluded that the Trust continues to meet the standard, which is a strong achievement for an ambulance trust.

Medical Emergency Response Incident Team
Specific EPRR improvements during 2024-25 included the introduction of the Medical Emergency Response Incident Team ('MERIT'). This is a doctor and specialist critical care paramedic team to better support major incidents and to provide enhanced clinical care to patients on a more routine basis. Previously MERIT was delivered via volunteer clinicians from larger hospitals who would be collected and brought to a major incident on an ad hoc basis. A review concluded that the time delay in assembling the team was excessive and that a smaller established team that could respond quicker would be of more benefit to patients at a major incident.

Ten Second Triage
Another EPRR improvement introduced in 2024-25 was the implementation of a new national triage system, called 'Ten Second Triage' (TST). TST was implemented by the Trust in the first quarter of 2024-25 and has been used at a range of multi-agency exercises across the Yorkshire region since then. The Trust also supported local fire and rescue services and police forces to adopt this new tool as it is designed for use by all first responders to triage casualties at major incidents.

Special Operations
Support to the wider health system has been provided by the Special Operations team, who have designed and delivered training, helping hospitals to deal effectively and safely with

patients who present with chemical, biological or radiological contamination. This is supplemented by processes carried out by Special Operations staff to provide assurance to the hospitals and wider health system that adequate arrangements are in place.

Equalities

Diversity and Inclusion
The Trust aims to achieve a diverse workforce that represents the communities it serves, and a positive and inclusive organisational culture that supports all staff to thrive. The Trust's strategy includes commitment to create a fair, respectful, and inclusive working environment for all colleagues and volunteers while ensuring equitable access and outcomes for the communities we serve.

The Trust meets all its mandated and statutory requirements in relation to equality, diversity, inclusion, and human rights.

The Trust complies with the Public Sector Equality Duty (PSED).

Equality Frameworks
The Trust has adopted the NHS Equality Delivery System (EDS) framework, a tool used by NHS organisations to help improve equalities performance, deliver better health outcomes, and create more inclusive workplaces. For 2024-25 the Trust achieved the category of 'High Developing'.
https://www.yas.nhs.uk/about-us/diversity-at-yas/equality-delivery-system-2-eds2/

The Trust also used the **ENEI Tidemark**, a benchmarking tool developed by the Employers Network for Equality and Inclusion (ENEI) to assess and improve diversity, equality, and inclusion (DEI) maturity. For 2024-25 the Trust was awarded a Gold TIDE Award for its performance in diversity and inclusion. This recognition places the Trust among the top-performing organisations in the UK for its commitment to creating inclusive workplaces and delivering equitable services.
https://www.yas.nhs.uk/about-us/diversity-at-yas/workforce-equality-standards-and-diversity-data/

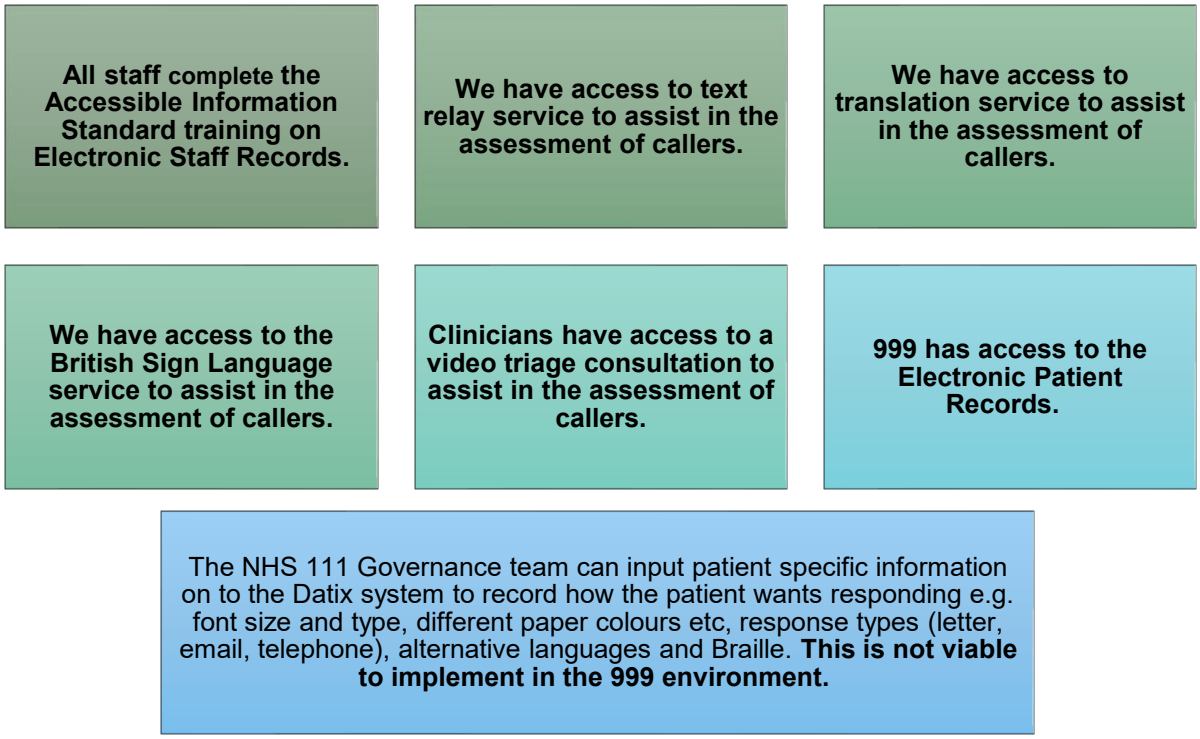
Workforce Equality Data
The Trust publishes annual reports on the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). These reports provide insights into the experiences of Black and Minority Ethnic (BME) and disabled staff, helping the Trust to identify and actively address areas for improvement. The Trust's **WRES** and **WDES** action plans outline specific measures to address disparities and promote inclusivity across all levels of the organisation.
https://www.yas.nhs.uk/about-us/diversity-at-yas/pay-gap-information/

Pay Gap Information
In compliance with the PSED and Equality Act 2010, the Trust publishes a gender pay gap annual report. This report outlines actions and strategies to address any identified gaps and promote gender equality within the workforce. In 2024-25 the Trust published its first Ethnicity Pay Gap Report, providing insights into the disparities in pay between different ethnic groups within the organization. During 2025 the Trust and expects to publish a Disability Pay Gap report. These reports are reviewed regularly to ensure progress and accountability and inform ongoing review and development of the Trust's Equality, Diversity and Inclusion Action Plan 2024-27.
https://www.yas.nhs.uk/media/4928/equality-diversity-and-inclusion-plan-2024-27-final.pdf

Support Networks
The Trust recognises the importance of providing support and fostering a sense of belonging among staff. The Trust maintains several support networks, including **Pride@YAS** (LGBTQ+ Network), **Race Equality Network** (REN), **Disability Support Network** (DSN), **Armed Forces Network** and the **Women and Allies' Network**. These networks play a crucial role in shaping EDI initiatives across the organisation and ensuring that all staff have a voice in the development of policies and practices.

Equality Impact Assessments
Equality Impact Assessments (EIAs) are actively conducted on all appropriate policies, procedures, and service delivery changes with a robust process in place that reviews all policies before approval. This allows the Trust to assess any potential negative impact on individuals with protected characteristics and adjust as needed using a data-informed approach on our workforce. Policies are in place to promote zero tolerance for harassment, discrimination, or inappropriate behaviour toward patients and staff, with a new Anti-Racism Charter in development for 2025.

Accessible Services for our Patients



The Trust continues to work with commissioners, regional and national partners in addition to NHS England to explore how we can meet the Accessible Information Standard and embed equality within service delivery by reviewing key service lines through the Equality Delivery System framework.

Recent developments include the introduction of dementia-friendly ambulances, designed with features such as calming environments, landscape imagery, and color-coded signage and enhanced accessibility. The Patient Transport Service provides specialist training on dementia recognition and care, promoting dignity and reducing distress.

The Trust provides access to interpreter services and assistive technologies to support patients with language or communication needs. As an indicative snapshot, in November 2024 across the Trust 2688 calls were made to the interpretation service, with an average connection time of under 20 seconds.

During 2024-25 the Trust implemented a new feature that enables text messaging with care advice to be sent to patients' mobile phones following their assessment. This allows patients to be able to read the information afterwards rather than needing to remember it at the time. This is reducing the number of call backs received by the Trust. It is also proving to be particularly helpful to people who are neurodiverse.

The Trust provides video consultation which allows clinicians to provide detailed assessments and to identify the most appropriate care in cases when patients find it difficult to describe their issues.

Mental Health Interactive Voice Response (IVR) - allows people who need mental health help to be able to press ‘option 2’ when ringing NHS 111 which will take them directly to the mental health line instead of waiting for a general health adviser.

The Trust can access various age specific services, such as children's hubs, provided through a local directory of services. This ensures patients have the required specialised staff, enabling them to receive the right care first time.

SMS patient survey was introduced to increase the number patient responses we receive from our postal survey. The 111 Patient survey is a great tool for patients to show their needs were met during a call. Dedicated mental health pathways, including training in trauma-informed care and de-escalation techniques, safeguard leads that support crews in identifying and escalating concerns involving vulnerable adults and children, and in-house Independent Domestic and Sexual Violence Advocates (IDVAs/ISVAs) offering domestic and sexual abuse support, are also available.

Community outreach initiatives such as Restart a Heart, demonstrate our commitment to accessibility.

FOCUS ON RESTART A HEART

- With ambitions to firmly place ourselves as an 'Anchor Institution' addressing Health Inequalities, YAS actively delivers its longstanding 11-year campaign 'Restart the Heart' in secondary schools across Yorkshire.
- This year saw the first five students, trained as part of the Restart a Heart Ambassador Programme, deliver the CPR training at E-ACT Parkwood Academy to their fellow pupils.
- In 2024, YAS launched the Heart of the Community accreditation scheme which recognises schools and colleges for their commitment to CPR training and defibrillator availability, another legacy of our Restart a Heart campaign.

The YAS Mental Health Transformation Programme focuses on comprehensive mental health training and education, including classroom-based training for all patient-facing staff. This initiative incorporates specialised roles such as Mental Health Pathways Manager, Advanced Paramedic Mental Health, and Specialist Paramedic Mental Health. Additionally, it provides professional mental health support to the Emergency Operations Centre (EOC) through the MH PUSH model, and deploys Mental Health Response Vehicles (MHRVs), with eight out of nine MHRVs currently in operation.

The NHS Pathways Transformation Project commenced in 2024 to change the 999-triage system from AMPDS to NHS Pathways. NHS Pathways is utilised nationally for NHS 111 service and across seven Ambulance Services in England. Training and go-live is planned for 2025. One of the key benefits is NHS Pathways will enable 999 call handlers to refer patients who do not require an ambulance to various other health care pathways. Currently 999 call handlers will refer patients to NHS 111 to assess this need. The project will streamline this process to give patients a better experience. Training includes modules to support patients with learning disabilities, neurodiverse patients, gender dysphoria, racial equality, wellness and anchor bias.

NHS England Statement on Information on Health Inequalities

NHS England in its recently published statement on information on health inequalities (https://www.england.nhs.uk/publication/nhs-englands-statement-on-information-on-health-inequalities/) suggests a number of topics on which trusts should focus their attention when measuring inequalities. These include:

- Urgent and emergency care
- Respiratory disease
- Mental health
- Cardiovascular disease
- Oral health
- Maternity.

YAS has developed a set of indicators that provide information on health inequalities within these topics from an ambulance service perspective. A summary of the inequalities from this analysis is provided here.

- Ambulance **calls** have **increased** overall by 14% **since 2023**, the rate of calls from the **most deprived** quintile is **twice** that in the **least deprived**.

- This is also true for under 18s; **children** in the **most deprived** quintile are **more than twice as likely** to have an ambulance called than those in the **least deprived**.

  Actions taken
  The clinical informatics and audit team completed a clinical audit in 2024 which looks at the care given to paediatric patients with a final working impression related to:
  - Seizures
  - Asthma
  - Suspected infection
  - Glycaemic emergencies.

  Areas for improvement were identified. The implementation of these actions will be monitored through the YAS Patient Safety Learning Group.

- Calls for **breathing problems** have increased year on year, with a 16% rise since 2023. This affects our **most deprived** communities most severely with **41%** of all breathing problem calls from our most deprived quintile compared to **9%** in the **least deprived**.

  Actions taken
  A deep dive into patients with breathing difficulties in the most deprived quintile was conducted in Leeds, in conjunction with colleagues from the West Yorkshire Integrated Care Board (ICB) who have access to the Leeds Linked Data Model. This generated a better understanding of patients who made repeat calls, where they accessed primary care and what happened to them when they were conveyed and attended the Emergency Department (ED). This new understanding will be incorporated into the development of a new Clinical Response Model for YAS.

- The rate of calls for **mental health** in the **most deprived** quintile is **almost four times** that in the **least deprived**. This is borne out when we look at variation across Yorkshire,

with calls for mental health in Hull more than twice that in York. For **young women**, the rate in **Hull** is almost **three times** that in **Rotherham**.

Actions taken
As part of the 2024-25 clinical audit programme, a deep-dive clinical audit has been conducted focusing on young women with mental health-related final working impressions. This audit produced qualitative themes and trends to assist in our understanding of the disparate demand from this group of patients, particularly within the Hull area. YAS will use the results of this audit to work with system partners to better understand the patient journey through the system for this population group and how we may use our data to influence community and patient engagement.

A separate deep dive describing and analysing 'calls of despair' to YAS has also been conducted.

- There is a **10-year gap** in the **average age** for an ambulance attendance for **stroke** between the **most and least deprived** quintiles.

  Actions taken
  Prehospital literature is scarce within the topic of addressing healthcare inequalities in acute care pathways. A clinician-led evaluation analysed the six distinct phases of the pre-hospital pathway whilst identifying patient groups at each stage that have been historically disenfranchised by healthcare inequalities. In doing so, we addressed the changes in demographics throughout the region to determine if the current pathway model is fit for purpose in detecting strokes in a timely manner across all population groups. An interesting finding based on this detailed analysis and availability of ethnicity data for this cohort was that there was a higher proportion of confirmed stroke patients in BME groups for whom YAS had recorded a non-stroke related working impression compared to White or Unknown groups. This was not statistically significant but may warrant further investigation.

  This exploratory approach is a method that YAS intends to utilise moving forwards to address prehospital healthcare inequalities and ensure that we address the changing demographics of our region for our service users, staff and partners.

- The **average age** of attendance for **STEMI** in the **most deprived** group is **63** compared to **71** in the **most affluent** group.

- Ambulance attendances for diabetes were strongly related to deprivation. Our analysis suggests that for **diabetes** the **inequalities** between the most and least deprived groups **are widening** over time.

- **57%** of **111 calls** for **dental pain** in **children** under 10 were from the **most deprived** quintile compared to **4%** in the **least deprived**. The rate of calls for dental pain in children in **Bradford** was **four times** that in **North Yorkshire**.

Actions taken
Currently public health teams use the number of decayed, missing and filled teeth to examine need and inequalities in dental problems and care. 111 data on tooth problems could enhance knowledge of this population together with levels of need in our communities. A separate deep dive into the potential benefits of using 111 data to describe the need for dental services in our communities has been produced.

- **Almost half** of all calls for **maternity-related** calls were from the **most deprived** quintile compared to **5%** in the **least deprived**. Rates of ambulance calls for maternity-related calls were significantly higher in younger mothers, with the rate of calls for mothers under 20 more than 4 times that for mothers in their thirties.

- Ambulance data is a key source of information on patients experiencing **homelessness** which is not available elsewhere. Over two years, there were **18 individuals** experiencing homelessness who had more than 10 ambulance attendances each. This accounted for a total of **334 calls**.

Actions taken
Over a period of 24 weeks, Healthwatch Hull engaged with people experiencing homelessness, Yorkshire Ambulance Service staff and wider stakeholders.
Feedback from people experiencing homelessness was positive; staff provide compassionate and dignified care and treatment. However, amongst this population there remains a fear of health service interaction, which creates barriers to accessing the most appropriate treatment.

Stakeholders, who work with people experiencing homelessness also identified systemic barriers and gaps. Mental health support, stigma, and barriers to accessing health services were significant concerns that stakeholders felt affected homeless people.

Healthwatch Hull proposed several recommendations to address these challenges which YAS is currently working through. The full list of recommendations can be found in the report which can be accessed here.

Social Value: Working with our Communities

Community engagement

Community engagement enables us to make contact with people across Yorkshire outside of our emergency response or service delivery role. We engage with our communities to raise awareness of our services, teach important skills, build trust and to learn about how we can improve access to our, and other, services.

Our community engagement objectives during 2024-25 have been to:

- Improve lives through targeted interventions
- Raise awareness of life-saving skills
- Engage with communities to be visible and develop relationships
- Improve access to our services for vulnerable populations by generating insight
- Develop volunteering across the Trust.

During 2024-25 we delivered 380 community engagement events and activities, engaging around 11,000 people across Yorkshire.

We recognise that heath inequalities have a significant impact on people's likelihood to need our services, their ability to access them and their access to other services and support. While we engage widely with all communities across Yorkshire, we have a particular focus on reaching communities most likely to experience poor health and face barriers to accessing services. Nearly half our engagement activity in 2024-25 was delivered in the most deprived areas nationally and we have delivered targeted engagement with disadvantaged groups including people with a learning disability, asylum seekers and refugees, vulnerable women, people recovering from addiction, people experiencing homelessness and a wide range of BME communities.

All our community engagement projects are supported by the YAS Charity.

Volunteering

During 2024-25, YAS volunteers (Critical Friends Network (CFN), Community First Responders, (CFRs), Volunteer Car Service (VCS) in the non-emergency Patient Transport Service, and Community Engagement Volunteers (CEVs)) collectively offered over 270,000 hours, supporting services across YAS to deliver exceptional patient and community care. This includes attending over 19,500 emergency patients and covering over 1.1 million miles transporting PTS patients to appointments, as well as bringing the patient and public voice into service improvements.

In the past year, significant progress has been made in relation to volunteering across YAS. The infrastructure to support continuous volunteering development has been strengthened with the establishment of a Volunteering Development Steering Group, which offers leadership and governance provision. This group has supported the development and implementation of a formal reward and recognition framework for volunteers, which includes the introduction of volunteer long service awards for those who have been in place for five years or more, to be launched as part of Volunteers' Week 2025.

The **Community Engagement Volunteer (CEV) Programme** has been established for existing YAS staff and volunteers, with this voluntary activity expanding the reach of our community engagement activities. 57 events delivered by CEVs have engaged an estimated 2,600

members of our communities through activities such as service awareness raising and CPR training.

We have developed a volunteer demographics report to better understand and monitor diversity amongst our volunteers, and to utilise the information to ultimately increase the diversity of those who volunteer their time and care to support our Trust and our communities.

Collaborative partnerships have been formed with other health and care providers, voluntary, community, and third-sector organisations to enhance care through volunteering, such as with the Royal Voluntary Service where volunteers supported the welfare or our staff at busy hospital emergency departments during winter. We also partnered with the British Islamic Medical Association (BIMA) to support their national Lifesavers campaign, delivered at mosques up and down the country, which aims to equip local communities with the skills they need to save lives in critical moments, including CPR and defibrillator use.

In the past year, members of the **Critical Friends Network (CFN)** have brought their expertise and lived experience to multiple discussions across the Trust, ensuring that we include the patient and public voice in our decision-making and service improvements. Their input into the development of our first Patient Experience Framework has been particularly important, as it sets out our commitment to ensuring our services are tailored to meet the diverse and evolving needs of our communities. CFN volunteers will continue to be involved in the delivery of this important framework, helping to improve the quality of care for our patients.

PTS volunteers have completed over 39,000 patient journeys, covering over 1.1 million miles in their own vehicles during the last year. Our PTS is looking at ways to increase the utilisation of volunteers and reduce the reliance on taxis, in recognition that volunteers offer the best quality experience for our patients, as well as being more cost-effective.

Community resilience

Volunteers in local communities have continued to play a major role in patient care and business continuity for Yorkshire Ambulance Service. Our Community First Responder (CFR) initiative is a partnership between the Trust and groups of volunteers who are trained to respond to life-critical and life-threatening emergencies such as breathing problems, chest pain, cardiac arrest, strokes and seizures.

We currently have 766 CFRs who belong to 298 CFR teams across Yorkshire and the Humber. In addition, we work with numerous system-wide co-responders in 10 teams across the region, which include fire and rescue services, Coastguard and Mountain Rescue and the Police.

In 2024-25, they responded to 20,454 incidents (compared to 21,138 in 2023-24) and volunteered a massive 202,682 hours to support our response to patients in need of emergency care.

In June 2024, we celebrated 25 years since the first CFR scheme in South Yorkshire, prior to the creation of the Yorkshire Ambulance Service. Supported by the YAS Charity team, executive colleagues hosted events in each of the ICB areas, giving volunteers an opportunity to share their experiences and celebrate the success of the initiative.

We have expanded the scope of practice for volunteers to now include blood glucose monitoring which will help CFRs continue to work closely with remote clinicians to assess patients and this will continue to be rolled out through 2025-26. In order to support this and the

wider development of CFRs, a new training package will help volunteers to develop their clinical skills which will launch early in 2025-26.

We ended the year with our bi-annual Continuing Professional Development (CPD) Day for volunteers, providing a range of sessions to support our CFRs to expand their skills and increase their knowledge of some of the wider work within the Trust that will support them in their volunteering roles. This provided an excellent opportunity to celebrate the success of the CFRs over the last twelve months and set ambitions for the future.

If you would like to learn more about our CFR opportunities you can find it on our website at: Make the difference and join a Community First Responder scheme in Yorkshire | Yorkshire Ambulance Service.

General information about volunteering with the Trust is available at https://www.yas.nhs.uk/get-involved/volunteer-with-us/

Community defibrillators and CPR awareness
In 2024-25, in total there were 8,191 defibrillators registered with Yorkshire Ambulance Service on The Circuit (www.thecircuit.uk). 5,753 of those are public access defibrillators (available 24/7) and 2,439 of those are restricted/static sites where the defibrillators are only available when their host location/premises are open. Static defibrillator sites include places such as business premises, supermarkets, airports, railway stations, shopping centres, GP and dental practices and police custody suites.

The Circuit advises guardians as soon as we have activated a defibrillator to an incident; guardians can then check their cPADs and make them available through their log in. This means we have defibrillators made available for use by communities much quicker. This has been the busiest year yet, exceeding last year's record, for activations of cPADs. In 2024-25 we activated a cPAD to a life-threatening emergency 22,752 times (compared to 12,186 in 2023-24 and 7,679 in 2022-23).

In 2025-25, around 1,600 members of the public were also provided with free automated external defibrillator (AED) training at over 76 locations across the region.

The Community Resilience Team has continued collaborative working with partner agencies, the YAS Charity and other departments within the organisation and recently secured additional funding to further develop volunteering within the Trust.

Yorkshire Air Ambulance (YAA)
During 2024-25, Yorkshire Air Ambulance (YAA) responded to a total of 2,237 incidents, of which the aircraft attended 79% of these calls and the rapid response vehicles (RRVs) attended 21%. 1,411 of all calls were trauma-related or attendance at road traffic collisions.

YAA continues to invest in delivering two helicopters, 365 days a year, which in partnership with YAS delivers the Critical Care Team which generally comprises of a consultant-level doctor qualified in Pre-Hospital Emergency Medicine (PHEM) and one Helicopter Emergency Medical Service (HEMS) trained paramedic in one of the aircraft and two HEMS paramedics in the second aircraft. YAA also has two RRVs that can be used at times when the aircraft are unable to fly, ensuring the critical care capability continues to be available throughout the region.

Yorkshire Ambulance Service Charity

Yorkshire Ambulance Service is aligned to a charity which receives funding and donations from grateful patients, members of the public and our own staff and volunteers. The Yorkshire Ambulance Service Charity (YAS Charity) also holds events and has other fundraising initiatives throughout Yorkshire.

The YAS Charity operates by providing grants to fund items, activities and projects in three key areas. These are:

- Engaging communities
- Supporting colleagues and volunteers
- Saving lives.

Funding is only provided by the YAS Charity for items of expenditure which are not the responsibility of government funding to the NHS. This means that donations do not subsidise the work of Yorkshire Ambulance Service NHS Trust, they enhance it.

The YAS Charity (registered Charity No. 1114106) is a separate legal entity from Yorkshire Ambulance Service NHS Trust with the Trust Board being the Charity's Trustee. This unique partnership enables us to direct charity donations to meaningful projects which complement the core NHS services provided by the Trust. We ensure these funds are managed completely independently from our public funding by administering them through a separate Charitable Funds Committee.

Highlights from 2024-25

- Further development of the charity governance and compliance framework.
- Development of a three-year fundraising and communications strategy.
- Increased capacity with the introduction of a charity officer role.
- Increased engagement with colleagues, volunteers and the public through regular communication on social media platforms.
- Investment in materials and merchandise to raise awareness and support fundraising activities.
- Introduction of a YAS Charity Champion volunteer role for Trust staff.
- Continued development of relationships across YAS and with external partners.

The Charity continued to make a positive impact across its three key areas:

Engaging communities

The Charity continued to fund equipment and resources for the Trust's Community Engagement Team including:

- Continued support for the Achieve programme and the expansion of this to more groups, including people recovering from drug and alcohol addition, serving prisoners, people with a learning disability and/or neurodivergent people, the homeless and rough sleeping community and vulnerable women.
- Funding to set up the Restart a Heart Ambassador Programme which trains students to become Basic Lifesaving Skills instructors who can then teach more students life-saving skills.

Supporting colleagues and volunteers

- The Charity continued to offer hardship support in the form of food vouchers to colleagues and volunteers in need.
- The Charity undertook a summer smoothie roadshow, bringing healthy smoothies and fruit to staff working in the Trust's four call centres.
- YAS Trust staff networks and sports teams received funding for equipment and events including:
    - League fees for the men's and women's football teams
    - New kit for the YAS rugby team
    - Sponsorship for the Pride network to attend the Doncaster Pride event
    - Funding for a Remembrance Day event for the Armed Forces Network.
- The Charity funded treats for staff working over the Christmas period and Christmas lunch and gifts for the Critical Friends Network.
- Funding and gifts to support the Community First Responder CPD event which took place in March 2025.

Saving lives

- Funding equipment and materials to support the delivery of free first aid sessions, Basic Life Support and Automated External Defibrillator (AED) training to groups and communities across the region.
- Providing grants to support the installation of 15 community Public Access Defibrillators (cPADs) across the region and supported six offline defibrillators to get back online with new batteries or pads.
- Supporting the 11th annual Restart a Heart Day campaign which saw more than 35,000 students learn CPR at 165 secondary schools in October 2024.

The YAS Charity continues to be grateful to all its supporters who have donated and fundraised over the last year.

Make a donation

The YAS Charity is completely dependent on the generosity of YAS colleagues and volunteers, patients and their families and the wider public in the region to be able to continue our support for our three priority areas. If you would like to make a donation, take on a fundraising challenge or find out more about the work of the YAS Charity, please visit www.yascharity.org.uk or email yas.charity@nhs.net and you can follow us on Facebook (www.facebook.com/YASCF) or Instagram (www.instagram.com/yascharity25/) or LinkedIn (https://www.linkedin.com/company/yascharity).

Part 3 – Accountability Report

Directors' Report

The Board of Directors

The NHS Code of Governance requires that every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust, generating value for patients, service users and the public.

The Trust is led by a Board of Directors comprising Non-Executive Directors, Executive Directors, and other supporting or 'contributing' directors, including Associate Non-Executive Directors. Together the Executive and Non-Executive directors form a unitary board that brings a good mix of knowledge, skills, professional expertise and lived experience.

The Board membership represents an appropriate balance of Non-Executive Directors and Executive Directors, and an appropriate composition in terms of equality, diversity, and other protected characteristics. The Trust is committed to ensuring that people from all communities are able to reach Board level positions. In order to support this, the Trust often hosts placements of aspirant Board members from under-represented groups. During 2024-25 the Trust recruited new Board-level colleagues who have enhanced the diversity profile of the Board.

All of our Board members are appointed to their roles following an open and transparent recruitment process. Our directors are highly experienced and professionally qualified experts in their fields. They also bring broad and deep generic leadership and management skills and experience, honed across multiple disciplines and within different operational and organisational contexts. Information about our individual Board members can be found on the Trust's website.

The Trust is confident that our Board of Directors is fit for purpose. However, the position is kept under review. All Board members undertake an annual appraisal and performance review process which includes the identification of training and development needs. All Board members maintain a skills matrix which identifies areas of strength and opportunities for development, both for individuals and across the Board as a whole. In addition, the Board participates in evaluations of its own performance, in focused training sessions on specialist topics, and in a broader development programme. This is to ensure that the Board's skills, knowledge and experience remain relevant, and its overall composition remains fit for purpose.

More information about the Board of Directors can be found on the Trust website.

The Board of Directors 2024-25

During 2024-25 the Board of Directors comprised the following:

Chair
Martin Havenhand

Chief Executive
Peter Reading

Deputy Chief Executive
Marc Thomas

Chief Operating Officer
Nick Smith

Executive Director of Finance
Kathryn Vause

Executive Director of Quality and Chief Paramedic
Dave Green

Executive Medical Director
Dr Julian Mark (retired 1 April 2025)

Director of People and Organisational Development
Amanda Wilcock

Non-Executive Directors
Tim Gilpin (Deputy Chair from April 2024 to October 2024)
Anne Cooper (Deputy Chair from October 2024 onwards)
Jeremy Pease (retired on 31 January 2025)
Andrew Chang
Amanda Moat
Saghir Alam OBE (from 1 February 2025)

Associate Non-Executive Directors
Tabitha Arulampalam (from 1 February 2025)
Katherine Lees (from 1 February 2025)
Rebecca Randell (from 1 February 2025)

During 2024-25 Jeremy Pease retired as a Non-Executive Director of the Trust at the end of his second three-year term. The Trust appointed Saghir Alam OBE as a replacement for Jeremy.

During 2024-25 the Trust appointed three new Associate Non-Executive Directors: Tabitha Arulampalam, Katherine Lees, and Rebecca Randell. Rebecca had previously held a placement with the Trust under the NExT Director programme which supports people from under-represented groups to gain experience of Board level positions.

The Chairman and each of the above named Non-Executive Directors are considered by the Trust to be independent in accordance with the criteria set out in the NHS Code of Governance. All members of the Board fully met the requirements of the Fit and Proper Person Test for 2024-25.

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.

Board Committees

A set of assurance committees supports the Board of Directors in the discharge of its duties. The Trust considers these committees to be an extension of the Board and not separate to it. The assurance committees of the Trust are:

- Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- People Committee
- Remuneration and Nominations Committee
- Charitable Funds Committee

The Terms of Reference for these committees are reviewed and approved by the Board of Directors annually. More details about the purpose and remit of these committees, including their Terms of Reference, is set out in a separate document available on the Trust's website – www.yas.nhs.uk

Committee Membership 2024-25

Committee	Membership
Quality Committee	Three Non-Executive Directors Executive Director of Quality and Chief Paramedic Executive Medical Director
People Committee	Three Non-Executive Directors Director of People and Organisational Development Chief Operating Officer
Audit and Risk Committee	Three Non-Executive Directors
Finance and Performance Committee	Three Non-Executive Directors Executive Director of Finance Chief Operating Officer
Charitable Funds Committee	Two Non-Executive Directors Executive Director of Finance One other Executive Director
Remuneration and Nominations Committee	Trust Chair All other Non-Executive Directors Chief Executive (when appointing or appraising Executive Directors)

Attendance at Meetings of the Board and Assurance Committees
The attendance record for meetings of the Trust Board and the main assurance committees held during 2024-25 is as follows.

Audit And Risk Committee Attendance
2024-25

Committee Members And Attendees	16 Apr 2024	26 Jun 2024	27 Jun 2024*	16 Jul 2024	12 Nov 2024	02 Dec 2024*	21 Jan 2025
Andrew Chang	✓	✓	✓	✓	✓	✓	✓
Anne Cooper	✓		✓	✓	✓	✓	✓
Amanda Moat	✓	✓	✓	✓	✓	✓	✓
Kathryn Vause	✓	✓	✓	✓		✓	✓
Dave Green	✓	✓		✓			✓
David O'Brien	✓	✓	✓	✓	✓		✓
Internal Audit	✓	✓		✓	✓		✓
External Audit	✓	✓	✓	✓	✓		✓
Counter Fraud Specialist	✓	✓		✓	✓		✓

*extraordinary meeting

Quality Committee Attendance
2024-25

Committee Members and Attendees	11 Apr 2024	16 May 2024	21 Jun 2024	18 Jul 2024	17 Sep 2024	17 Oct 2024	21 Nov 2024	17 Dec 2024	16 Jan 2025	20 Feb 2025	20 Mar 2025
Anne Cooper		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jeremy Pease (left post in Feb 2025)	✓	✓	✓	✓	✓		✓	✓	✓		
Andrew Chang	✓	✓	✓			✓		✓	✓	✓	✓
Dave Green	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Julian Mark	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Katie Lees (commenced Feb 2025)										✓	✓
Marc Thomas											✓
David O'Brien	✓	✓	✓	✓	✓	✓	✓		✓		✓
Adam Layland	✓		✓	✓	✓				✓	✓	✓
Clare Ashby	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Julia Nixon	✓	✓	✓				✓	✓	✓		✓

Finance And Performance Committee Attendance
2024-25

Committee Members and Attendees	23 Apr 2024	23 May 2024	25 Jun 2024	23 Jul 2024	09 Aug 2024*	24 Sep 2024	22 Oct 2024	26 Nov 2024	19 Dec 2024	28 Jan 2025	25 Feb 2025	25 Mar 2025
Amanda Moat	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jeremy Pease (left post Feb 2025)	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Tim Gilpin						✓	✓		✓	✓		✓
Andrew Chang		✓	✓								✓	
Kathryn Vause	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Nick Smith	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Marc Thomas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sam Robinson (commenced in post June 2024)							✓	✓	✓	✓	✓	
Carol Weir	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
David O'Brien	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓
Jeevan Gill	✓	✓	✓		✓			✓		✓	✓	✓
Louise Engledow		✓				✓	✓	✓	✓	✓		

* extraordinary meeting

People Committee Attendance
2024-25

Committee Members and Attendees	14 May 2024	09 Jul 2024	10 Sep 2024	19 Nov 2024	21 Jan 2025	18 Mar 2025
Tim Gilpin		✓	✓	✓		✓
Jeremy Pease	✓					
Amanda Moat	✓	✓	✓	✓	✓	✓
Andrew Chang	✓	✓	✓	✓	✓	✓
Mandy Wilcock	✓		✓	✓	✓	✓
Nick Smith	✓	✓	✓		✓	✓
Rebecca Randell						✓
Marc Thomas						
Suzanne Hartshorne	✓	✓	✓			✓
Dawn Adams	✓	✓	✓	✓	✓	✓
David O’Brien	✓		✓	✓	✓	✓
Rachel Gillott	✓		✓	✓	✓	✓

Public Trust Board Attendance 2024-25

	25 Apr 2024	30 May 2024	20 Jun 2024	25 Jul 2024	26 Sep 2024	28 Nov 2024	30 Jan 2025	27 Mar 2025
Martin Havenhand				✓	✓	✓	✓	✓
Tim Gilpin		✓	✓	✓	✓	✓	✓	✓
Anne Cooper	✓	✓	✓	✓	✓	✓		✓
Andrew Chang	✓		✓	✓			✓	
Amanda Moat	✓		✓	✓	✓	✓	✓	✓
Jeremy Pease (left post in Feb 2025)	✓	✓	✓	✓	✓	✓	✓	
Peter Reading	✓	✓	✓	✓	✓	✓	✓	✓
Kathryn Vause	✓	✓	✓	✓	✓	✓	✓	✓
Nick Smith	✓	✓	✓	✓	✓	✓	✓	✓
Julian Mark (retired on 1 April 2025)	✓	✓	✓	✓	✓	✓	✓	
Steven Dykes (commenced as Acting Medical Director on 1 April 2025)								✓
Dave Green	✓	✓	✓	✓	✓	✓		✓
Marc Thomas	✓	✓	✓	✓	✓	✓	✓	
Mandy Wilcock	✓	✓		✓	✓	✓	✓	✓

Public Trust Board Attendance 2024-25

	25 Apr 2024	30 May 2024	20 Jun 2024	25 Jul 2024	26 Sep 2024	28 Nov 2024	30 Jan 2025	27 Mar 2025
Tabitha Arulampalam (commenced post in Feb 2025)								✓
Katherine Lees (commenced post in Feb 2025)								✓
Rebecca Randell (commenced post in Feb 2025)								✓
Adam Layland	✓	✓	✓	✓	✓	✓	✓	✓
Jeevan Gill	✓		✓	✓	✓	✓	✓	
Rachel Gillott	✓	✓	✓	✓	✓		✓	✓
Carol Weir	✓	✓	✓	✓	✓	✓	✓	✓
David O'Brien	✓		✓	✓	✓		✓	✓
Sam Robinson (commenced post in Jul 2024)				✓	✓	✓	✓	✓

Declaration of Interests for the Financial Year 2024-25

Board Members and Non-Voting Directors

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interest	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
Martin Havenhand	Chair	NIL						N/A	N/A
Anne Cooper	Non-executive Director	Ethical Healthcare Ltd	✓					06 August 2021	Current
		Fellow for The Queen's Institute of Community Nursing		✓				2015	Current
Tim Gilpin	Non-executive Director	NIL						N/A	N/A
Andrew Chang	Non-executive Director	NPL Management Ltd, the National Metrology Institute - an arm's length body under the purview of the Department for Science, Innovation and Technology	✓					08 January 2022	Current
		York St John University, higher education provider	✓					08 January 2022	Current
		Luminate Education Group, educational group consisting of Leeds City College, Keighley College, Harrogate College, University Centre Leeds, Leeds Conservatoire, Leeds Sixth Form College, Pudsey Sixth Form College – providers of sixth-form, further and higher education	✓					12 January 2023	Current

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interest	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
		The Seacole Group, an association of NHS NEDs who are of the BAME community interested in increasing, protecting and defending the opportunities of BAME people in the NHS					✓	18 May 2020	Current
Amanda Moat	Non-executive Director	NIL						N/A	N/A
Saghir Alam	Non-executive Director	NIL						N/A	N/A
Peter Reading	Chief Executive	Company Secretary of Catherine Reading Limited, a company which provides clinical psychology services and on very rare occasions has its services paid for by an NHS organisation	✓					31 March 2003	Current
		Disabled NHS Directors Network - a group which advocates for the interests of disabled NHS staff			✓			01 March 2021	Current
		Daughter works for Robert Walters Limited - a recruitment company				✓		01 August 2024	Current
		Sister-in-law works for AQUA - a management consultancy				✓		2016	Current
		Wife is Director of Catherine Reading Limited - a company which provides clinical psychology services	✓					21 March 2003	Current

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interest	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
Nick Smith	Chief Operating Officer	NIL						N/A	N/A
Kathryn Vause	Executive Director of Finance	NIL						N/A	N/A
Dave Green	Executive Director of Quality and Chief Paramedic	Honorary Lecturer at University of Bradford				✓		31 October 2023	Current
Steven Dykes	Acting Medical Director (with effect from 1 April 2025)	North East and Yorkshire Clinical Senate Council member		✓				21 January 2021	Current
		West Yorkshire Medic Response Team Vice Chair and Senior Doctor			✓			02 January 2013	Current
Marc Thomas	Deputy Chief Executive	Pfizer, pharmaceutical company	✓					26 April 2024	Current
Mandy Wilcock	Director of People and Organisational Development	NIL						N/A	N/A
Adam Layland	Director of Partnerships and Operations (SY)	Bank Paramedic - Yorkshire Ambulance Service	✓					01 April 2023	Current
		Bank Emergency Care Practitioner - University Hospitals of Derby and Burton	✓					01 May 2022	Current
		Principal Academic - Warwick University (Warwick Medical School)	✓					01 September 2020	Current

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interest	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
		Bank Consultant Paramedic - Medical Solutions Ltd	✓					01 January 2007	Current
		Executive Chair and Managing Director - Unity Reach Ltd and Unity Reach (Care) Ltd - supportive living business for people with learning disabilities and autism	✓					01 September 2024	Current
		Honorary Professor and Fellow - University College Birmingham		✓				01 September 2022	Current
		Visiting Professor - York St John University		✓				01 September 2020	Current
		Editorial Board Member - British Journal of Healthcare Management - Voluntary		✓				1 August 2017	Current
		Member of BSI Committee on Healthcare Organization Management (Voluntary) and Previous Chair of Committee and Chair of ISO Working Group		✓				1 January 2019	Current
		Board Member - International Network of Healthcare Workforce Education - Voluntary		✓				1 April 2020	Current
		Reviewer for Multiple Journals - Voluntary		✓				August 2017	Current

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interest	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
		Chair of Trustees (and previous Trustee) - Community Transport Charity (Voluntary)			✓			1 August 2018	Current
Jeevan Gill	Director of Partnerships and Operations (HNY)	Director of Property Company - Optimas Property Limited (No salary taken)			✓			1 January 2020	Current
		School Governor - West End Primary School, Leeds			✓			7 January 2023	24 March 2025
		Husband is Director of Property Company - Optimas Property Limited				✓		1 January 2016	Current
Rachel Gillott	Director of Partnerships and Operations (WY)	Chairperson of grassroots sports club in Sheffield			✓			1 May 2023	Current
		Related to Yorkshire Ambulance Service employee				✓		1 April 2024	Current
		Service Providers in West Yorkshire Integrated Care System					✓	1 December 2022	Current
Carol Weir	Director of Planning, Strategy and Performance	HCPC registered dietitian health and wellbeing advisor/consultant for Xyla, health part of Acacium Group	✓					1 July 2019	Current
		Husband Royce Neagle is a YAS employee				✓		1 April 2021	Current
David O'Brien	Director of Corporate Services and Company Secretary	Related through marriage to two Labour Party Parliamentarians: Judith Blake, Baroness Leeds (House of Lords), Olivia Blake, Member of Parliament, Sheffield Hallam				✓		25 September 2023	Current

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interest	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
Sam Robinson	Chief Digital Information Officer	Trustee and Deputy Chair - Children's Heart Surgery Fund - a Yorkshire based charity			✓			9 June 2024	Current
		My husband, Dr Richard Robinson, is the Medical Director at Mid Yorkshire Teaching Hospitals Trust				✓		9 June 2024	Current
Tabitha Arulampalam	Associate Non-executive Director	NIL						N/A	N/A
Katherine Lees	Associate Non-executive Director	Local Care Direct	✓					1 May 2020	Current
		West Yorkshire ICB Lead for neurodiversity					✓	3 April 2025	Current
Rebecca Randell	Associate Non-executive Director	University of Bradford, HEI	✓					1 January 2020	Current
		University of Bradford, HEI		✓				2 January 2020	Current
Jeremy Pease	Non-executive Director	Director, Green Oak Associates Ltd (paid role providing consultancy - including for the NHS)						12 December 2006	Current
		Trustee, The Welcome Centre (Huddersfield)		✓				21 January 2025	Current
Julian Mark	Executive Medical Director	NIL						N/A	N/A

Remuneration Report

Salaries and allowances of Senior Managers 2024-25 (subject to audit)

Name	Title	Notes	(a) Salary (bands of £5,000) £'000	(b) Benefits in Kind and taxable expenses to nearest £100* £	(e) All pension-related benefits (bands of £2,500) £'000	(f) TOTAL (a to e) (bands of £5,000) £'000
Martin Havenhand	Chair		45 - 50	-	-	45 - 50
Anne Cooper	Deputy Chair / Non-Executive Director	1	10 - 15	-	-	10 - 15
Tim Gilpin	Deputy Chair / Non-Executive Director	1	10 - 15	-	-	10 - 15
Peter Reading	Chief Executive	2	205 - 210	5,700	-	210 - 215
Marc Thomas	Deputy Chief Executive	3	150 - 155	-	40 - 42.5	190 - 195
Kathryn Vause	Executive Director of Finance		140 - 145	1,100	75 - 77.5	220 - 225
Dr Julian Mark	Executive Medical Director	4	150 - 155	-	2.5 - 5	155 - 160
Nick Smith	Chief Operating Officer		135 - 140	1,500	52.5 - 55	190 - 195
David Green	Executive Director of Quality and Chief Paramedic		120 - 125	1,400	95 - 97.5	215 - 220
Amanda Wilcock	Director of People and Organisation Development		130 - 135	-	15 - 17.5	145 - 150
Sam Robinson	Chief Digital Information Officer	5	95 - 100	-	32.5 - 35	130 - 135
David O'Brien	Director of Corporate Services and Company Secretary		115 - 120	-	30 - 32.5	145 - 150
Carol Weir	Director of Strategy, Planning and Performance		110 - 115	-	72.5 - 75	185 - 190
Jeevan Gill	Director of Partnerships & Operations		110 - 115	1,300	32.5 - 35	145 - 150
Rachel Gillott	Director of Partnerships & Operations		105 - 110	1,100	30 - 32.5	135 - 140
Adam Layland	Director of Partnerships & Operations		115 - 120	-	27.5 - 30	145 - 150
Saghir Alam OBE	Non-Executive Director	6	0 - 5	-	-	0 - 5
Andrew Chang	Non-Executive Director		10 - 15	-	-	10 - 15
Amanda Moat	Non-Executive Director		10 - 15	-	-	10 - 15
Jeremy Pease	Non-Executive Director	7	10 - 15	-	-	10 - 15
Tabitha Arulampalam	Associate Non-Executive Director	8	0 - 5	-	-	0 - 5
Katherine Lees	Associate Non-Executive Director	9	0 - 5	-	-	0 - 5
Rebecca Randell	Associate Non-Executive Director	10	0 - 5	-	-	0 - 5
Rod Barnes	Ex Chief Executive	11	25 - 30	900	-	25 - 30

* Benefits in kind relate to use of vehicles provided by the Trust in 2024-25 and minimal taxable expenses (Total - £100)

There were no (c) Performance pay and bonuses or (d) Long-term Performance pay and bonuses in 2024-25.

Notes

1 Tim Gilpin was Deputy Chair from April 2024 to October 2024. Anne Cooper was appointed Deputy Chair in October 2024.

2 Peter Reading was Interim Chief Executive from 1 June 2023. The Trust paid a contribution to his salary from 1 August 2023 to 30 April 2024 to his employer, North Lincolnshire and Goole NHS Foundation Trust. The cost for 2024-25 was £10,000 - £15,000, the full year equivalent salary is £155,000 - £160,000.
Peter Reading was formally contracted as Chief Executive on 1 May 2024. The full year equivalent salary is £235,000 - £240,000.

3 Marc Thomas commenced in post as Deputy Chief Executive on 1 April 2024.

4 Dr Julian Mark worked on a part time basis for the Trust during 2024-25 (0.6 WTE). He retired as the Trust's Chief Medical Director on 1 April 2025.

5 Following the departure from the Trust of Simon Marsh, Chief Information Officer, on 31 March 2024, Sam Robinson was appointed as Chief Digital Information Officer on 24 June 2024. The full year equivalent annual salary for Sam Robinson is £125,000 - £130,000.

6 Saghir Alam OBE commenced in post as a Non-Executive Director on 1 February 2025. The full year equivalent annual salary is £10,000 - £15,000.

7 Jeremy Pease left the Trust on 31 January 2025. The full year equivalent annual salary is £10,000 - £15,000.

8 Tabitha Arulampalam commenced in post as Associate Non-Executive Director on 1 February 2025. The full year equivalent annual salary is £5,000 - £10,000.

9 Katherine Lees commenced in post as Associate Non-Executive Director on 1 February 2025. The full year equivalent annual salary is £5,000 - £10,000.

10 Rebecca Randell commenced in post as Associate Non-Executive Director on 1 February 2025. The full year equivalent annual salary is £5,000 - £10,000.

11 Rod Barnes was Chief Executive Officer from 1 April to 31 May 2023, and was on paid secondment from 1 June 2023 to 31 May 2024. He retired from the Trust on 31 May 2024.
The cost from 1 April 2024 to 31 May 2024 was £25,000 - £30,000. The full year equivalent annual salary is £160,000 - £165,000.

Salaries and allowances of Senior Managers 2023-24 (Restated)

Name	Title	Notes	(a) Salary (bands of £5,000)	(b) Benefits in Kinds and taxable expenses to nearest £100*	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£'000	£	£'000	£'000
Martin Havenhand	Chairman	1	45 - 50	-	-	45-50
Tim Gilpin	Deputy Acting Chairman		10 - 15	-	-	10-15
Rod Barnes	Chief Executive	2	165 - 170	5,900	-	170 - 175
Kathryn Vause	Executive Director of Finance		125 - 130	1,000	-	125 - 130
Dr Julian Mark	Executive Medical Director	3	70 - 75	-	-	70 - 75
Dr Steven Dykes	Acting Executive Medical Director	4	60 - 65	-	-	60 - 65
Nick Smith	Executive Director of Operations		120 - 125	1,500	27.5 - 30	150 - 155
David Green	Executive Director of Quality & Chief Paramedic	5, 12	40 - 45	-	27.5 - 30	65 - 70
Clare Ashby	Interim Executive Director of Quality, Governance and Performance Assurance	6	55 - 60	-	-	55 - 60
Amanda Wilcock	Director of People and Organisational Development		125 - 130	-	-	125 - 130
Karen Owens	Director of Urgent Care and Integration	7	15 - 20	-	-	15 - 20
Simon Marsh	Chief Information Officer		100 - 105	-	25 - 27.5	125 - 130
David O'Brien	Director of Corporate Services	8,12	55 - 60	-	12.5 - 15	65 - 70
Carol Weir	Director of Strategy	9, 13	45 - 50	-	65 - 67.5	110 - 115
Adam Layland	Director of Partnerships & Operations	10	105 - 110	-	-	105 - 110
Jeevan Gill	Director of Partnerships & Operations	10	100 - 105	-	-	100 - 105
Rachel Gillott	Director of Partnerships & Operations	10	95 - 100	-	-	95 - 100
Anne Cooper	Non-Executive Director		10 - 15	-	-	10 - 15
Amanda Moat	Non-Executive Director		10 - 15	-	-	10 - 15
Jeremy Pease	Non-Executive Director		10 - 15	-	-	10 - 15
Andrew Chang	Non-Executive Director		10 - 15	-	-	10 - 15
Zafir Ali	Associate Non-Executive Director	13	10 - 15	-	-	10 - 15

* Benefits in kind relate to use of vehicles provided by the Trust in 2023-24 and 2022-23

There were no (c) Performance pay and bonuses or (d) Long-term Performance pay and bonuses in 2023-24 or 2022-23

Notes

1	Martin Havenhand commenced in post from 1 April 2023
2a	Rod Barnes was Chief Executive Officer from 1 April to 31 May 2023, and was on paid secondment from 1 June 2023.
2b	Peter Reading was Interim Chief Executive from 1 June 2023. The Trust paid a contribution to his salary from 1 August 2023 to 31 March 2024 to his employer, North Lincolnshire and Goole NHS Foundation Trust. The cost for this period was £105,000 - £110,000, the full year equivalent salary is £155,000 - £160,000
3	Dr Julian Mark returned from secondment and rejoined the Trust on 1 October 2023 as 0.6 WTE. The full time, annual equivalent salary is £140,000 - £145,000 and Dr Mark receives protected pay.
4	Dr Steven Dykes role of Acting Medical Director ceased on 30 September 2023. The full year equivalent annual salary is £120,000 - £125,000.
5	Dave Green commenced in post on 1 November 2023. The full year equivalent annual salary is £115,000 - £120,000.
6	Clare Ashby's role of interim executive director ceased on 31 October 2023. The full year equivalent annual salary is £105,000 - £110,000.
7	Karen Owens retired on 31 May 2023. The full year equivalent annual salary is £125,000 - £130,000
8	David O'Brien commenced in post from 28 September 2023. The full year equivalent annual salary is £110,000 - £115,000.
9	Carol Weir commenced in post from 1 November 2023. The full year equivalent salary is £105,000 – £110,000.
10	The role of System Partnership Director changed to Director of Partnership & Operations on 5 February 2024.
11	Zafir Ali left the Trust on 31 January 2024. The full year equivalent annual salary is £10,000 - £15,000.
12	Pension related benefits were disclosed for the full year in 2023-24. These have now been corrected and time apportioned to reflect the period of time that the Senior Manager was a Board member in 2023-24.
13	Carol Weir's disclosures have been restated to correct a misstatement in respect of pension details in 2023-24.
14	Benefits in Kind are disclosed in £'s to the nearest £00.

2024-25 Pension Entitlement Table

Name	Title	Notes	(a) Real increase in pension at pension age (Bands of £2,500) £'000	(b) Real increase in pension lump sum at pension age (Bands of £2,500) £'000	(c) Total accrued pension at pension age at 31 March 2025 (Bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (Bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 1 April 2024 £'000	(f) Real increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 31 March 2025 £'000	(h) Employer's contribution to stakeholder pension £'000	(i) All pension-related benefits (Bands of £2,500) £'000
Marc Thomas	Deputy Chief Executive	2	2.5 - 5	-	15 - 20	-	230	29	292	-	40 - 42.5
Kathryn Vause	Executive Director of Finance		2.5 - 5	5 - 7.5	50 - 55	125 - 130	997	86	1,166	-	75 - 77.5
Dr Julian Mark	Executive Medical Director	3	0 - 2.5	2.5 - 5	55 - 60	150 - 155	1,220	27	1,347	-	2.5 - 5
Nick Smith	Chief Operating Officer		2.5 - 5	0 - 2.5	60 - 65	70 - 75	1,014	54	1,152	-	52.5 - 55
David Green	Executive Director of Quality and Chief Paramedic		5 - 7.5	7.5 - 10	30 - 35	80 - 85	555	95	701	-	95 - 97.5
Amanda Wilcock	Director of People and Organisation Development		0 - 2.5	-	50 - 55	135 - 140	1,135	22	1,249	-	15 - 17.5
Sam Robinson	Chief Digital Information Officer	4	0 - 2.5	0 - 2.5	25 - 30	65 - 70	481	51	595	-	32.5 - 35
David O'Brien	Director of Corporate Services and Company Secretary		0 - 2.5	-	5 - 10	-	96	20	137	-	30 - 32.5
Carol Weir	Director of Strategy, Planning and Performance		2.5 - 5	5 - 7.5	35 - 40	90 - 95	641	69	767	-	72.5 - 75
Jeevan Gill	Director of Partnerships & Operations		0 - 2.5	0 - 2.5	25 - 30	65 - 70	485	26	557	-	32.5 - 35
Rachel Gillott	Director of Partnerships & Operations		0 - 2.5	0 - 2.5	40 - 45	105 - 110	857	35	963	-	30 - 32.5
Adam Layland	Director of Partnerships & Operations		0 - 2.5	-	20 - 25	40 - 45	299	14	348	-	27.5 - 30
Rod Barnes	Ex Chief Executive	5	0 - 2.5	-	70 - 75	185 - 190	1,663	-	-	-	-

Notes

1 The above table only includes details for directors and senior managers who are currently contributing members of the NHS Pension schemes.

2 Marc Thomas commenced in post as Deputy Chief Executive on 1 April 2024.

3 Dr Julian Mark retired from the Trust as Executive Medical Director on 1 April 2025.

4 Sam Robinson commenced in post as Chief Digital Information Officer on 24 June 2024.

5 Rod Barnes retired from the Trust on 31 May 2024. The figures disclosed for (c), (d) and (g) are as at 31 May 2024.

2023-24 Pension Entitlement Table (restated)

Name	Title	Notes	(a) Real increase in pension at pension age (bands of £2,500) £'000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £'000	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 1 April 2023 £'000	(f) Real increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 31 March 2024 £'000	(h) Employer's contribution to stakeholder pension £'000	(i) All pension-related benefits (bands of £2,500) £'000
Rod Barnes	Chief Executive	1, 8, 9	-	35 - 37.5	65 - 70	185 - 190	1,364	140	1,663	-	-
Kathryn Vause	Executive Director of Finance	8, 9	-	20 - 22.5	40 - 45	115 - 120	807	92	997	-	-
Julian Mark	Executive Medical Director	8, 9	-	15 - 17.5	50 - 55	140 - 145	995	53	1,220	-	-
Steven Dykes	Acting Executive Medical Director	2, 8, 9	-	10 - 12.5	35 - 40	95 - 100	620	29	757	-	-
Nick Smith	Executive Director of Operations	9	0 - 2.5	-	50 - 55	65 - 70	780	139	1,014	-	27.5 - 30
David Green	Executive Director of Quality	3, 9, 10	0 - 2.5	0 - 2.5	25 - 30	65 - 70	435	26	555	-	27.5 - 30
Claire Ashby	Interim Executive Director of Quality, Governance and Performance Assurance	4, 8, 9	-	12.5 - 15	30 - 35	90 - 95	583	74	782	-	-
Amanda Wilcock	Director of People and Organisational Development	8, 9	-	2.5 - 5	45 - 50	130 - 135	934	91	1,135	-	-
Karen Owens	Director of Urgent Care and Integration	5, 8, 9	-	-	55 - 60	115 - 120	1,070	-	-	-	-
Simon Marsh	Chief Information Officer	9	0 - 2.5	-	15 - 20	-	208	37	278	-	25 - 27.5
David O'Brien	Director of Corporate Services	6, 9, 10	0 - 2.5	-	5 - 10	-	61	8	96	-	12.5 - 15
Carol Weir	Director of Strategy	7, 9	2.5 - 5	7.5 - 10	30 - 35	80 - 85	433	22	641	-	65 - 67.5
Adam Layland	System Partnership Director	8, 9	-	17.5 - 20	15 - 20	40 - 45	187	78	299	-	-
Jeevan Gill	System Partnership Director	8, 9	-	25 - 27.5	25 - 30	60 - 65	314	125	485	-	-
Rachel Gillott	System Partnership Director	8, 9	-	22.5 - 25	35 - 40	100 - 105	683	92	857	-	-

Notes

1 Rod Barnes was Chief Executive Officer from 1 April to 31 May 2023, and was on paid secondment from 1 June 2023. The full year equivalent annual salary is £170,000-£175,000.

2 Steven Dykes role of Acting Medical Director ceased on 30 September 2023. The full year equivalent annual salary is £120,000-£125,000.

3 Dave Green commenced in post on 1 November 2023. The full year equivalent annual salary is £115,000-£120,000.

4 Clare Ashby's role of interim executive director ceased on 31 October 2023. The full year equivalent annual salary £105,000-£110,000.

5 Karen Owens retired on 31 May 2023. The full year equivalent annual salary is £125,000-£130,000.

6 David O'Brien commenced in post from 23 September 2023. The full year equivalent annual salary is £110,000-£115,000.

7 Carol Weir commenced in post from 4 December 2023. The full year equivalent salary is £105,000-£110,000. The Greenbury pension figures utilised in the 2023-24 calculation were incorrect. These have now been corrected in the above table.

8 These individuals are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.

9 In the 2023-24 accounts, contributions were disclosed in respect of "Employer's Contribution to Stakeholder Pension". No contributions are made by the Trust to Stakeholder Pensions for any of the Senior Managers. Therefore, this disclosure has been corrected for the 2023-24 comparatives in the 2024-25 annual report.

10 Pension related benefits were disclosed for the full year in 2023-24. These have now been corrected and time apportioned to reflect the period of time that the Senior Manager was a Board member in 2023-24.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

Remuneration is calculated on the annualised full time equivalent staff of the Trust at each reporting date.

The banded remuneration of the highest paid director in the Trust in the financial year 2024-25 was £230,000 - £235,000 (2023-24: £170,000 - £175,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table overleaf:

2024-25	25th percentile	Median	75th percentile
Total remuneration (£)	29,775	36,115	47,586
Salary component of total remuneration (£)	29,775	36,115	47,586
Pay ratio information	7.81 : 1	6.44 : 1	4.89 : 1

2023-24	25th percentile	Median	75th percentile
Total remuneration (£)	29,276	36,140	47,762
Salary component of total remuneration (£)	29,276	36,140	47,762
Pay ratio information	5.89 : 1	4.77 : 1	3.61 : 1

In 2024-25 and 2023-24 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £12,516 to £230,326 (2023-24: £10,423 to £174,606).

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 highest paid director mid-point banding has increased by 12 bands on the last financial year. This follows a review of the Trust Board composition and the requirement to bring in experienced members to steer the Trust through the financial and operational challenges in the current financial year and going forward. This increase in highest paid director remuneration has resulted in increases in pay rations for all percentiles. Year on year, the median salary has reduced marginally by 0.1% whilst the salary of the highest paid director has increased by 31.9%.

Peter Reading
Chief Executive

26 June 2025

Staff Report - Our People

Our People 2024-25
Looking after our people is a cornerstone of the Trust's strategy. This is supported by the NHS People Plan and promotes the Trust's ambition to be a great place to work where everyone feels valued, included, proud to work and can thrive.

Recruitment, Retention and Resourcing
During 2024-25 multiple recruitment and retention initiatives have grown the Trust's clinical workforce to ensure that patients get the right care, at the right time. This has been achieved through numerous approaches, including regional and international recruitment initiatives, and by attracting a diverse range of candidates to help give patients the best possible experience. As an anchor institution the Trust actively encourages applications from all local communities. The Trust continues to prioritise staff retention, with a focus on wellbeing initiatives to contribute to making this organisation a great place to work.

During 2024-25 the Trust's overall headcount increased by around 1.5%, from 7,073 to 7,175. Employee turnover was 9.4% on average during the year, down from 11.9% the previous year and below the ambulance sector average (12.5%). Higher turnover was experienced in the Trust's remote care contact centres but that is not unusual for this sector.

Recruiting to the patient facing workforce
The Trust has a clear workforce plan to ensure that frontline services have sufficient staff to deliver our operational targets and business plan priorities. During 2024-25 the most important workforce trajectories were met, with a 96% occupancy rate across key frontline roles, including paramedics and other ambulance roles. This supported the trust's capacity and capability to deliver high quality patient care and services.

Multiple activities strengthened the frontline recruitment pipeline in 2024-25. Recruitment campaigns for key intakes commenced earlier than in previous years, which allowed for longer lead times to complete pre-employment checks (e.g. C1 driving licence requirements) and onboarding activity ahead of training start dates. Additionally, engagement sessions with partner universities began in November 2024, along with strategic course alignments and targeted regional recruitment campaigns. This greatly improved the number of high-quality applicants for core frontline roles.

For remote care call handling centres, 262 health advisors were appointed for NHS 111 and 103 call handlers were appointed in for our 999 Emergency Operations Centre.

Our Workforce Profile (Headcount)

	2023 (31 March 2023)	2024 (31 March 2024)	2025 (31 March 2025)
Paramedics	1,953	1,960	2,165
Technicians (including Ambulance Practitioners*)	1,373	1,532	1,536
Emergency Care Assistants (including Ambulance Support Worker)	404	235*	329

Other frontline staff (including Assistant Practitioners, A&E Support Assistants, Intermediate Care Assistants)	43	72	88
Patient Transport Service (Band 2, Band 3, and apprentices)	800	816	826
Emergency Operations Centre (EOC)	621	600	593
Integrated Urgent Care (NHS 111)	760	781	901
Administration and Clerical staff	823	821	919
Managerial (including Associate Directors)	226	242	311
Other (Chief Executive, Directors, and Non-Executive Directors)	17	14	14
Total	**7,020**	**7,073**	**7,682**

* A reduction in Emergency Care Assistants is due to the regrading of this role, those regraded now sit in the Technicians' category.

Workforce Levels (Whole Time Equivalent (WTE))

Staff category	Establishment 31 March 2023		Establishment 31 March 2024		Establishment 31 March 2025	
	Headcount	WTE	Headcount	WTE	Headcount	WTE
A&E Operations	3,773	3,297	3,854	3,369	4,109	3,637
PTS	800	629	750	590	826	640
EOC/IUC	1,381	1,001	1,387	967	1,592	1,194
Support staff	823	722	843	731	912	784
Management	243	227	239	225	243	230
Total	**7,020**	**5,876**	**7,073**	**5,883**	**7,682**	**6,485**

* The Trust has 722 staff who are undertaking apprenticeship programmes of study (10% of workforce) where the apprenticeship levy is utilised. These staff are undertaking substantive roles and hence are not shown separately in the data above.

Staff Profile – Gender (Headcount)

	2023 (31 March 2023)	2024 (31 March 2024)	2025 (31 March 2025)
Male	3,133 44.63%	3,103 43.87%	3,261 42.45%
Female	3,887 55.37%	3,970 56.13%	4,421 57.55%

Staff Costs (subject to audit)

Cost type	2024-25 Permanent £000	2024-25 Other £000	2024-25 Total £000	2023-24 Permanent £000	2023-24 Other £000	2023-24 Total £000
Salaries and wages	259,992	947	**260,939**	235,532	648	233,180
Social security costs	25,347	-	**25,347**	24,851	-	24,851
Apprenticeship levy	1,288	-	**1,288**	1,061	-	1,061
Employer's contributions to NHS pension scheme	32,614	-	**32,614**	29,297	-	29,297
Pension cost - employer contributions paid by NHSE on YAS's behalf (2024-25 9.4%; 2023-24 6.3%)	21,164	-	**21,164**	12,495	-	12,495
Termination benefits	126	-	**126**	325	-	325
Temporary staff	-	5,110	**5,110**	-	4,988	4,988
Total staff costs	**340,531**	**6,057**	**346,588**	**303,561**	**5,636**	**306,197**

Average number of employees (WTE basis)

Staff group	2024-25 Permanent Number	2024-25 Other Number	2024-25 Total Number	2023-24 Permanent Number	2023-24 Other Number	2023-24 Total Number
Medical and dental	3	-	**3**	2	-	2
Ambulance staff	4,089	69	**4,158**	4,624	173	4,797
Administration and estates	2,010	92	**2,101**	1,002	22	1,024
Nursing, midwifery and health visiting staff	119	11	**129**	83	15	98
Scientific, therapeutic and technical staff	5	-	**5**	2	1	3
Total average numbers	**6,225**	**171**	**6,396**	**5,713**	**211**	**5,924**

Note

* Call centre staff are classified within Administration and Estates for 2024-25. In 2023-24, call centre staff were classified within Ambulance Staff.

Exit Packages (subject to audit)

Details of exit packages agreed over the year are detailed in the following tables.

Exit Packages agreed in 2024-25

Exit packages 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	£000	Number	£000	Number	£000
Less than £10,000	-	-	7	29	**7**	29
£10,000 - £25,000	-	-	-	-	**-**	-
£25,001 - £50,000	-	-	-	-	**-**	-
£50,001 - £100,000	1	97	-	-	**1**	97
£100,001 - £150,00	-	-	-	-	**-**	-
£150,001 - £200,000	-	-	-	-	**-**	-
>£200,000	-	-	-	-	**-**	-
Total	**1**	**97**	**7**	**29**	**8**	**126**

Exit Packages agreed in 2023-24

Exit packages 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	£000	Number	£000	Number	£000
Less than £10,000	-	-	1	2	1	2
£10,000 - £25,000	1	14	1	11	2	25
£25,001 - £50,000	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	-	-
£100,001 - £150,00	1	120	-	-	1	120
£150,001 - £200,000	1	178	-	-	1	178
>£200,000	-	-	-	-	-	-
Total	**3**	**312**	**2**	**13**	**5**	**325**

Exit Packages – other departures analysis

Other exit packages - disclosures (Exclude Compulsory Redundancies)	2024-25 Number of exit package agreements	2024-25 Total value of agreements	2023-24 Number of exit package agreements	2023-24 Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-		
Mutually agreed resignations (MARS) contractual costs	-	-		
Early retirements in the efficiency of the service contractual costs	-	-		
Contractual payments in lieu of notice	7	29	2	13
Exit payments following employment tribunals or court orders	-	-		
Non-contractual payments requiring HMT approval	-	-		
Total	**7**	**29**	**2**	**13**
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

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.

There were no departures where special payments have been made in 2024-25 or 2023-24.

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number of exit packages may not necessarily match the total number in the table above.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Consultancy costs
The Trust spent £453k in 2024-25 (2023-24: £705k) on external consultancy costs.

Off-payroll engagements
The Trust does not have any off-payroll engagements.

Volunteers

We are proud of the number of individuals who provide unpaid work for the Trust who are a crucial part of our workforce. These roles support colleagues working in our Patient Transport Service (PTS) and operational roles.

Volunteer role	Sum of Headcount
Volunteer Car Driver	205
Community First Responder	766
Patient Safety Partner	2
Community Engagement Volunteer	20
Critical Friend	12
Total	**1,005**

Safeguarding and Employment Checks

In accordance with safeguarding requirements the Trust ensures full compliance with the NHS Employment Checking Standards for all appointments. The Trust is committed to meeting the requirements of the fit and proper persons testing (FPPT) process and applies this rigorously. During 2024-25, the Trust's FPPT processes were audited and received significant assurance in recognition of the Trust's robust processes.

Staff Health and Wellbeing

The physical and mental health and wellbeing of staff remains a top priority for the Trust. However, demand pressures across the health system coupled with the high levels of anxiety, stress and sickness absence remain a challenge.

During 2024-25 the Trust implemented its Health and Wellbeing Plan with a focus on holistic approaches to support the physical and mental needs of staff. The eleven priorities contained within the plan were driven by evidence-base and user experience. The year end position against the plan was positive, with most priorities delivered as planned and with demonstrable impact.

Sickness absence during 2024-25 was 7%, an increase from 6.6% in the previous year. Sickness absence peaked at around 8%, with the highest increases affecting operational staff groups. Towards the end of 2024-25 sickness absence levels began to decrease and stabilise.

Month	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Sum of Absence FTE Days (Assignment)	10,792	11,613	11,214	12,589	11,952	12,133	13,494	14,053	17,670	16,210	13,682	14,582

Month	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Sickness Percentage	6.0%	6.3%	6.2%	6.7%	6.3%	6.5%	6.9%	7.4%	8.9%	8.1%	7.5%	7.2%

The Trust is committed to creating a safer working environment for its staff. Evidence of progress in this area comes from the most recent National NHS Staff Survey results which show increasingly positive scores regarding staff health, safety and wellbeing. For example, 53% of

respondents either agreed or strongly agreed that the Trust takes positive action on health and wellbeing. The survey results for staff morale also improved for the fourth consecutive year.

Culture Development
Full advantage was taken of the NHS England funded People Promise Exemplar initiative enabling continuation of the YAS Together culture development journey. The YAS Together ways of working recognise that our people are what makes YAS great and includes the YAS Together pillars (Care Together, Lead Together, Grow Together, Excel Together, Everyone Together), and enablers such as a talent management framework, succession planning, leadership behaviours, as well as a range of interventions used to foster team development and enable organisational development.

The YAS Together culture development work was based on a Board-level Culture Maturity self-assessment, an NHS England People Promise self-assessment and our NHS Staff Survey results. As part of this work strong progress has been made against all six of the Ambulance-specific recommendations of the Culture Review of Ambulance Trusts.

The NHS Staff Survey 2024 results show year-on-year improvements, with improvements in all themes from the 2023 results and that YAS benchmarks as best in sector, or very close to best, in six of the nine themes. Statistically significant progress was made in 'We are safe and healthy', 'We work flexibly' and 'Morale' themes.

The embedding of YAS Together ways of working and pillars included alignment to our STARS Awards, development of services, interventions and support tools available now, digital assets developed to visually connect YAS initiatives to the relevant pillar, e.g., branded leadership development programmes to Lead Together, and a series of roadshows delivered jointly with the Strategy Team.

Safer Culture: Sexual Safety
The Trust is committed to the provision of a safe working environment for all. During 2024-25 the Trust established a Sexual Safety working group to proactively promote sexual safety in the workplace and to develop training, support and sanctions relating to this. The Trust established a Professional Standards Panel (PSP) which ensures that senior leaders have a robust framework for decision making relating to sexual safety in the workplace. This provides greater assurance for all parties regarding the expected standards of behaviour and the appropriate and proportionate actions to be taken when these standards are not met. Senior leaders have received specialist training with regards to handling sexual safety concerns in the workplace.

Our people policies
The Trust's workforce and organisational development policies are formally reviewed every three years, or more frequently if required to ensure that they are fit for purpose and reflect the latest requirements, legislation, and good practice. This includes engagement with trade union colleagues and input from equality networks in the policy review and development process. The Trust develops toolkits and additional guidance for managers to support the implementation of policies.

Engagement with staff representatives
The Trust remains fully committed to working in partnership with recognised Trade Unions (UNISON, GMB, Unite the Union and Royal College of Nursing.) The Trust works closely with trade union colleagues and maintains several forums for both informal and communications.

For example, the main Joint Steering Group is a mechanism for trade union leads to meet with senior management to maintain regular dialogue and resolve matters swiftly. All policies and procedures that have a potential impact on staff are reviewed with trade union partners.

Trade Union Facility Time
The Trust supports regular and consistent trade union facility time across main union partners which is returned in line with requirements for all public sector bodies. Details of the disclosures required under the Trade Union (Facility Time Publication Requirements) Regulations 2017 are available on the Trust website at: https://www.yas.nhs.uk/publications/facility-time-publication/

Leadership and Organisational Development

Appraisal and Career Conversations
The focus for 2024-25 has been to embed and enable quality Appraisal and Career Conversation and to achieve a minimum Trust compliance rate of 90% by the end of March 2025. At the end of March 2025, the appraisal compliance was 74.5% with three directorates over 90% and two above 80%.

Operational winter pressures including the prioritisation of services resulted in appraisals for operational areas being stood down which has had an impact on the compliance rate, that had been showing a positive trajectory until this point.

The development of the Online Appraisal and Career Conversation with a Robotic Process Automation (RPA) has been ongoing throughout 2024-25. Final testing and launch started in March 2025 and should see an increase in completion and compliance as this is fully adopted across the organisation.

Leadership Development
Our commitment for 2024-25 was to continue to deliver our newly developed leadership development programmes (Aspiring Leaders and Lead Together). Both programmes have been fully implemented into the Leadership Development Pathway with:

- Aspiring Leaders - 4 programmes delivered with 50 participants in total.
- Lead Together - 6 programmes delivered with 58 participants in total.

The Aspiring Leaders programme was oversubscribed and demand for this was high. Additional programmes have been facilitated and waiting lists created. All programmes are full up to and including February 26 cohort 6 2025-26.

Education and Learning
As part of our People Bold Ambition, we have maintained our commitment to apprenticeships to develop core skills and roles. YAS was rated #23 in the Department for Education Top 100 Apprenticeship Employers 2024 and was the third highest rated NHS Trust. This was an improved rating from #36 in 2023. The rankings are based on the number of new apprentices starts, the diversity of apprentices and the number completing their end point assessment.

The total number of apprentices in YAS at the end of March 2024 was 769, which equates to 10.6% of our workforce as apprentices. We saw 523 new apprentices in 24-25, which is an increase from 396 in 23-24. This is the highest representation we have recorded and is in part due to the variety of staff apprenticeships being utilised (Project Management, Customer Service, Cyber Security, Business Administration, Improvement Practitioner, Team Leaders and

Senior Leadership) and the introduction of a new Enhanced Clinical Practitioner apprenticeship at Level 7 to develop our Specialist Paramedics.

The quality outputs of our apprenticeship programmes remain strong with 51% of our Ambulance Support Workers (Level 3) and 95% of our Associate Ambulance Practitioner (Level 4) achieving a distinction, and 56% of our Paramedic Degree Apprentices achieving a first-class honours degree.

We are very grateful to our ten apprenticeship levy transfer partners where 2024-25 saw the highest apprenticeship levy transferred to support our workforce development. £4.94K was received representing a saving to the Trust of £247K (offsetting 5% co-investment) compared to £2.74K in 23-24.

In collaboration with key stakeholders the pipeline for the 'Pathway to Paramedic' has been strengthened adopting a quality improvement approach. An initiative to optimise the capacity on scheduled workforce development programmes has been highly successful with an average 98% learner places occupied and workforce requirements fulfilled.

Awards

STARS Awards 2024
Inspirational Yorkshire Ambulance Service (YAS) staff and volunteers who have gone the extra mile for patients and colleagues were honoured at the Trust's annual STARS Awards in November 2024.

The event, held in Leeds, was an opportunity to celebrate exceptional achievements and recognise their ongoing commitment to providing the best care to the people of Yorkshire and supporting their colleagues and the wider YAS team.

This year, we received over 120 nominations, which were reviewed by panels of judges made up of our executive and non-executive directors who had the difficult job of selecting individuals and teams to be shortlisted.

Highlights included staff who were recognised for their bravery in a firearms incident, a crew who helped to rescue a patient who had fallen into a river and a colleague who works with rough sleepers to better understand barriers to accessing the ambulance service.

Long Service Awards
During the 2024 Long Service Awards event, we recognised over 260 colleagues with a combined service of over 5,470 years. Awards included those for staff who have reached their 20, 30, 40 and 50-year milestone in the NHS. Also presented were the King's and Queen's Long Service and Good Conduct Medals, given to colleagues with 20 years' exemplary frontline emergency service.

At the event in Harrogate, the awards were presented by Chair Martin Havenhand and Simon Mackaness, His Majesty's Deputy Lieutenant of North Yorkshire.

Among our awardees were colleagues who have reached an incredible 40 years' service. They included Neil Bellamy, Bob Greenwood, Stuart McPherson, Stephen Whiteley, Julie Hook and Russell Brunt. Husband and wife team Alan and Diane Laverie, who have clocked up a remarkable 99 years of combined service between them, also received their long service awards.

We also celebrated the fantastic achievement of Stefan Frankowiak, who has worked in the ambulance service for over 50 years. Stefan stepped down from A&E five years ago and moved onto our non-emergency Patient Transport Service.

Corporate Governance

Openness and Accountability Statement

The Trust complies with the Nolan Principles on Conduct in Public Life and the Trust's Duty of Candour 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 six times each year 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 yas.patientrelations@nhs.net

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

Fraud prevention
Yorkshire Ambulance Service NHS Trust is committed to supporting NHS Counter Fraud Authority 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 in 2023-24 was via 360 Assurance, Oak House, Moorhead Way, Bramley, Rotherham, South Yorkshire S66 1YY, www.360assurance.co.uk

NHS Code of Governance

NHS Trusts are expected to publish a declaration of their compliance with the NHS Code of Governance (2023). The Trust undertakes an annual self-assessment of its compliance with the Code of Governance. The output of this assessment is reported to the Audit and Risk Committee. For 2024-25 the Trust is declaring a position of full compliance.

An internal audit review undertaken during 2024-25 confirmed that the Trust's approach to self-assessment against the Code is robust. It also confirmed that areas of partial compliance and non-compliance identified by the 2023-24 self-assessment had been addressed satisfactorily.

The NHS Code of Governance requires trusts to provide a specific set of disclosures in their annual report. The disclosures listed below are supported by information found in this annual report. The table indicates the sections of the annual report in which the relevant information is found.

Code of Governance Reference		Annual Report Disclosure Requirements	YAS Annual Report Section(s)
Section	**Para**		
A	2.1	The board of directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships.	Performance Report
A	2.1	The Trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Performance Report Annual Governance Statement
A	2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action.	Our People
A	2.3	The annual report should explain the Board's activities and any action taken, and the Trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Our People
A	2.8	The Board of Directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for	Our Partners System Working

Code of Governance Reference		Annual Report Disclosure Requirements	YAS Annual Report Section(s)
Section	**Para**		
		collaboration with other providers into which the Trust has entered.	
A	2.8	The Board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Annual Governance Statement
B	2.6	The Board of Directors should identify in the annual report each non-executive director it considers to be independent, in accordance with the Code's criteria for independence.	Directors' Report
B	2.13	The annual report should give the number of times the Board and its committees met, and individual director attendance.	Directors' Report
C	4.2	The Board of directors should include in the annual report a description of each director's skills, expertise and experience.	Directors' Report
C	4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Annual Governance Statement
C	4.13	The annual report should describe the work of the remuneration and nominations committee.	Annual Governance Statement
D	2.4	The annual report should include the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed.	Not applicable to 2024-25.

Code of Governance Reference		Annual Report Disclosure Requirements	YAS Annual Report Section(s)
Section	**Para**		
D	2.4	The annual report should include an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans.	Annual Governance Statement
D	2.4	The annual report should include, where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit.	Not applicable to 2024-25
D	2.4	The annual report should include an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Not applicable to 2024-25
D	2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Statement of Directors' Responsibilities
D	2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks.	Annual Governance Statement
D	2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The Board should report on internal control through the annual governance statement in the annual report.	Annual Governance Statement
D	2.9	In the annual accounts, the Board of Directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern.	Performance Report
E	2.3	Where a Trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable to 2024-25

NHS Oversight Framework

NHS England's Oversight Framework is a national assurance framework for overseeing provider performance and to help identify trusts that potentially have additional support needs.

All NHS organisations are allocated to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs for a Trust, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met.

At the end of 2024-25 Yorkshire Ambulance Service NHS Trust continued to be allocated to segment 2.

The Care Quality Commission

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 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 2024-25.
- YAS has not participated in any special reviews or investigations by the CQC during 2024-25.

The most recent full CQC inspection of the Trust took place in 2019. This resulted in an overall rating of **Good** for the Trust. Since then, the Trust has continued its own programme of internal inspections, self-assessments, and action plans, including an external Well-Led review supported by NHS England, to ensure that the standards required by the CQC are sustained.

Annual Governance Statement

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

The Purpose of the System of Internal Control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Yorkshire Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

<u>The Board of Directors</u>
The Board of Directors ('the Board') has overall responsibility for the management of risk within the organisation. The Board ensures that the Trust's system of governance, risk management and internal control meets the needs of the organisation, aligns with good practice, and complies with regulatory requirements.

The Board sets the strategic objectives for the Trust and allocates suitable resources to deliver these. The Board receives assurance regarding principal risks to these strategic objectives, including updates on controls and mitigation actions. This assurance is achieved via the Board Assurance Framework, risk management reports, and other assurance reports received from internal and external sources.

<u>Board Membership</u>
During 2024-25 the Trust Board membership was as follows:

- Chair*
- Five Non-Executive Directors*
- Chief Executive Officer*
- Chief Operating Officer*
- Executive Director of Finance*
- Executive Medical Director*
- Executive Director of Quality and Chief Paramedic*
- Deputy Chief Executive
- Director of People and Organisational Development

(* denotes full / voting members)

Contributory directors operating at Board-level were as follows:

- Three Directors of Partnerships and Operations, aligned to integrated care systems.
- Director of Strategy, Planning and Performance
- Director of Corporate Services and Company Secretary
- Chief Digital Information Officer

Changes to Board Membership and Related Director Roles.
Changes to Non-Executive Director positions or personnel during 2024-25 were as follows:

- Jeremy Pease left the position of Non-Executive Director in January 2025.
- Saghir Alam commenced as Non-Executive Director in February 2025.

During 2025-26 two Non-Executive Directors will reach the end of their terms of office with the Trust. These are Tim Gilpin (July 2025) and Anne Cooper (December 2025).

During 2024-25 the Trust appointed three Associate Non-Executive Directors. Katherine Lees, Tabitha Arulampalam and Rebecca Randell each commenced as Associate Non-Executive Director in February 2025. (Rebecca Randell had been a NExT Director with the Trust since April 2024).

Changes to Executive Board positions or personnel during 2024-25 were as follows:

- Marc Thomas commenced as Deputy Chief Executive in April 2024.
- Julian Mark retired from the position of Executive Medical Director on 1 April 2025 and was replaced by Steven Dykes as Acting Medical Director.

Changes to Contributory Director positions or personnel during 2024-25 were as follows:

- Samantha Robinson commenced as Chief Digital Information Officer in June 2024.

The Role and Work of the Board
The Board is primarily responsible for:

- Strategy: vision, Trust objectives, key plans, organisational development and change.
- Culture: sustained focus on patients and care; Trust values; visible and supportive leadership; culture and behaviour within the workforce and in the workplace
- Accountability: significant decisions, delivery priorities, and performance assurance.
- Engagement: building and sustaining value-adding relationships with stakeholders to promote the Trust and its objectives.
- Resources: securing and allocating resource to invest in people and infrastructure whilst safeguarding the Trust's financial stability.
- Corporate health: governance, risk management and internal control, organisational resilience, compliance with regulatory, legal and policy frameworks.

The work of the Board is co-ordinated by the Trust's corporate governance function which fulfils the role of Trust secretariat. Board-level business is managed via a structured work plan co-ordinated across the Board and its assurance committees. This ensures appropriate focus on

formal governance and assurance and is sufficiently agile to flex in response to changing circumstances or urgent matters.

During 2024-25 the Board held seven ordinary meetings in public. The Annual General Meeting held in September 2024. The Board also held formal sessions in private as appropriate. In addition, a programme of informal Board Strategic Forum sessions facilitated in-depth coverage of specific topics. Key items addressed during the 2024-25 Board Strategic Forum sessions included:

- Business Plan Priorities
- Financial Planning
- Health Inequalities and Social Value
- Community Engagement
- Board Assurance Framework
- Sexual Safety
- Patient Transport Service: Contracting Strategy
- Emergency Preparedness, Resilience and Response
- Board Governance / Insightful Provider Board
- Charitable Trustee
- Cyber Security
- Performance Management Framework
- Equality, Diversity and Inclusion, including Anti-Racism
- System and Partnership Working

During 2024-25 the Board was supported by the following committees:

- Audit and Risk Committee
- Finance and Performance Committee
- Quality Committee
- People Committee
- Trust Executive Group
- Remuneration and Nominations Committee.
- Charitable Funds Committee, which supports Board members in discharging their responsibilities as the corporate trustee of the Yorkshire Ambulance Service Charity.

<u>Trust Executive Group</u>
The Trust Executive Group maintains an effective risk management system within the Trust, meeting statutory requirements and adhering to guidance issued by governmental and other statutory or regulatory bodies. The Trust Executive Group includes key roles relating to governance, risk and assurance including:

- The Deputy Chief Executive is the Trust's Senior Information Risk Owner (SIRO) and has overall responsibility for risk management policy and processes, including information governance and cyber security.
- The Executive Director of Quality and Chief Paramedic is responsible for maintaining effective and compliant quality governance systems, including patient safety, incidents, and investigations.

- The Executive Director of Finance is responsible for managing all aspects of financial risk and control, including the Trust's financial systems and procedures, income and expenditure, revenue and capital budgets, business cases and investment opportunities, procurement and contracts, fleet, and estates.
- The Medical Director is responsible for clinical governance and clinical risk management, ensuring that clinical practice is appropriate and effective, compliant, and current.
- The Director of Corporate Services and Company Secretary is responsible for effective systems of board and committee governance, compliance with the NHS Code of Governance and other regulatory frameworks, and strategic risk management.

Everybody's Business

The Trust considers risk management to be everybody's business. Directors and managers throughout the Trust ensure that effective risk management is implemented within their scope of responsibilities in accordance with Trust policies. The Trust promotes a positive risk culture that empowers all employees and volunteers to identify and assess risks. The Trust supports staff and volunteers to manage risk through:

- Corporate and local induction processes, which includes specific content on risk and incident management.
- Risk management training.
- The Trust's risk management policy and procedures, including tools and templates to identify, evaluate and manage risk.
- The Risk and Assurance Group, which provides oversight and moderation of risks and is a forum for developing and sharing good practice.
- Thematic groups which oversee areas of technical or specialist risk, such as the Information Governance Working Group and the Clinical Governance Group.
- A network of designated risk management leads in services and functions.
- The corporate Risk and Assurance Team, which supports staff to develop consistent risk management practice.
- Access for staff to the Trust's risk management system, plus training and support to make the most effective use of these systems.

The Risk and Control Framework

Risk Management

The Board identifies risk as part of the Trust's cycles of strategic development and annual planning. The Board assesses its overall risk profile, considering key business risks, Trust capacity and capability to address these, and its appetite for risk exposure and tolerance of residual risk. The Board Assurance Framework captures strategic risks to Trust objectives and is reviewed and refreshed by the Board at least annually.

Corporate risks, and areas of emerging risk, are reviewed and moderated by the Risk and Assurance Group. Risks that cannot be managed through the Risk and Assurance Group are escalated to the Trust Executive Group and reported to the appropriate assurance committee or the Board. The Board is routinely notified of all new corporate risks and material changes to existing risks via the corporate risk register and assurance reports.

Risk management is linked to other governance and managerial processes in the Trust, including incident management, operational risk assessments, and impact assessments relating to quality, equalities, and data protection.

Quality Governance
Quality is critical to the Trust's mission and is central to proceedings of the Board. Quality is primarily understood in terms of three dimensions: patient safety, clinical effectiveness, and patient experience. Assurance reporting includes a focus on key quality indicators, supplemented by detailed reports containing qualitative and quantitative information on specific aspects of quality governance.

The Quality Committee scrutinises the Trust's clinical governance and quality plans, provides oversight of clinical strategy and practice, compliance with external quality regulations and standards, processes to ensure learning from adverse events, and infection prevention and control. In addition, the Quality Committee provides scrutiny in relation to the Trust's Quality Improvement strategy, actions resulting from external investigations and inspections, patient experience, complaints and concerns, and coroners' court proceedings.

During 2024-25 the Trust experienced no nationally defined 'Never Events' in relation to the quality of its care or services.

Annual Quality Account
Under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) the Trust is required to prepare Quality Accounts for each financial year. The Quality Account reports on key indicators of quality relating to patient safety, clinical effectiveness, and patient experience.

The Trust's Quality Account is formally published alongside the Annual Report and Accounts as part of the Trust's suite of year-end reporting.

Risk Governance
The Trust recognises that risk management must be embedded in the organisation's culture, practices, and business processes.

<u>Risk Management and Assurance Strategic Framework</u>
The Risk Management and Assurance Strategic Framework sets out the Trust's overall approach to risk management. The Framework is based on the three lines of assurance model. It emphasises the links between risk management and organisational strategies, plans and objectives, and it explains the roles and responsibilities of individuals, management groups, and governance bodies.

During 2024-25 the Risk Management and Assurance Strategic Framework was reviewed and updated to align with the Trust's 2024-29 strategy and to reflect changes to the Trust's leadership and governance structures.

<u>Board Assurance Framework</u>
The Board Assurance Framework is owned by the Trust Board. It embodies the ownership by the Board of strategic risks to Trust objectives. The Board Assurance Framework sets out the strategic risks to the organisation's objectives and associated controls and mitigations. It identifies opportunities to develop and strengthen controls, and it identifies key sources of internal and external assurance.

Strategic risks for 2024-25 were set out in the Board Assurance Framework and organised under the Trust's four strategic ambitions as follows:

Our Patients

- Ability to respond in a timely manner to patients
- Ability to provide patients with appropriate access to care.
- Ability to support patient flow across the health and care system.
- Ability to strengthen quality governance and medicines management.
- Ability to develop and maintain effective emergency preparedness, resilience and response arrangements.

Our People

- Ability to develop and sustain an open and positive workplace culture.
- Ability to support staff health and well-being effectively.
- Ability to deliver and sustain improvements in recruitment and retention.
- Ability to deliver and sustain improvements in leadership and staff development.

Our Partners

- Ability to act as a collaborative, integral, and influential system partner.
- Ability to collaborate effectively to improve population health and reduce health inequalities.

Our Planet and Pounds

- Ability to secure sufficient levels of revenue resource and use this well.
- Ability to secure sufficient levels of capital resource and use this well.
- Ability to deliver safe and effective digital technology and cyber security developments.
- Ability to respond responsibly and effectively to climate change.

Mitigation plans were developed and implemented for each strategic risk. Progress in implementing the actions set out in the Board Assurance Framework is assessed following review by Executive Directors and other senior leaders, triangulated with other sources of assurance, and reported to the Trust Board and its committees. Quarterly iterations of the Board Assurance Framework are supported by reports on current and forecast risk exposures and analysis of deviations from expected levels of risk.

During 2024-25 three of the Board Assurance Framework strategic risks were subject to heightened risk exposures above the forecast risk trajectory:

- Strategic Risk 3: Patient Flow
  Hospital handover times deteriorated markedly during the autumn. Mitigations included focused work with partners, including the implementation of operational / clinical protocols ('Transfer of Care') relating to handover time limits. Implementation of these protocols had a notable positive impact, resulting in clear reductions in handover delays and associated improvements in ambulance response times.
- Strategic Risk 8. Recruitment and Retention
  This risk was forecast for reduction from high risk to moderate risk during the year, based

on the planned improvement in both recruitment and retention levels. The Trust did achieve high levels of recruitment across most service areas, although modest variances have affected some staff groups. However, retention remained more challenging and although some improvements were evident the People Committee advised that it would be premature to reduce the risk.

- Strategic Risk 12. Revenue Resources
  The Trust's revenue position carried significant risk during much of the year, derived from internal and external factors. Mitigations included a series of 'grip and control' measures and budget reviews introduced by the Trust to reduce discretionary expenditure, as well as enacting technical adjustments. The impact of these and other measures meant that the Trust achieved a break-even position for 2024-25.

During 2024-25 the Trust's Board Assurance Framework and associated processes underwent an internal audit review. The review reported 'significant assurance' and identified instances of leading practice.

Corporate Risks

The Board and its committees receive regular risk reports to enable oversight of current risk exposures and to provide early sight of emerging risks. During 2024-25 the most significant areas of corporate risk managed by the Trust included the following:

- The impact of hospital handover delays on ambulance capacity and patient safety.
- The potential impact of industrial action by General Practitioners.
- The impact of the Right Care Right Person operational policing model.
- Operational performance, particularly during winter pressures.
- Ambulance fleet availability.
- Delayed system approval of eligibility criteria for the Patient Transport Service.
- Availability of capital funding, particularly for estates.
- Clinical staffing levels in call-handling operations.
- Adherence to controlled drugs and medicines management procedures.
- Major incident planning, capability, exercising and capacity.
- Technology risk, including communications system issues, system vulnerability, and clinical data records management.
- Capacity and capability to manage safeguarding allegations, incident investigations, complaints, and other governance and assurance processes.

Corporate Governance: Provider License and Code of Governance

In line with the requirements of the NHS Provider Licence and the NHS Code of Governance (2023), the Trust has in place a sound system of corporate governance and arrangements are in place to manage risks relating to:

- The effectiveness of governance structures.
- The responsibilities of directors and committees.
- Reporting lines and accountabilities between the Board, assurance committees, and the executive team.
- The submission of timely and accurate information to assess risks to compliance with the conditions of the provider licence.
- The degree and rigour of oversight the board has over the Trust's performance.

During 2024-25 the Trust progressed actions to identity and mitigate any notable risks relating to the above. This included:

- Review and update of the structures, accountabilities, and reporting lines of the Board assurance committees.
- Review and update of Board meeting formats and agendas, with strengthened arrangements for performance and assurance reporting.
- Review and update of the Trust's Standing Orders and Standing Financial Instruments.
- Development of a strengthened Performance Management Framework and associated processes and reporting.
- An internal audit review of the Board Assurance Framework. This review reported significant assurance.
- An internal audit review of compliance with the NHS Code of Governance. This review reported significant assurance.
- An internal audit review of compliance with the Fit and Proper Person Test for Board members. This review reported significant assurance.

During 2024-25 the Board continued a structured development programme supported by an external facilitator (Integrated Development Ltd). This facilitator is independent of the Trust and no board member has a commercial or otherwise prejudicial connection with the company concerned. A board development action plan was developed and implemented during 2024-25. Further Board development work will be undertaken during 2025-26, in line with good practice guidance such as the Insightful Provider Board framework.

Strategic Risk Outlook

The Trust's strategic risk outlook for 2025-26 is informed by routine review of corporate risks and the Board Assurance Framework combined with analysis of ongoing developments and changes affecting the organisation and the wider health and care system.

For the 2025-26 the main areas of strategic risk to the Trust remain as set out in the Board Assurance Framework. Within that context, however, particular elements of risk are likely to be significant. Examples include:

- Operating with available revenue finances during 2025-26, including the need to identify and deliver significant cost reductions and productivity gains.
- The impact of national and system-level restructuring and cost reduction programmes (NHS England, Integrated Care Boards)
- Implementation of major infrastructure schemes such as NHS Pathways and the Hull hub.

Review of Economy, Efficiency, and Effectiveness of the Use of Resources

Financial Risk

Executive management of financial risk is led by the Executive Director of Finance. During 2024-25 the Board's duties relating to financial risk were discharged via the Finance and Performance Committee. This committee scrutinises the Trust's financial plans, policies and major investment decisions, reviews proposals for major business cases, and oversees the commercial activities of the Trust. The committee also scrutinises the content and delivery of the Trust's organisational efficiency initiatives.

Information Governance

The Trust has an Information Governance Framework and supporting policies which establish control regarding information risk and data security. The Trust complies with information governance and data protection obligations as defined by the United Kingdon General Data Protection Regulations (UK GDPR) and the Data Protection Act. In accordance with UK GDPR requirements, the Trust has a Senior Information Risk Owner (supported by two deputies), a designated Data Protection Officer, and a register of Data Protection Impact Assessments.

Management of information risk is supported by the Trust's Information Governance Working Group, which reports through the Risk and Assurance Group. Areas of information risk identified and assured by the Information Governance Working Group during 2024-25 included:

- Transition from the DSPT to the new CAF standards
- Storage and retention of paper records.
- Management and destruction of confidential waste.
- Compliance with mandatory data security awareness training.
- Staff susceptibility to email phishing campaigns.
- Cleansing and re-structuring of data files.
- Closure of NHSmail accounts for employees who leave the Trust.
- Management of shared mailboxes and distribution lists within NHSmail.
- Management of Subject Access Requests and Freedom of Information requests.

During 2024-25 the Trust took the following actions to mitigate information and data security risks and to strengthen assurance relating to these:

- Provision of mandatory Data Security Awareness e-Learning to all staff.
- Communications campaigns to raise staff awareness of malicious emails and how to manage these.
- A proactive email phishing exercise delivered via the Trust's internal audit plan.
- Continued engagement and development of Information Asset Owners.
- Board-level training in cyber security and information assurance.
- Reviewed and updated the central Information Asset Register.
- Reviewed and updated the central suite of data flow maps.
- Data Protection Impact Assessments relating to system and service developments.
- Secure archiving and destruction of records in accordance with the Records Management Policy and retention schedule.
- Actions arising from the Trust's Data Security and Protection Toolkit audit.
- Training and support for the Senior Information Risk Owner and deputies.
- Strengthened provision regarding the Clinical Systems IT Safety Officer and compliance with associated regulations.

The Trust observes the expectations of the Data Security and Protection Toolkit, a regulatory framework that requires NHS organisations to assess compliance with data security standards set by the National Data Guardian. During 2024-25 the Trust used this toolkit to provide assurance that it practises good data security, and that personal information is handled correctly. The Trust reported that all standards were met.

The Trust's Data Security and Protection Toolkit self-assessment is reviewed annually by internal auditors to provide independent assurance regarding the declared degree of compliance. For 2024-25 this exercise reported a 'moderate' level of assurance, which is the second highest of four available ratings in the NHS England assurance model.

The Trust has a designated Caldicott Guardian (the Deputy Medical Director) and upholds the Caldicott principles concerning the governance of patient identifiable information.

During 2024-25 the Trust experienced no information governance incidents of sufficient significance to merit reporting to the Office of the Information Commissioner (ICO) or other statutory or regulatory bodies.

Cyber Assessment Framework

In September 2024 the Data Security and Protection Toolkit changed its basis for cyber security and information governance assurance to adopt the National Cyber Assessment Framework (CAF) supported by the Cyber Security Centre. This framework:

- Emphasises good decision-making over compliance, with better understanding and ownership of information risks at the level at which those risks can most effectively be managed.
- Supports a culture of evaluation and improvement, as the Trust will need to understand the effectiveness and impact of its practices.
- Creates opportunities for better practice, by prompting and enabling the Trust to remain current with new security measures to meet new threats and risks.

Under the new arrangements the expectations for cyber security and information governance controls remain broadly comparable to the outgoing Data Security and Protection Toolkit, tightening only in those areas where NHSE and DHSC believe the higher standard to be a necessary obligation.

Data Quality and Governance

During 2024-25 the Trust undertook multiple actions to support good data quality. The Trust:

- Continued to develop the Electronic Patient Record and Electronic Staff Record systems, delivering enhancements that improve the quality and use of data.
- Progressed digital change projects that present opportunities to improve the quality and use of data and information flows, within the Trust and in partnership across integrated care systems.
- Furthered the use of the analytics platform, Power BI, including the development of dashboards to support the performance management of teams and individuals.
- Undertook an internal audit review of data quality relating to inequalities performance metrics.
- Continued to provide general staff training in the use of systems, including on the importance of accurate data entry, data quality and reporting.

During 2024-25 the Trust did not submit records to the Secondary Uses Service for inclusion in the published Hospital Episode Statistics datasets. This requirement does not apply to ambulance trusts.

Workforce

In support of the ‘Developing Workforce Safeguards’ requirements the Trust develops annual workforce plans, targets and trajectories for recruitment, development, and retention to provide sufficient and safe workforce numbers across key staff groups.

The Trust's operational planning processes include a systematic approach to determining the number of staff and range of skills required to meet the needs of our service users. This is to ensure that care provision is timely and effective, that patients have a positive experience of our services, and that they are safe in our hands.

In 2024-25 the Trust continued its focus on the 'Our People' strategic risks associated with workforce through the People Committee (an assurance committee of the Board) and the People and Culture Group (an executive management group), and through the relevant sections of the Trust business plan priorities and Board Assurance Framework actions.

The Trust has longer-term workforce plans in place as part of the 'Our People' elements of the Trust strategy for 2024-29. This includes improved approaches to recruitment and retention, the continued success of apprenticeship programmes, training and development, talent management, leadership development, and succession planning. It also includes a focus on professional standards and the ongoing development of the paramedic profession.

General Compliance

The Trust maintains robust internal overview of statutory and regulatory compliance to ensure that standards are maintained across all functions. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has published an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

The Trust's counter fraud work is delivered via an annual counter fraud plan approved by the Audit and Risk Committee. For 2024-25 the Trust is reporting full compliance with the counter fraud functional standards developed by the NHS Counter Fraud Authority (NHSCFA). Independent assurance of the Trust's counter fraud work is provided by 360 Assurance (who also provide the organisation's internal audit service) and monitored by the Audit and Risk Committee.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Control measures are in place to ensure that the Trust complies with its statutory and regulatory obligations under equality, diversity, disabilities and human rights legislation, including in relation to gender pay gap reporting.

The Trust complies with its obligations under the Modern Slavery Act 2015.

During 2024-25 the Trust maintained robust processes to support staff in raising concerns about quality and safety in line with the national Freedom to Speak Up recommendations. The Trust has two designated Freedom to Speak Up Guardians and a Non-Executive Director champion. The Trust has adopted the national model policy issued by the Office of the National Guardian. Assurance regarding the Trust's Freedom to Speak Up activity is provided through reporting to the People and Culture Group, the Audit and Risk Committee, and the Trust Board.

Review of Effectiveness

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by internal audit, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for and operate within the internal control framework.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board and its supporting committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review of effectiveness is informed by other key sources of assurance, including:

- The Trust's Head of Internal Audit, who provides a formal 'opinion' of assurance regarding the framework of governance, risk management and control.
- Assurance reports from Executive Directors and senior managers who are accountable for developing and operating the system of internal control.
- The Board Assurance Framework which provides me with evidence of effective risk management, controls and mitigations relating to strategic risks.

My review is also informed by:

- Periodic internal self-assessment against the Care Quality Commission Fundamental Standards and the Well-Led Framework.
- Audited self-assessment against the Data Security and Protection Toolkit standards.
- Reports issued by the Trust's internal auditors, including core assurance reviews, risk-based and advisory work, counter fraud assurance, and technology risk assurance.
- Reports issued by the Trust's external auditors.
- Ad hoc reports commissioned from external agencies regarding the Trust's governance arrangements, leadership and management, systems and controls, and strategic capacity and capability, including periodic external evaluations against the Well-Led Framework.
- The most recent statutory regulatory compliance reporting and processes overseen by bodies such as the Care Quality Commission, NHS England, and the Department of Health and Social Care.

Care Quality Commission

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust is registered with the CQC and has no conditions on its registration. The CQC has not taken any enforcement action against the Trust during 2024-25. The Trust has not been subject to any special reviews or investigations by the CQC during 2024-25.

The most recent full inspection of the Trust took place in 2019. The CQC rated all functions examined during the inspection as 'good' across all domains and rated the Trust's Well-Led arrangements as 'good'. The inspection found no breaches in regulations and reported no actions that the Trust must take.

During 2022-23 NHS England supported the Trust to undertake a developmental review against the Well-Led framework. The outcome of this exercise was generally positive, albeit with improvement opportunities identified in most areas of the framework. The Trust developed a Well-Led action plan which was progressed during 2023-24.

Effectiveness of Risk Assurance

The Trust's risk assurance approach is based on the three lines assurance model. This model sets out how the Trust's risk management and assurance functions operate, including the interactions and boundaries between different roles, managerial functions and governance bodies. This supports the Trust to maintain effective risk management, governance, and control.

The Trust's first line assurance contains functions that directly manage risks, such as teams and managers in operational functions. Typically, these are operational managers and staff who handle risks as part of their day-to-day work.

The Trust's second line assurance contains specialist functions that oversee risk management, control, and compliance activities. These second line functions provide policies and procedures, systems and tools, advice, guidance, and other support to enable first line functions to manage risk effectively.

The Trust's third line provides independent and objective assurance regarding the effectiveness of risk management and controls. Internal audit is the key function in the Trust's third line of assurance. This third line often has interfaces with other providers of independent assurance, including external audit, regulators, and commissioners.

The Board draws evidence from all three lines to gain assurance that risk management systems and processes are identifying and managing risk appropriately. Sources of risk assurance include:

- At least annually, a review of the effectiveness of the system of internal control.
- A regular review of the Trust's Risk Management and Assurance Framework.
- Reviews in each meeting of the Audit and Risk Committee of the adequacy of assurances received by the other Board committees in relation to the principal risks assigned to them.
- Quarterly reviews of the Board Assurance Framework, including reports to the Audit and Risk Committee, assurance committees, and the Board.
- Monthly integrated performance reporting outlining achievement against key performance, safety, workforce, and quality indicators.
- Assurance reports at each meeting of the Board and the assurance committees.

- Assurance from internal and external audit reports, and other third-party assurances as may be received.

Internal Audit Programme

The Trust undertakes an annual programme of internal audit reviews to provide independent and objective third line assurance on matters of risk management, compliance and internal control. Reports from internal audit reviews provide assurance regarding the effectiveness of control frameworks and the degree of compliance with these. Outcomes of audit reviews reported during 2024-25 were as follows:

- 7 reviews reported significant assurance.
- 6 review reported limited assurance.
- 4 reviews were advisory.
- No reviews reported weak assurance.

'Limited assurance' indicates there are weaknesses in the design and / or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the objectives of the system under review. The reviews that reported limited assurance were:

- Expenses.
- Pay Expenditure Controls and Input Measures
- Data Quality: Patient Ethnicity and Health Inequalities Data.
- Controlled Drugs (revisit).
- Statutory, Mandatory and Job-Specific Training Compliance
- Health and Safety Compliance: Risk Assessments

Management action plans have been agreed to address the governance, risk management and control issues identified by all reviews.

The Trust considers that none of the individual matters identified by the 2024-25 internal audit reviews reach a level of materiality that constitutes a significant internal control issue. Similarly, the Trust considers that amongst all matters identified by internal audit reviews there is no common theme or discernible pattern, or cumulative materiality, which constitutes a significant internal control issue.

The Audit and Risk Committee is focused on the timely completion of management actions arising from internal audit reviews. During 2024-25 the organisation made good progress in resolving historically overdue actions and in improving the timely completion of new actions. During the year 98% of actions were completed (48 of 49), and 83% of medium-risk and high-risk actions were completed on time.

Head of Internal Audit Annual Opinion

The Head of Internal Audit issues an annual 'opinion' regarding the adequacy of the Trust's system of internal control. For 2024-25 the Head of Internal Audit has reported a significant level of assurance, meaning that that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

The formal statement of the Head of Internal Audit Annual Opinion is as follows:

> I am providing an opinion of significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.
>
> My opinion recognises the improvements made by the Trust in action implementation and the work undertaken to strengthen and embed strategic risk management arrangements. Reviews of fundamental systems largely received significant assurance opinions. Whilst our work to date has identified a number of areas for improvement, we acknowledge that in the main, we were directed by the Trust to areas of concern.

Audit and Risk Committee

The Audit and Risk Committee provides independent oversight of risk management, governance, and internal control within the Trust, including the annual report, accounts and financial statements.

The Audit and Risk Committee concludes upon the adequacy and effectiveness of the organisation's system of internal control, including a focus on the Board Assurance Framework and the annual internal audit programme. The committee utilises the work of internal audit, external audit, and other assurance functions, but is not limited to these. It also seeks reports and assurances from directors and managers and from other assurance committees, each of which provides formally reported assurances to the Audit and Risk Committee on risks relevant to their terms of reference.

During 2024-25 the Audit and Risk Committee undertook effectiveness reviews of both internal audit and external audit.

For the financial year 2024-25 the Audit and Risk Committee has not been required to deal with any significant issues relating to the Trust's financial statements.

During 2024-25 the Trust conducted an externally facilitated review of the effectiveness of the Audit and Risk Committee. The committee reviewed and updated its Terms of Reference in line with the HFMA Handbook for NHS Audit Committee, agreed and delivered an annual work plan, and issued an annual report.

Conclusion

No significant issues have been identified.

Peter Reading
Chief Executive

26 June 2025

Statements of Responsibility

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

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

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

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

Peter Reading
Chief Executive

26 June 2025

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Peter Reading
Chief Executive

26 June 2025

Kathryn Vause
Executive Director of Finance

26 June 2025

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF YORKSHIRE AMBULANCE SERVICE NHS TRUST

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Yorkshire Ambulance Service NHS Trust (the 'Trust') for the year ended 31 March 2025, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statements of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024/25.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report.

We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006; as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024/25; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit;
- 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 incurring of 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 make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Directors for the financial statements

As explained more fully in the Statement of the Directors' responsibilities in respect of the accounts the Directors are responsible for the preparation of the financial statements for being satisfied that they give a true and fair view. They are also responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern and disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors have been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We have considered the nature of the sector, control environment and financial performance;
- We have considered the results of enquiries with management, internal audit and the Audit and Risk Committee in relation to their own identification and assessment of the risk of irregularities within the entity, and whether they were aware of any instances of non-

compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud;
- We have reviewed the documentation of key processes and controls and performed walkthroughs of transactions to confirm that the systems are operating in line with documentation;
- Any matters identified having obtained and reviewed the Trust's documentation of their policies and procedures relating to:
    - Identifying, evaluation and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - Detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud;
    - The internal controls established to mitigate risks of fraud or non-compliance with laws and regulations;
- We have considered the matters discussed among the audit engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, we have considered the opportunities and incentives that may exist within the organisation for fraud and identified the highest area of risk to be in relation to income and expenditure recognition, with a particular risk in relation to year-end cut off. In common with all audits under ISAs (UK) we are also required to perform specific procedures to respond to the risk of management override.

We have also obtained understanding of the legal and regulatory frameworks that the Trust operates in, focusing on provisions of those laws and regulations that had a direct effect on the determination of material amounts and disclosures in the financial statements. The key laws and regulations we considered in this context are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024/25).

In addition, we considered the provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which may be fundamental to the Trust's ability to operate or avoid a material penalty. These include data protection regulations, health and safety regulations, employment legislation, and money laundering legislation.

Our procedures to respond to risks identified included the following:

- Reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- Performing analytical procedures to identify unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- Reviewing Board meeting minutes;
- Enquiring of management in relation to actual and potential claims or litigations;
- Performing detailed transactional testing in relation to the recognition of income, with a particular focus around year-end cut off; and
- In addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgments made in accounting estimates are indicative of potential bias; and evaluating the business rationale of significant transactions that are unusual or outside the normal course of business.

We also communicated identified laws and regulations and potential fraud risks to all members of the engagement team and remained alert to possible indicators of fraud or non-compliance with laws and regulations throughout the audit.

As a result of the inherent limitations of an audit, there is a risk that not all irregularities, including material misstatements in the financial statements or non-compliance with regulation, will be detected by us, even though the audit is properly planned and performed in accordance with the ISAs (UK). The risk increases the further removed compliance with a law or regulation is from the events and transactions reflected in the financial statements, given we will be less likely to be aware of it, or should the irregularity occur as a result of fraud rather than a one-off error, as this may involve intentional concealment, forgery, collusion, omission or misrepresentation.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory matters

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

As explained in the Statement of Accountable Officer's Responsibilities, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and 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. 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.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024 and related statutory guidance. We considered whether the Trust has proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2025 in accordance with the requirements of Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have:

- confirmation from the NAO that no additional work will be required in respect of the Consolidated NHS Provider Accounts exercise.

We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. 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 Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Alex Walling, Key Audit Partner
for and on behalf of Bishop Fleming LLP
Chartered Accountants and Statutory Auditors

Bristol

27 June 2025

Annual accounts for the year ended 31 March 2025

Statement of Comprehensive Income

	Note	2024-25 £000	2023-24 £000
Operating income from patient care activities	3	438,426	395,182
Other operating income	4.1	9,335	10,338
Operating expenses	5	(447,238)	(406,047)
Operating surplus/(deficit) from continuing operations		**523**	**(527)**
Finance income	9	2,815	3,860
Finance expenses	10	(687)	(605)
PDC dividends payable		(3,365)	(2,485)
Net finance (costs)/income		**(1,237)**	**770**
Other gains / (losses)	11	311	14
Surplus / (deficit) for the year		**(403)**	**257**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(4,055)	-
Revaluations	15	-	3,292
Total comprehensive income / (expense) for the period		**(4,458)**	**3,549**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	12	2,532	2,574
Property, plant and equipment	13	128,044	123,058
Right of use assets	16	25,890	21,872
Receivables	18	1,383	366
Total non-current assets		**157,849**	**147,870**
Current assets			
Inventories	17	2,657	2,402
Receivables	18	12,427	9,781
Cash and cash equivalents	21	44,177	60,207
Total current assets		**59,261**	**72,390**
Current liabilities			
Trade and other payables	22	(33,850)	(36,842)
Borrowings	24	(8,297)	(6,261)
Provisions	25	(1,908)	(3,055)
Other liabilities	23	(56)	(34)
Total current liabilities		**(44,111)**	**(46,192)**
Total assets less current liabilities		**172,999**	**174,068**
Non-current liabilities			
Borrowings	24	(17,404)	(15,174)
Provisions	25	(6,877)	(7,193)
Total non-current liabilities		**(24,281)**	**(22,367)**
Total assets employed		**148,718**	**151,701**
Financed by			
Public dividend capital		95,837	94,362
Revaluation reserve		18,455	22,510
Income and expenditure reserve		34,426	34,829
Total taxpayers' equity		**148,718**	**151,701**

The notes on pages 136 to 184 form part of these accounts.

Name: Peter Reading
Position: Chief Executive
Date: 26 June 2025

Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024	**94,362**	**22,510**	**34,829**	**151,701**
Surplus/(deficit) for the year	-	-	(403)	**(403)**
Impairments	-	(4,055)	-	**(4,055)**
Public dividend capital received	1,475	-	-	**1,475**
Taxpayers' and others' equity at 31 March 2025	**95,837**	**18,455**	**34,426**	**148,718**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023	**93,326**	**19,218**	**34,572**	**147,116**
Surplus/(deficit) for the year	-	-	257	**257**
Revaluations	-	3,292	-	**3,292**
Public dividend capital received	1,036	-	-	**1,036**
Taxpayers' and others' equity at 31 March 2024	**94,362**	**22,510**	**34,829**	**151,701**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2024-25 £000	2023-24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		523	(527)
Non-cash income and expense:			
Depreciation and amortisation	5	19,376	15,410
Net impairments	6	495	(341)
Income recognised in respect of capital donations	4.1	-	(32)
(Increase) / decrease in receivables and other assets		(3,714)	10,774
(Increase) / decrease in inventories		(255)	153
Increase / (decrease) in payables and other liabilities		(3,560)	(6,669)
Increase / (decrease) in provisions		(1,531)	(2,835)
Other movements in operating cash flows		(1)	(1)
Net cash flows from / (used in) operating activities		**11,333**	**15,932**
Cash flows from investing activities			
Interest received		2,921	3,865
Purchase of intangible assets		(872)	(305)
Purchase of PPE and investment property		(21,447)	(12,326)
Sales of PPE and investment property		383	147
Receipt of cash donations to purchase assets		-	32
Net cash flows from / (used in) investing activities		**(19,015)**	**(8,587)**
Cash flows from financing activities			
Public dividend capital received		1,475	1,036
Movement on loans from DHSC		(334)	(334)
Capital element of lease rental payments		(5,316)	(7,138)
Interest on loans		(54)	(57)
Other interest		(2)	-
Interest paid on lease liability repayments		(632)	(384)
PDC dividend (paid) / refunded		(3,485)	(2,148)
Net cash flows from / (used in) financing activities		**(8,348)**	**(9,025)**
Increase / (decrease) in cash and cash equivalents		**(16,030)**	**(1,680)**
Cash and cash equivalents at 1 April		**60,207**	**61,887**
Cash and cash equivalents at 31 March	21.1	**44,177**	**60,207**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Secretary of State for Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. No circumstances were identified causing the Directors to doubt the continued provision of NHS services.

The Trust continues to enjoy a healthy cash position of £44.2m and has sufficient liquidity with working capital (total current assets less current liabilities) of £15.2m and a cash ratio (cash and cash equivalents/total current liabilities) of 1.0.

Our going concern assessment is made up to 31 March 2026. NHS operating and financial guidance as is customary, is not produced beyond the next financial year. The Trust has assumed, in the absence of anything to the contrary, that the Department of Health and Social Care arrangements for 2025-26 and beyond will continue to support Yorkshire Ambulance Service NHS Trust in delivering high quality healthcare services for the foreseeable future.

Note 1.3 Consolidation
The Trust is the Corporate Trustee to Yorkshire Ambulance Service NHS Charities Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and could affect those returns and other benefits through its power over the fund.

The balances of Charity Funds, and transactions between the Charity and the Trust during the year were not material. The Charity accounts have not been consolidated in these accounts.

Note 1.4 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when, or as, performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Most of the Trust's income comes through contracts with NHS commissioners and performance obligations are therefore met as a consequence of elapsed time with the typical timing of payment being monthly. Given these factors, the application of IFRS 15 to contract balances does not result in a material change to the timing of income recognition.

Revenue from NHS contracts
The main source of income for the Trust is contracts with NHS commissioners for health care services. Funding envelopes are set at an Integrated Care Board (ICB) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts (API) form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. For Ambulance Services the 'fixed' element of their API contracts comprises the majority of income, with the 'variable' income element limited to compliance with national quality incentive schemes (CQUIN) only.

The fixed payment is a block value to fund an agreed level of activity at agreed performance standards. In 2024-25 the specific value of the fixed payment was agreed with commissioners through the annual planning and contract negotiation process, based on the rules set out in the NHSPS.

Revenue from NHS contracts (continued)
The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed. A proportion of the Trust's income from commissioners is considered to be the 'variable' element of the API contract. This is associated with the delivery of the local and national initiatives under the Commissioning for Quality and Innovation (CQUIN) incentive scheme. CQUIN payments are not considered distinct performance obligations in their own right. Instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2024-25 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria, with local agreement that the Trust's entitlement to consideration for CQUIN will not vary based on performance.

The Trust also receives additional income outside of the core fixed payments to reimburse specific costs incurred in 2024-25, notably delivery of the Ambulance Mental Health Programme under the national Mental Health Investment Standard (MHIS). For this programme local agreement has been reached that income will equal expenditure. Reimbursement for MHIS is therefore accounted for as variable consideration.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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

Note 1.6 Expenditure on employee benefits

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

Pension costs

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

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

National Employment Savings Trust Pension (NEST)
Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme. NEST is a defined contribution scheme managed by a third-party organisation. It carries no possibility of actuarial gain or loss to the Trust and there are no financial liabilities other than payment of the 3% employers' contribution of qualifying earnings. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. Further details of the scheme can be found at www.nestpensions.org.uk.

Note 1.7 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

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

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

Measurement

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

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

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

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

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

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, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation
Freehold land is considered to have an infinite life and is not depreciated.

Depreciation is charged to write off the costs or valuation of property, plant and equipment, 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.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

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

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

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

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

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

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

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

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

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

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

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

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

	Min life Years	Max life Years
Buildings, excluding dwellings	10	60
Plant & machinery	5	15
Transport equipment	2	7
Information technology	2	7
Furniture & fittings	4	10

Note 1.9 Intangible assets

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

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

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

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets the recognition criteria."

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating.

Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

	Min life Years	Max life Years
Software licences	2	7

Note 1.10 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Between 2020-21 and 2023-24, the Trust received inventories including personal protective equipment from the Department of Health and Social Care (DHSC) at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the DHSC ceased in March 2024.

Note 1.11 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 three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.12 Financial assets and financial liabilities

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

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

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

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

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

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

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

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

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

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

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

Note 1.13 Leases
A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor
The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases
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 to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Income from operating leases is recognised on a straight-line basis or another systematic 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 as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation as a result of a past event of uncertain timing or amount as a result of a past event; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Note 1.14 Provisions (continued)

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution, the trading name of the NHS Litigation Authority (NHSLA), operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to operating expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 24.1 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Where the time value of money is material, contingent assets and contingent liabilities are disclosed at their present value.

Note 1.16 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

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

Note 1.17 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Climate change levy
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.20 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.21 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been adopted early in 2024-25.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024-25. These Standards are still subject to HM Treasury FReM adoption.

- **IFRS 17 Insurance Contracts**
The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025-26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025-26 is not expected to have a material impact on the financial statements.

- **IFRS 18 Presentation and Disclosure in Financial Statements**
The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

- **IFRS 19 Subsidiaries without Public Accountability: Disclosures**

The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

- **Changes to non-investment asset valuation**

Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a five-year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. However, the Trust currently use an alternative site valuation methodology and although the impact has not been quantified, the revised valuation assumption may have a material or significant impact on PPE measurement in future periods.

Note 1.24 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are reviewed regularly.

The following are the judgements, apart from those involving estimations (see Note 1.25) 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:

Segmental reporting

The Trust has one material segment, being the provision of healthcare. Divisions within the Trust all have similar economic characteristics. Private patient activity is not considered material enough to warrant segmental reporting.

Charities consolidation
Management consider the Yorkshire Ambulance Services Charitable Fund, of which the Trust is a corporate Trustee, to have an immaterial impact on the group results. Therefore, these accounts do not include a consolidated position under the requirements of IFRS10.

Note 1.25 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Non-Current Assets
Values are as disclosed in Note 13, Property, Plant and Equipment, and Note 12 Intangible Assets.

Asset lives, with the exception of land and buildings, are set out in Note 1.8 and 1.9 with maximum lives being set by reference to the type of asset and its expected useful life in normal use. Land and building lives are based on the recommendations received from the District Valuer Service, part of the Valuation Office Agency of HM Revenue and Customs.

A revaluation of the Trust's Land and Buildings has been conducted by the District Valuer Service during February and March 2025 with a prospective valuation date of 31 March 2025 (Note 15). These values and assets lives reflect both local and national property indices.

Provisions for early retirements and injury benefits (Note 29)
The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the year, taking into account the risks and uncertainties.

The carrying amount of both the early retirement and injury benefit provisions is estimated as the present value of those cash flows using HM Treasury's pension discount rate of 2.4% in real terms (prior year: 2.45%). The period over which future cash flows will be paid is estimated using the National life expectancy tables (England) as published by the Office of National Statistics.

Other Provisions (Note 29)
Provisions including staff claims and employment tribunals have been estimated based on the best information available at the time of the compilation of the accounts.

Estimates of employer and public liability legal claims are made on 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 £10,000.

The Trust has continued to provide the reinstatement costs for leased/tenancy properties and leased fleet vehicles to the extent that these leases and associated dilapidation provisions were in existence at IFRS16 transition and for new or extended leases where such costs are deemed not to be capital in nature.

Allowance for credit losses (Note 22.2)
The Trust recognises the credit and liquidity risk of receivables which are past their due date. The impairment of such debt is based on a combination of the age of the debt and likelihood of payment and information held by management on the individual circumstances surrounding the debt. No impairment of NHS receivables is recognised.

Note 1.26 Foreign Currencies
The Trust's functional currency and presentational currency is pounds sterling, and the figures are presented in thousands of pounds unless expressly stated otherwise.

Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on the settlement of the transaction or on the retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

Note 2 Operating Segments

The Trust has determined that the 'chief operating decision maker' (as defined by IFRS 8) is the Board of Directors (Trust Board) on the basis that all strategic decisions are made by the Board.

The Trust has judged that it only operates as one operating segment; that of the provision of healthcare. The main source of Trust income was received from NHS commissioners.

Note 3 Operating income from patient care activities

The majority of income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	2024-25 £000	2023-24 £000
Ambulance services *		
A & E income	331,795	304,408
Patient transport services income	50,177	45,020
Other income	35,251	33,219
All services		
Private patient income	39	40
Additional pension contribution central funding**	21,164	12,495
Total income from activities	**438,426**	**395,182**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023-25 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023-24: 20.6%) and related NHS England funding (9.4%, 2023-24: 6.3%) have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2024-25 £000	2023-24 £000
NHS England	21,378	14,215
Integrated care boards	413,692	377,985
Other NHS providers	1,075	926
Local authorities	52	52
Non-NHS: private patients	39	40
Injury cost recovery scheme	748	659
Non NHS: other	1,442	1,305
Total income from activities	**438,426**	**395,182**
Of which:		
Related to continuing operations	438,426	395,182

Note 4.1 Other operating income

	2024-25			2023-24		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	960	-	**960**	581	-	**581**
Education and training	4,649	1,348	**5,997**	4,930	1,283	**6,213**
Income in respect of employee benefits accounted on a gross basis	463		**463**	966		**966**
Receipt of capital grants and donations and peppercorn leases		-	**-**		32	**32**
Charitable and other contributions to expenditure		-	**-**		91	**91**
Other income	1,915	-	**1,915**	2,455	-	**2,455**
Total other operating income	**7,987**	**1,348**	**9,335**	**8,932**	**1,406**	**10,338**
Of which:						
Related to continuing operations			9,335			10,338

Note 4.2 Operating leases - Yorkshire Ambulance Service NHS Trust as lessor

This note discloses income generated in operating lease agreements where Yorkshire Ambulance Service NHS Trust is the lessor.

Yorkshire Ambulance Service NHS Trust did not have any operating lease arrangements where it was the lessor in either 2024-25 or 2023-24.

Note 5 Operating expenses

	2024-25 £000	2023-24 £000
Purchase of healthcare from NHS and DHSC bodies	234	185
Purchase of healthcare from non-NHS and non-DHSC bodies	11,666	15,305
Staff and executive directors' costs **	336,960	296,691
Remuneration of non-executive directors	128	136
Supplies and services - clinical (excluding drugs costs)	8,293	10,025
Supplies and services - general	2,251	1,745
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	403	354
Consultancy costs	453	705
Establishment	4,767	4,925
Premises	11,995	11,707
Transport (including patient travel)	28,837	28,260
Depreciation on property, plant and equipment	18,392	14,381
Amortisation on intangible assets	984	1,029
Net impairments	495	(341)
Movement in credit loss allowance: contract receivables / contract assets	10	(14)
Increase/(decrease) in other provisions	(788)	162
Change in provisions discount rate(s)	195	(304)
Fees payable to the external auditor		
audit services- statutory audit *	176	249
Internal audit costs	134	98
Clinical negligence	3,030	2,944
Legal fees	437	262
Insurance	48	35
Research and development **	1,151	759
Education and training **	11,203	11,970
Expenditure on short term leases	3,303	2,152
Redundancy **	126	325
Hospitality	58	9
Losses, ex gratia & special payments	14	762
Other	2,283	1,531
Total	**447,238**	**406,047**
Of which:		
Related to continuing operations	447,238	406,047

*The statutory audit fee is disclosed inclusive of irrecoverable VAT. The audit fee excluding VAT is £147k (2023-24 - £208k).

** For comparability with the 2024-25 operating expenses analysis, 2023-24 staff costs relating to Education and Training, Research and Development and Redundancy have been allocated to these expense headings.

Note 5.1

No other auditor remuneration was paid to the external auditor in 2024-25 (2023-24: £nil)

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2023-24: £1,000k).

Note 6 Impairment of assets

	2024-25 £000	2023-24 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(120)	(341)
Other	615	-
Total net impairments charged to operating surplus / deficit	**495**	**(341)**
Impairments charged to the revaluation reserve	4,055	-
Total net impairments	**4,550**	**(341)**

Note 7 Employee benefits

	2024-25 Total £000	2023-24 Total £000
Salaries and wages	260,939	233,180
Social security costs	25,347	24,851
Apprenticeship levy	1,288	1,061
Employer's contributions to NHS pensions	53,778	41,792
Pension cost - other	-	-
Termination benefits	126	325
Temporary staff (including agency)	5,110	4,988
Total staff costs	**346,588**	**306,197**
Of which		
Costs capitalised as part of assets	362	113

Note 7.1 Retirements due to ill-health

During 2024-25 there were 15 early retirements from the Trust agreed on the grounds of ill-health (27 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements are £1,154k (£1,629k in 2023-24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

The 2023-24 comparative figures for retirements due to ill health have been restated.

Note 8 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

c) National Employment Savings Trust Pension (NEST)
Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme.

NEST is a defined contribution scheme managed by a third-party organisation. It carries no possibility of actuarial gain or loss to the Trust and there are no financial liabilities other than payment of the 3% employer's contribution of qualifying earnings. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. Further details of the scheme can be found at www.nestpensions.org.uk.

Note 9 Finance income

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

	2024-25 £000	2023-24 £000
Interest on bank accounts	2,815	3,860
Total finance income	**2,815**	**3,860**

Note 10.1 Finance expenditure

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

	2024-25 £000	2023-24 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	53	57
Interest on lease obligations	632	384
Interest payable to HMRC	2	-
Total interest expense	**687**	**441**
Unwinding of discount on provisions	-	164
Total finance costs	**687**	**605**

Note 10.2 The late payment of commercial debts (interest) Act 1998

	2024-25 £000	2023-24 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 11 Other gains / (losses)

	2024-25 £000	2023-24 £000
Gains on disposal of assets	311	14
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	**311**	**14**

Note 12.1 Intangible assets - 2024-25

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024	**5,102**	**252**	**5,354**
Additions	-	942	**942**
Valuation / gross cost at 31 March 2025	**5,229**	**1,067**	**6,296**
Amortisation at 1 April 2024	**2,780**	**-**	**2,780**
Provided during the year	984	-	**984**
Amortisation at 31 March 2025	**3,764**	**-**	**3,764**
Net book value at 31 March 2025	**1,465**	**1,067**	**2,532**
Net book value at 1 April 2024	**2,322**	**252**	**2,574**

Note 12.2 Intangible assets - 2023-24

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023	**8,168**	**107**	**8,275**
Additions	140	145	**285**
Disposals / derecognition	(3,206)	-	**(3,206)**
Valuation / gross cost at 31 March 2024	**5,102**	**252**	**5,354**
Amortisation at 1 April 2023	**4,947**	**-**	**4,947**
Provided during the year	1,029	-	**1,029**
Disposals / derecognition	(3,196)	-	**(3,196)**
Amortisation at 31 March 2024	**2,780**	**-**	**2,780**
Net book value at 31 March 2024	**2,322**	**252**	**2,574**
Net book value at 1 April 2023	**3,221**	**107**	**3,328**

Note 13.1 Property, plant and equipment - 2024-25

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2024	**20,669**	**49,984**	**27,596**	**16,400**	**51,524**	**14,188**	**285**	**180,646**
Additions	-	-	22,032	-	-	-	-	**22,032**
Impairments	(105)	(7,562)	-	-	(546)	(971)	-	**(9,184)**
Reversals of impairments	-	2	-	-	-	-	-	**2**
Revaluations	10	1,836	-	-	-	-	-	**1,846**
Reclassifications	-	9,534	(26,060)	1,484	14,411	631	-	**-**
Disposals / derecognition	(10)	-	-	(1,398)	(5,584)	(1,002)	-	**(7,994)**
Valuation/gross cost at 31 March 2025	**20,564**	**53,794**	**23,568**	**16,486**	**59,805**	**12,846**	**285**	**187,348**
Accumulated depreciation at 1 April 2024	**-**	**-**	**-**	**10,853**	**38,475**	**8,017**	**243**	**57,588**
Provided during the year	-	1,774	-	1,991	5,928	2,714	17	**12,424**
Impairments	-	(3)	-	-	(426)	(587)	-	**(1,016)**
Reversals of impairments	-	(118)	-	-	-	-	-	**(118)**
Revaluations	-	(1,652)	-	-	-	-	-	**(1,652)**
Disposals / derecognition	-	-	-	(1,379)	(5,541)	(1,002)	-	**(7,922)**
Accumulated depreciation at 31 March 2025	**-**	**1**	**-**	**11,465**	**38,436**	**9,142**	**260**	**59,304**
Net book value at 31 March 2025	**20,564**	**53,793**	**23,568**	**5,021**	**21,369**	**3,704**	**25**	**128,044**
Net book value at 1 April 2024	**20,669**	**49,984**	**27,596**	**5,547**	**13,049**	**6,171**	**42**	**123,058**
Property, plant and equipment financing								
Owned - purchased	20,564	53,793	23,568	5,021	21,369	3,704	25	**128,044**

Note 13.2 Property, plant and equipment - 2023-24

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2023	**20,599**	**47,961**	**16,764**	**16,681**	**50,738**	**21,698**	**285**	**174,726**
Additions	-	-	14,232	211	-	1,950	-	**16,393**
Reversals of impairments	-	198	-	-	-	-	-	**198**
Revaluations	70	1,825	-	-	-	-	-	**1,895**
Reclassifications	-	-	(3,400)	-	3,400	-	-	**-**
Disposals / derecognition	-	-	-	(492)	(2,614)	(9,460)	-	**(12,566)**
Valuation/gross cost at 31 March 2024	**20,669**	**49,984**	**27,596**	**16,400**	**51,524**	**14,188**	**285**	**180,646**
Accumulated depreciation at 1 April 2023	**-**	**-**	**-**	**9,411**	**36,375**	**14,705**	**224**	**60,715**
Provided during the year	-	1,540	-	1,920	4,655	2,722	19	**10,856**
Reversals of impairments	-	(143)	-	-	-	-	-	**(143)**
Revaluations	-	(1,397)	-	-	-	-	-	**(1,397)**
Disposals / derecognition	-	-	-	(478)	(2,555)	(9,410)	-	**(12,443)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**10,853**	**38,475**	**8,017**	**243**	**57,588**
Net book value at 31 March 2024	**20,669**	**49,984**	**27,596**	**5,547**	**13,049**	**6,171**	**42**	**123,058**
Net book value at 1 April 2023	**20,599**	**47,961**	**16,764**	**7,270**	**14,363**	**6,993**	**61**	**114,011**
Property, plant and equipment financing								
Owned - purchased	20,669	49,984	27,596	5,547	13,049	6,171	42	**123,058**

Note 14 Donations of property, plant and equipment
There were no donations of property, plant and equipment received during the 2024-25 (2023-24 - £nil).

Note 15 Revaluations of property, plant and equipment
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Details are provided in note 6.

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 and March 2025 with a prospective valuation date of 31 March 2025.

Note 16 Leases - Yorkshire Ambulance Service NHS Trust as a lessee
This note details information about leases for which the Trust is a lessee.

The Trust has lease arrangements for both property and vehicles in line with the normal course of its business.

Note 16.1 Right of use assets - 2024-25

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024	**7,199**	**5,885**	**15,873**	**28,957**	**877**
Additions	1,609	-	6,660	**9,918**	-
Movements in provisions for restoration / removal costs	68	-	-	**68**	-
Disposals / derecognition	(73)	-	(84)	**(157)**	-
Valuation/gross cost at 31 March 2025	**8,803**	**5,885**	**22,449**	**38,786**	**877**
Accumulated depreciation at 1 April 2024	**1,452**	**-**	**5,633**	**7,085**	**266**
Provided during the year	913	1,139	3,871	**5,968**	135
Disposals / derecognition	(73)	-	(84)	**(157)**	-
Accumulated depreciation at 31 March 2025	**2,292**	**1,139**	**9,420**	**12,896**	**401**
Net book value at 31 March 2025	**6,511**	**4,746**	**13,029**	**25,890**	**476**
Net book value at 1 April 2024	**5,747**	**5,885**	**10,240**	**21,872**	**611**

Net book value of right of use assets leased from other NHS providers	313
Net book value of right of use assets leased from other DHSC group bodies	163

Note 16.2 Right of use assets - 2023-24

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023	**6,052**	**-**	**11,689**	**17,741**	**709**
Additions	1,342	5,885	4,184	**11,411**	168
Movements in provisions for restoration / removal costs	(195)	-	-	**(195)**	-
Valuation/gross cost at 31 March 2024	**7,199**	**5,885**	**15,873**	**28,957**	**877**
Accumulated depreciation at 1 April 2023	800	-	2,760	**3,560**	134
Provided during the year	652	-	2,873	**3,525**	132
Accumulated depreciation at 31 March 2024	**1,452**	**-**	**5,633**	**7,085**	**266**
Net book value at 31 March 2024	**5,747**	**5,885**	**10,240**	**21,872**	**611**
Net book value at 1 April 2023	**5,252**	**-**	**8,929**	**14,181**	**575**

Net book value of right of use assets leased from other NHS providers	422
Net book value of right of use assets leased from other DHSC group bodies	189

Note 16.3 Revaluations of right of use assets
The Trust did not undertake any revaluation of its Right of Use assets during 2024-25.

Note 16.4 Reconciliation of the carrying value of lease liabilities
Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in Note 24.1.

	2024-25 £000	2023-24 £000
Carrying value at 1 April	**18,602**	**14,329**
Lease additions	9,918	11,411
Lease liability remeasurements	-	-
Interest charge arising in year	632	384
Lease payments (cash outflows)	(5,948)	(7,522)
Carrying value at 31 March	**23,204**	**18,602**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 5. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.5 Maturity analysis of future lease payments

	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000
Undiscounted future lease payments payable in:				
- not later than one year;	7,963	135	5,925	135
- later than one year and not later than five years;	12,527	323	10,901	286
- later than five years.	4,270	170	2,749	229
Total gross future lease payments	**24,760**	**628**	**19,575**	**650**
Finance charges allocated to future periods	(1,556)	(32)	(973)	(15)
Net lease liabilities at 31 March 2025	**23,204**	**596**	**18,602**	**635**
Of which:				
Leased from other NHS providers		366		450
Leased from other DHSC group bodies		230		185

Note 17 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	180	174
Consumables	1,954	1,415
Other	523	813
Total inventories	**2,657**	**2,402**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £18,859k (2023-24: £12,291k). Write-down of inventories recognised as expenses for the year were £0k (2023-24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023-24 the Trust received £91k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 18.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	7,522	5,300
Allowance for impaired contract receivables / assets	(548)	(557)
Prepayments (non-PFI)	3,661	3,343
Interest receivable	196	302
PDC dividend receivable	55	-
VAT receivable	829	847
Other receivables	712	546
Total current receivables	**12,427**	**9,781**
Non-current		
Contract receivables	1,383	366
Total non-current receivables	**1,383**	**366**
Of which receivable from NHS and DHSC group bodies:		
Current	5,538	2,857

Note 18.2 Allowances for credit losses

Contract receivables and contract assets	**2024-25 £000**	**2023-24 £000**
Allowances as at 1 April	**557**	**586**
Changes in existing allowances	10	-
Reversals of allowances	-	(14)
Utilisation of allowances (write offs)	(19)	(15)
Allowances as at 31 March 2025	**548**	**557**

Note 18.3 Exposure to credit risk

The nature of the Trust's income and operations as part of the NHS mean that the Trust is not significantly exposed to credit risk.

Note 19 Finance leases (Yorkshire Ambulance Service NHS Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Yorkshire Ambulance Service NHS Trust is the lessor.

The Trust has no finance leases where they are lessor.

Note 20 Non-current assets held for sale and assets in disposal groups
The Trust has no non-current assets held for sale and assets in disposal groups at 31 March 2025 (31 March 2024: £nil).

Note 21.1 Cash and cash equivalents movements

	2024-25 £000	2023-24 £000
At 1 April	**60,207**	**61,887**
Net change in year	(16,030)	(1,680)
At 31 March	**44,177**	**60,207**
Broken down into:		
Cash with the Government Banking Service	44,177	60,141
Other current investments	-	66
Total cash and cash equivalents as in SoFP	**44,177**	**60,207**
Total cash and cash equivalents as in SoCF	**44,177**	**60,207**

Note 21.2 Third party assets held by the Trust
The Trust does not hold any cash and cash equivalents on behalf of patients or other parties.

Note 22.1 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	2,857	1,964
Capital payables	9,567	8,912
Accruals	10,983	15,740
Receipts in advance and payments on account	2	-
Social security costs	5,840	5,998
PDC dividend payable	-	65
Pension contributions payable	4,536	4,136
Other payables	65	27
Total current trade and other payables	**33,850**	**36,842**
Of which payables from NHS and DHSC group bodies:		
Current	1,565	1,144

Note 22.2 Early retirements in NHS payables in Note 22.1
The payables note above includes £nil (31 March 2024 - £nil) in relation to early retirements.

Note 23 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	56	34
Total other current liabilities	**56**	**34**

Note 24.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	334	336
Lease liabilities	7,963	5,925
Total current borrowings	**8,297**	**6,261**
Non-current		
Loans from DHSC	2,163	2,497
Lease liabilities	15,241	12,677
Total non-current borrowings	**17,404**	**15,174**

Note 24.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Lease Liabilities £000	Total £000
Carrying value at 1 April 2024	**2,833**	**18,602**	**21,435**
Cash movements:			
Financing cash flows - payments and receipts of principal	(334)	(5,316)	**(5,650)**
Financing cash flows - payments of interest	(54)	(632)	**(686)**
Non-cash movements:			
Additions	-	9,918	**9,918**
Application of effective interest rate	52	632	**684**
Carrying value at 31 March 2025	**2,497**	**23,204**	**25,701**

	Loans from DHSC £000	Lease Liabilities £000	Total £000
Carrying value at 1 April 2023	**3,168**	**14,329**	**17,497**
Cash movements:			
Financing cash flows - payments and receipts of principal	(334)	(7,138)	**(7,472)**
Financing cash flows - payments of interest	(57)	(384)	**(441)**
Non-cash movements:			
Additions	-	11,411	**11,411**
Application of effective interest rate	56	384	**440**
Carrying value at 31 March 2024	**2,833**	**18,602**	**21,435**

Note 25 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2024	**447**	**5,235**	**181**	**-**	**4,385**	**10,248**
Change in the discount rate	6	108	-	-	82	**196**
Arising during the year	27	55	44	110	614	**850**
Utilised during the year	(61)	(444)	(10)	-	(1,410)	**(1,925)**
Reversed unused	-	-	-	-	(584)	**(584)**
Unwinding of discount	3	(3)	-	-	-	**-**
At 31 March 2025	**422**	**4,951**	**215**	**110**	**3,087**	**8,785**
Expected timing of cash flows:						
- not later than one year;	90	231	215	110	1,262	**1,908**
- later than one year and not later than five years;	299	1,685	-	-	1,429	**3,413**
- later than five years.	33	3,035	-	-	396	**3,464**
Total	**422**	**4,951**	**215**	**110**	**3,087**	**8,785**

Pensions related provisions represent amounts payable to the NHS Business Services Authority (NHS BSA) to meet the costs of early retirements and industrial injury benefits. Amounts are determined by the NHS BSA - Pensions Division based on actuarial estimates of life expectancy and there is therefore, a degree of uncertainty regarding the value of future payments.

Legal claims relate to employer and public liability claim estimates made on 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 £10,000.

Included in "Other" are provisions categorised as: leased fleet vehicles and tenancy properties provisions for estimated deferred repairs and restoration costs as applicable £2,494k (2023-24 £2,874k); staff related claims and employment tribunals £488k (2023-24 £1,511k).

Note 25.1 Clinical negligence liabilities

At 31 March 2025, £24,284k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Yorkshire Ambulance Service NHS Trust (31 March 2024: £26,567k).

Note 26 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(8)	(99)
Gross value of contingent liabilities	**(8)**	**(99)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(8)**	**(99)**
Net value of contingent assets	**902**	**-**

The Trust has recognised a contingent asset in respect of overpayments of Employer's National Insurance for employees between the age of 21 and 25 participating in approved apprenticeship schemes.

Claims have already been made for 2018-19 and 2024-25. The value of the claims in respect of the financial years 2019/20, 2020-21, 2021-22, 2022-23 and 2023-24 is estimated at £457k.

A contingent asset of £445k has also been recognised in respect of an insurance claim made in respect of damage caused during the winter storms in December 2024 to Thirsk Ambulance Station.

Note 27.1 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	6,677	9,633
Intangible assets	101	-
Total	**6,778**	**9,633**

Note 27.2 Leases: exposure to future cash outflows not included in lease liabilities

	31 March 2025 £000	31 March 2024 £000
Commitments for leases not yet commenced to which the Trust is contractually committed	10,035	-
Total	**10,035**	**-**

Note 28 Other financial commitments

Other than the commitments noted above the Trust is not committed to making payments under non-cancellable contracts which are not leases.

Note 29 Financial instruments

Note 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.

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 end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under aligned payment and incentive contract arrangements with NHS Commissioners which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	9,265	**9,265**
Cash and cash equivalents	44,177	**44,177**
Total at 31 March 2025	**53,442**	**53,442**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	4,743	**4,743**
Cash and cash equivalents	60,207	**60,207**
Total at 31 March 2024	**64,950**	**64,950**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	2,497	**2,497**
Obligations under leases	23,204	**23,204**
Trade and other payables excluding non financial liabilities	20,086	**20,086**
Provisions under contract	3,411	**3,411**
Total at 31 March 2025	**49,198**	**49,198**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	2,833	**2,833**
Obligations under leases	18,602	**18,602**
Trade and other payables excluding non financial liabilities	26,643	**26,643**
Provisions under contract	4,565	**4,565**
Total at 31 March 2024	**52,643**	**52,643**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025 £000	31 March 2024 £000
In one year or less	30,014	34,956
In more than one year but not more than five years	15,408	13,657
In more than five years	5,522	4,865
Total	**50,944**	**53,478**

Note 29.5 Fair values of financial assets and liabilities

The Trust considers that book value (carrying value) is a reasonable approximation of fair value.

Note 30 Losses and special payments

	2024-25		2023-24	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	7	1	11	9
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	41	18	19	6
Stores losses and damage to property	9	3	-	-
Total losses	**57**	**22**	**30**	**15**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	3	13
Extra-contractual payments	-	-	-	-
Ex-gratia payments	22	20	32	226
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**22**	**20**	**35**	**239**
Total losses and special payments	**79**	**42**	**65**	**254**
Compensation payments received		-		-

There were no individual losses or special payments exceeding £300,000 in 2024-25 (2023-24 - nil).

Note 31 Related parties
The Department of Health and Social Care 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, and with other entities for which the Department is regarded as the parent Department. These include NHS England and the entities listed below. In addition, the Trust has had a number of significant transactions with other government departments and their agencies e.g. HMRC.

NHS Integrated Care Boards
NHS Trusts
NHS Foundation Trusts
NHS Litigation Authority
NHS Resolution
NHS Property Services

The organisations noted below represent related parties where income or expenditure is more than 1% of the Trust's operating income or expenditure (the Trust's main NHS commissioners). Transactions below this level are not considered material for the purposes of this disclosure.

ICB Name
NHS West Yorkshire ICB
NHS South Yorkshire ICB
NHS Humber & North Yorkshire ICB

No related party transactions were noted with key management personnel other than the compensation paid to them.

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.

The Trust works with the Yorkshire Air Ambulance charity and provides medical staff for that service.

Note 32 Events after the reporting date
There have been no non-adjusting events after the reporting date.

Note 33 Better Payment Practice code

Non-NHS Payables	2024-25 Number	2024-25 £000	2023-24 Number	2023-24 £000
Total non-NHS trade invoices paid in the year	33,855	116,684	35,543	104,830
Total non-NHS trade invoices paid within target	32,777	111,911	33,648	98,707
Percentage of non-NHS trade invoices paid within target	96.8%	95.9%	94.7%	94.2%
NHS Payables				
Total NHS trade invoices paid in the year	542	9,142	590	10,428
Total NHS trade invoices paid within target	522	8,629	520	8,995
Percentage of NHS trade invoices paid within target	96.3%	94.4%	88.1%	86.3%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 34 Capital Resource Limit

	2024-25 £000	2023-24 £000
Gross capital expenditure	32,892	28,089
Less: Disposals	(72)	(133)
Less: Donated and granted capital additions	-	(32)
Charge against Capital Resource Limit	**32,820**	**27,924**
Capital Resource Limit	32,820	27,924
Under / (over) spend against CRL	**-**	**-**

Note 35 Breakeven duty financial performance

	2024-25 £000	2023-24 £000
Adjusted financial performance surplus / (deficit) – on a control total basis*	92	51
Breakeven duty financial performance surplus / (deficit)	**92**	51

*Adjusted financial performance (control total basis) calculation

	2024-25 £000	2023-24 £000
Surplus / (deficit) for the period	(403)	257
Remove net impairments not scoring to the Departmental expenditure limit	495	(341)
Remove I&E impact of capital grants and donations	-	(32)
Remove net impact of DHSC centrally procured inventories	-	167
Adjusted financial performance surplus / (deficit)	**92**	**51**

Note 36 Breakeven duty rolling assessment

	1997-98 to 2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		518	237	428	2,223	2,633	2,991	6,103	2,719
Breakeven duty cumulative position	3,501	4,019	4,256	4,684	6,907	9,540	12,531	18,634	21,353
Operating income		197,910	195,228	200,333	209,772	233,384	241,328	248,965	255,424
Cumulative breakeven position as a percentage of operating income		2.0%	2.2%	2.3%	3.3%	4.1%	5.2%	7.5%	8.4%

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	10,154	9,250	5,524	(960)	8,203	236	51	92
Breakeven duty cumulative position	31,507	40,757	46,281	45,321	53,524	53,760	53,811	53,903
Operating income	269,451	281,698	288,172	334,125	359,194	382,208	405,520	447,761
Cumulative breakeven position as a percentage of operating income	11.7%	14.5%	16.1%	13.6%	14.9%	14.1%	13.3%	12.0%

Glossary of Terms

Term/Abbreviation	Definition/Explanation
Accident and Emergency 999 (A&E) Service	A responsive service for patients in an emergency situation with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.
Advanced Medical Priority Dispatch System (AMPDS)	An international system that prioritises 999 calls using information about the patient as supplied by the caller.
Ambulance Quality Indicators (AQIs)	AQIs were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients. The AQIs are ambulance specific and are concerned with patient safety and outcomes.
Ambulance Response Programme (ARP)	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. The trial helped to inform changes in national performance standards for all ambulance services which were introduced in 2018.
Annual Assurance Statement	The means by which the Accountable Officer declares their 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	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.
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.

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.
Cardio-pulmonary Resuscitation (CPR)	A procedure used to help resuscitate a patient when their heart stops beating and breathing stops.
Care Bundle	A care bundle is a group of interventions (practices) related to a disease process that, when 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.
Chair	The Chair provides leadership to the Board of Directors 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 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.
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.
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.

Clinical 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.
Department of Health (DH)	The government department which provides strategic leadership for public health, the NHS and social care in England.
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	For a small number of people who are approaching the last days of life, cardiopulmonary 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.
Electrocardiograms (ECG)	An interpretation of the electrical activity of the heart. This is done by attaching electrodes onto the patient which record the activity of the different sections of the heart.
Electronic Patient Record (ePR)	A comprehensive electronic record of the care provided to patients.
Emergency Department (ED)	A hospital department responsible for assessing and treating patients with serious injuries or illnesses.
Emergency Operations Centre (EOC)	The department which handles all our emergency and routine calls and deploys the most appropriate response. The two EOCs are based in Wakefield and York.
Equality and Diversity	Equality legislation protects people from being discriminated against on the grounds of their sex, race, disability, etc. Diversity is about respecting individual differences such as race, culture, political views, religious views, gender, age, etc.
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.
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. There are also local Healthwatch organisations where networks of individuals and community groups, such as faith groups and residents' associations, work together to improve health and social care services.
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 cardiopulmonary 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.
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.
Information Management and Technology (IM&T)	This department consists of the IT Service Desk, Voice Communications Team, IT Projects Team and Infrastructure, Systems and Development Team which deliver all the Trust's IT systems and IT projects.
Integrated Business Plan (IBP)	Sets out an organisation's vision and its plans to achieve that vision in the future.
Integrated Care System (ICS)	In 2016, NHS organisations and local councils came together to form Sustainability and Transformation Partnerships (STPs) covering the whole of England and set out their proposals to improve health and care for patients. These partnerships have evolved to form Integrated Care Systems (ICSs), which are the new partnerships between the organisations that meet health and care needs across an area, to

	coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
Key Performance Indicator (KPI)	A measure of performance.
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 e.g., 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 Early Warning Score (NEWS)	The NEWS is a simple physiological scoring system that can be calculated at the patient's bedside, 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.
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.
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.
Patient Report Form (PRF)	A comprehensive paper record of the care provided to patients.

Patient Transport Service (PTS)	A non-emergency medical transport service, for example, to and from out-patient appointments.
Personal Development Reviews (PDRs)	The PDR process provides a framework for identifying staff development and training needs and agreeing objectives.
Personal Digital Assistants (PDAs)	Small computer units which help to capture more accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.
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.
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.
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.
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.
ST Elevation Myocardial Infarction (STEMI)	A type of heart attack.
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.

Back Page Information

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