NHS
Yorkshire
Ambulance Service
NHS Trust

Yorkshire Ambulance Service Annual Report and Accounts 2025-26

FINAL – 24 September 2026

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Part 1 - Overview

Chair's Foreword

It continues to be a privilege to serve as Chair of the Trust and have oversight across all our core services and support teams.

The caring and compassionate approach from staff and volunteers towards our patients every day fills me with pride, and I am delighted that the work of our 999 Operations and Emergency Operations Centre (EOC) teams has been showcased to the public as part of the BBC *Ambulance* documentary series broadcast in Autumn 2025 and Spring 2026.

Alongside providing high-quality clinical triage and treatment, our colleagues look after thousands of patients every day with great warmth and empathy when they are at their most vulnerable.

These important qualities are always at the centre of everything we do whether it's related to emergency and urgent care provision, our non-emergency patient transport service or our interactions with our partners.

Senior leadership changes
During 2025-26 there were several changes to our Non-Executive Director (NED) positions.

NED and Senior Independent Director Tim Gilpin, who joined the Trust Board in January 2017 following a career in public sector HR, left us in July 2025 when his term of office came to an end. We thank him for his significant contribution to YAS during his time with the Trust and his part in its transformation.

NED Anne Cooper left the Trust in November 2025, most recently as Deputy Chair and Chair of the Quality Committee. Anne, an accomplished senior nurse leader, has been on the Trust Board since December 2018, following a career spanning 35 years in the NHS. The Board would like to recognise Anne's important contribution during her time at YAS.

Melanie Hudson, who has spent more than 30 years working in the Further Education sector, joined us as a NED in September 2025.

Becky Malby BEM, a professor of innovation in healthcare, joined the Trust as a NED in December 2025. She has worked in the NHS as a nurse and in managerial and policy roles, before moving into universities to champion the very best approaches to healthcare, working nationally and internationally.

In addition, there were some changes to Executive Director positions during the year.

Marc Thomas extended his role as Deputy Chief Executive and took on additional responsibilities as Chief Operating Officer.

Dr Shona McCallum joined the YAS Executive team in October 2025 as Executive Medical Director. She trained in respiratory and general medicine across the North West of England and has been a consultant for over 20 years. In her previous role Shona worked as Medical Director at Rochdale Infirmary (Northern Care Alliance NHS Trust).

YAS Strategy
We have continued to progress the business plan priorities highlighted in our 2024-29 strategy - Great Care, Great People, Great Partner.

As part of the five-year strategy, we have four bold ambitions to drive us - Our patients, Our people, Our partners, Our planet and pounds. You will see these referenced throughout this annual report, alongside examples of the progress we are making.

Some of the milestones marking successful implementation of the strategy this year include:

- Completing the integration of our Emergency Operations Centre (EOC) and Integrated Urgent Care (IUC) services into a unified Remote Patient Care provision.

- Rolling out the NHS Pathways telephone system, which assesses patients needing urgent and emergency medical help, into our Wakefield and York EOCs. Since switching to NHS Pathways, the way 999 calls are handled and coded has changed and we have already seen a decrease in the number of calls designated as category 1. This means that we can respond more quickly to those patients with a life-threatening condition.

- We have successfully rolled out the maximum 45-minute transfer of care (handover) time at hospitals across the region, meaning that more of our resources are available to respond in their local communities.

- We have received confirmed contracts from all three Integrated Care Boards for our non-emergency Patient Transport Service.

In terms of our staff, their health, wellbeing and safety remains paramount, and we continue to drive further improvements in the organisation's culture.

Colleague recognition
Our annual STARS Awards took place in October 2025 when we recognised staff and volunteers who have gone above and beyond to help patients and colleagues. The event was an opportunity to honour some of the outstanding achievements of colleagues from core services and support departments across the organisation, and their ongoing commitment to providing the best care for the people of Yorkshire. Highlights included staff who went the extra mile to provide exemplary care to palliative patients, a Community First Responder who has volunteered at YAS for over 10 years, and two off-duty colleagues who saved the life of a patient who went into cardiac arrest.

All nominees were individuals who live and work by the Trust's values - Kindness, Respect, Teamwork and Improvement. These values are the foundation of everything we do as an organisation and I am immensely proud of how they were highlighted at the STARS Awards ceremony and every day across the Trust.

Many colleagues who work in the ambulance service tend to commit their whole career to it. At our 2025 Long Service Awards event, we recognised 128 colleagues with a combined service of over 5,560 years. Awards included those for staff who have reached their 20, 30, 40 and 50-year milestone in the NHS. We also presented King's and Queen's Long Service and Good Conduct Medals, which were given to colleagues with 20 years' exemplary frontline emergency service.

Providing excellent care
Providing excellent patient care remains at the heart of what we do every day. During 2025-26, colleagues and volunteers continue to show dedication, compassion and resilience, often in busy and challenging circumstances. I'm very proud of their commitment to patient care and watching out for each other. Thank you to all staff and volunteers for everything that you do.

I am pleased to present the 2025-26 Annual Report which, as well as our statutory obligations, highlights the achievements of the Trust during the last year. We look forward to making further progress in 2026-27.

We do hope that you find the contents of this report both interesting and reassuring.

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 the Trust will operate and 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 that our plans meet the needs of those we serve and work with.

This Annual Report for 2025-26 tells the story of the second full year of the delivery our strategy.

The Trust's business plan for 2026-27 takes forward our next steps for the third full year of our 2024-29 strategy delivery period.

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

Our Purpose, Vision and Values

Yorkshire Ambulance Service is a values-led organisation. As part of the transformation of the Trust, and alongside the development of our strategy for the period 2024-29, we adopted a new purpose, vision and values, as follows.

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 2025-26 we made good progress in implementing the second year of our 2024-29 strategy. The Trust delivered many of its business plan priorities, demonstrating continued commitment, adaptability, and resilience despite high demand and ongoing system pressures in order to improve patient response and experience, operational performance, staff engagement, and organisational development.

The Trust delivered tangible progress towards delivering bold ambitions for Our Patients, Our People, Our Partners, and Our Planet and Pounds. In doing so the Trust maintained financial balance and delivered improvements to efficiency and productivity, 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 2026-27 and beyond to support 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 that patients receive the right care at the earliest point in their journey. During 2025-26 the Trust continued to improve how patients access and experience care. Examples of progress and achievement include:

- A strengthened clinical quality, safety, and learning infrastructure, including further development of the Patient Safety Incident Response Framework, enhanced clinical supervision, learning from clinical audits and research, and improvements in patient experience arrangements and complaint response times.
- The development of a new Clinical Response Model.
- Better operational performance in key areas, with improved category 2 response times, fewer excessive waits, improved handover times, and less avoidable conveyance.
- Expanded provision for mental health, frailty, and community-based alternatives to support more care closer to home.
- New contracts for NHS 111 and the Patient Transport Service, providing stability and sustainability for key services upon which our patients rely.

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 the NHS People Plan values. 2025-26 saw the Trust continue to invest in workforce wellbeing, inclusion, organisational development and culture work, essential for workforce sustainability in an increasingly complex health system. Examples of progress and achievement include:

- Strong progress on National Staff Survey engagement and results, demonstrating positive direction of travel across many areas of organisational culture and staff experience.

- Further embedding of YAS Together (the Trust's organisational culture programme), leadership development, Freedom To Speak Up, sexual safety, and other cultural development initiatives.
- Indicators of staff engagement, psychological safety, inclusion, retention, and staff experience have improved.
- Recruitment, apprenticeships, volunteering and leadership infrastructure, along with improvements in appraisals and essential learning, provide a stronger base for sustained capacity and enhanced capability.

Our Partners

System Collaboration and Integration
The Trust is increasingly recognised as an integrated system leader and strategic partner, through effective collaboration with Integrated Care Boards (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 is supporting addressing health inequalities and population health management. The Trust's role in care systems has evolved significantly during 2025-26. Areas of progress and achievement include:

- Stronger working with ICBs and other partners in local health systems.
- Partnership working on key operational issues, including hospital handover and pathways development.
- Community engagement and anchor activity, especially in deprived and underserved communities.
- YAS is becoming a more connected and visible system partner and community anchor.
- Executive Leadership Board structure and collaboration.

Our Planet and Pounds

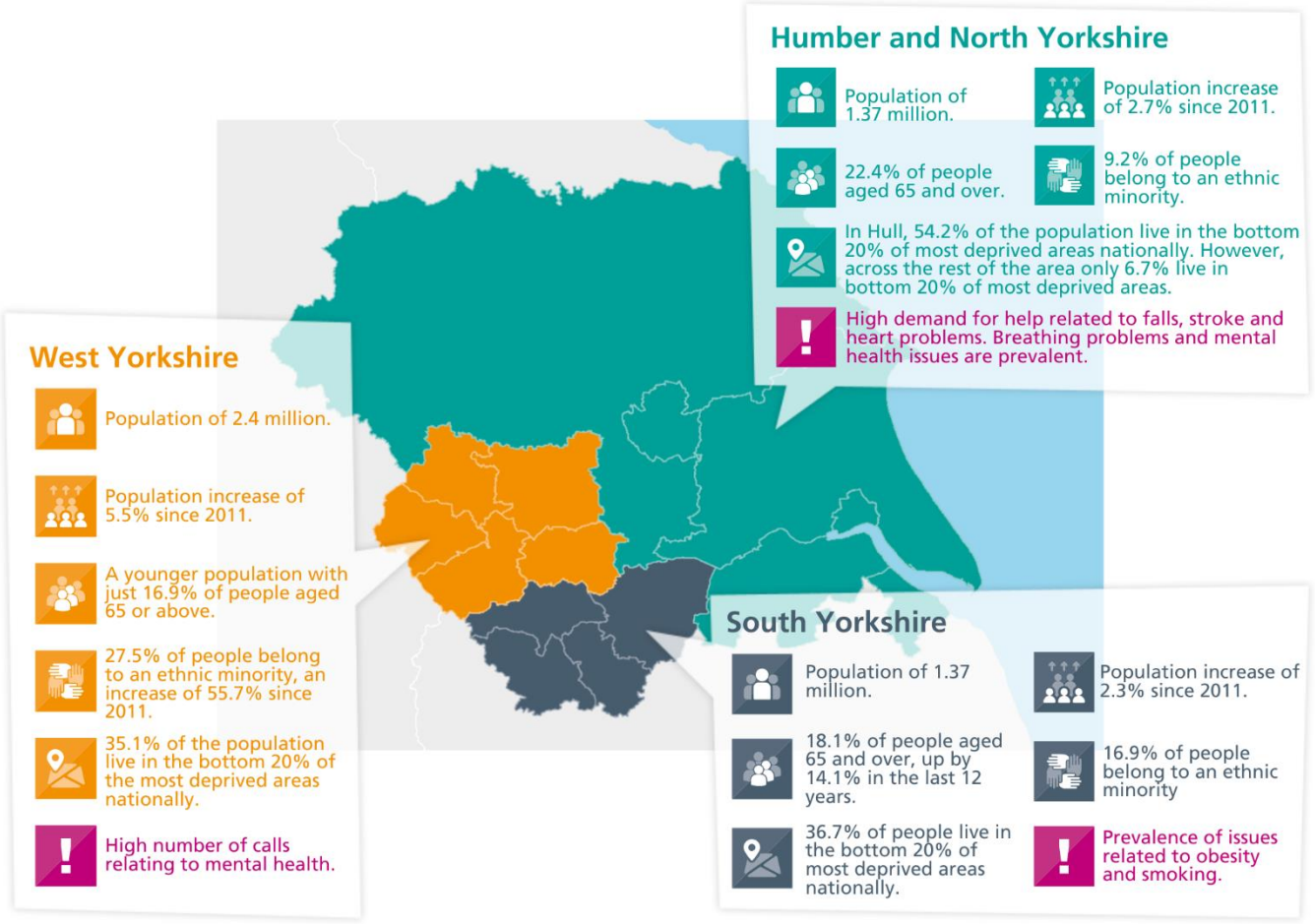
Sustainability and Innovation
The Trust achieved a modest surplus financial position for 2025-26 and delivered significant efficiency and cost improvement programme requirements whilst improving service performance and quality. The Trust moved into 2026-27 on a strong foundation of financial balance, improved governance and performance management, to support transformation and delivery of efficiencies in an increasingly challenging environment. Areas of progress and achievement include:

- Strong and sustainable financial grip, including a 2025-26 surplus position and delivery of efficiencies.
- Improved productivity and better use of resources through technology, fleet enhancements, lower NHS 111 costs, and reduced reliance on private providers.
- Visible progress on digital and technology developments, including the implementation of a new digital telephony and triage system (NHS Pathways)
- Progress on estates infrastructure and sustainability, including the Hull hub development and the adoption of a new Green Plan.

Our Partnerships

Yorkshire and Humber Partners

Yorkshire Ambulance Service forms an important part of the health services landscape across Yorkshire and the Humber and is an integral partner to three Integrated Care Boards (ICBs) – 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 2025-26 we continued to work closely with colleagues in the three ICBs, developing ever stronger 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, neighbourhood and community level that has improved service delivery and patient experience.

Northern Ambulance Alliance

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 to reduce the overall costs of the collective budgets of the four services.

The Trust 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 2025-26.

Statement from the Chief Executive

Over the past year, Yorkshire Ambulance Service NHS Trust continued to deliver vital care to communities across Yorkshire and the Humber against a backdrop of sustained demand, system-wide pressure and ongoing reform across health and social care. Throughout 2025-26, the Trust remained focused on improving patient outcomes, strengthening operational resilience and supporting its workforce, while continuing to transform services to meet future needs.

Operational Review

999 Operations
Operationally, the year saw consistent improvements in emergency response performance, particularly for the most time-critical incidents.

In our 999 Operations service in 2025-26 the average response time for a category 1 incident (for the most seriously ill or injured patients) was seven minutes and 48 seconds; an improvement of 13 seconds on the year before, and bringing us closer to 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 32 seconds (13 minutes and 59 seconds in 2024-25).

For category 2 incidents, our average response time in 2025-26 was 26 minutes and 15 seconds, which is 5 minutes and 42 seconds quicker than 2024-25 and within the standard of 30 minutes. The 90th percentile response time was 55 minutes and 20 seconds (72 minutes and two seconds in 2024-25), against the standard of 40 minutes.

With regard to hospital handover delays, we continue to see good progress following the region-wide introduction of our Transfer of Care process. The 2025-26 average was 19 minutes and 15 seconds which is 58.8% lower than in 2024-25.

These improvements were supported by closer working with system partners, notably to reduce hospital handover delays, helping ambulances return to local communities more quickly and improving patient safety.

Delivering the right care in the right place
Throughout the year, the Trust continued to expand its use of alternative care pathways and specialist responses, supporting the delivery of care closer to home, and reducing avoidable conveyance to emergency departments. This included enhanced mental health responses, improved access to same day emergency care, urgent community response services and specialist clinical advice.

These developments supported safer decision making for clinicians, improved patient experience and reduced avoidable hospital conveyance, aligning strongly with national priorities to shift care from hospital to community settings.

National priorities
For 2026-27, national NHS ambulance priorities focus on improving category 2 response times to an average of 25 minutes (aiming for an 18-minute average by 2028-29), increasing 'hear and treat' and 'see and treat' clinical models to reduce hospital conveyances, and reducing handover delays. Key initiatives include strengthening workforce wellbeing, implementing new technology, and integrating services.

System integration remains important, with a particular focus on aligning ambulance services more closely with community multi-disciplinary teams, particularly in relation to frailty, dementia, and palliative care.

In terms of operational efficiency, there will be utilisation of national demand and forecasting tools for optimised scheduling, alongside updating fleet with improved, safe vehicles.

Digital integration is also a priority, with expansion of the use of the NHS App for triage and improving clinical assessment in emergency operations centres.

The combination of these priorities is designed to move beyond traditional emergency response to a more preventive, integrated urgent care role.

Emergency Operations Centre
In our Emergency Operations Centre (EOC), we received over 1.25 million calls during 2025-26, which was nearly 20,000 more than in 2024-25. We achieved an average answer time of 10 seconds for a 999 call, and 81.5% of calls were answered within the national target of 5 seconds.

Introduction of NHS Pathways to emergency call telephone triage
A major milestone during the year was the successful transition to the NHS Pathways telephony and triage system for 999 call handling, aligning emergency and urgent care triage and enabling more detailed clinical assessment at the point of first contact. This change has strengthened decision-making, improved access to community and specialist services, and supported a more integrated approach across 999 and NHS 111 services.

The team responsible for the delivery of the new telephone triage system in the EOC was recognised with a national award in the 'Exceptional Team' category at the Ambulance Leadership Forum (ALF) Awards 2026.

Hosted by the Association of Ambulance Chief Executives (AACE), the annual ALF Awards honour individuals who go above and beyond to improve ambulance services. The team was recognised for its professional approach, dedication, empowerment, and a focus on improving patient outcomes, as well as embodying the Trust's values. They not only delivered on the transformation project but worked together effectively across many different services to solve problems, support colleagues and each other, and demonstrated how effective and successful teams should operate.

BBC *Ambulance*
During late 2025 and early 2026, BBC viewers got the opportunity to see our emergency operations centre and 999 Operations staff featured in highly regarded *Ambulance* programme.

Filming has continued at the Trust in 2026 with production company Dragonfly TV and we look forward to seeing more episodes of this fly-on-the-wall documentary series in 2027.

More detailed information on frontline 999 Operations activity is provided in this section of the annual report. Whilst response times remain an important measure, the empathy and compassion shown by our staff and volunteers to patients is a key part of the care we provide and we should be very proud of all that they do 24/7.

Integrated Urgent Care
In our Integrated Urgent Care service (NHS 111) service demand increased by 5.9% with a total of 1,910,756 calls offered throughout the year. The average call answer time for the year was 39 seconds and the proportion of call being answered within 60 seconds was 84.18% (just under 90% in 2024-25).

In March 2026 the contract to provide the NHS 111 service across the Yorkshire and Humber region was confirmed for YAS, for at least the next five years. The award of the contract recognises the delivery of a high performing and well-regarded NHS 111 service with fantastic commitment to providing excellent service to our patients.

Patient Transport Service
Our non-emergency Patient Transport Service (PTS) saw lower activity with 675,000 journeys made during the year, a 31% decrease on the same period in 2024-25. This is as a result of the implementation of the national eligibility criteria and means we can continue to focus our resources on those whose medical conditions make independent travel to and from healthcare settings unsafe or impossible.

The five-year contract to provide non-emergency PTS for the Humber and North Yorkshire area was confirmed for YAS in March 2026 following a rigorous tender process. We now have three PTS contracts, providing a service across the whole of the region. The awards of all these contracts recognise the delivery of a high performing and well-regarded non-emergency PTS.

We know that the contracts include some ambitious targets to deliver for our patients and we will be building on our successful implementation of the eligibility criteria last year.

NHS Oversight Framework
The Trust maintained a strong national position through the NHS Oversight Framework, remaining in the highest performance segment throughout the year. This reflected balanced performance across access, quality, people, finance and productivity, while also providing clear insight into priority areas for continued improvement, including staff wellbeing and sickness absence. During the course of the year, the Trust improved its ranking among the ten English ambulance trusts from third highest in Quarter 1 to be ranked first out of the ten in Quarter 4.

Supporting and developing people remained a central priority. The Trust continued to invest heavily in education, apprenticeships and leadership development, strengthening workforce pipelines and creating opportunities for colleagues at all stages of their careers. Staff engagement remained strong, with improvements across all themes of the NHS People Promise, reinforcing progress towards a compassionate, inclusive and values-led culture. Volunteers also continued to make an invaluable contribution, supporting patient care, community resilience and life-saving education across the region.

Tackling Health Inequalities
Throughout the year, Yorkshire Ambulance Service strengthened its role in tackling health inequalities and improving population health. This included targeted community engagement, innovative mental health responses, expanded use of specialist paramedics, and partnerships focused on prevention, early intervention and care closer to home.

Programmes such as Restart a Heart, community first responder schemes and work with schools, prisons and marginalised communities helped improve access to care, build trust and equip people with skills that can save lives.

Workforce and Leadership

Investing in People and Culture
Supporting colleagues remained a central priority. During the year, the Trust continued to invest in education, apprenticeships and leadership development, strengthening workforce pipelines and creating opportunities for progression across clinical and non-clinical roles.

Staff engagement remained strong, with improvements across all seven themes of the NHS People Promise, reinforcing progress towards a compassionate, inclusive and values-led culture. Recognition of staff achievements, long service and leadership excellence continued to be an important part of celebrating the contribution colleagues make every day.

Volunteers also played a vital role, contributing significant hours to frontline support, community first response, patient transport and public education, helping to strengthen community resilience across the region.

Top Apprenticeship Employer Ranking
We retained and improved our Top 100 Apprenticeship Employer status in the 2025 rankings, which celebrates England's outstanding apprenticeship employers. The Trust was placed 12th overall – a significant rise from last year's 23rd and 2023's 36th places.

The rankings are produced annually by *The Sunday Times* which independently assesses and ranks the nation's top apprenticeship employers. YAS was recognised for its continued commitment to the use and growth of apprenticeship schemes to develop core skills and workforce roles. In 2024-25 the Trust saw the introduction of the Enhanced Clinical Practitioner Programme (Level 6) to develop Specialist Paramedics with 43 now enrolled, and a Team Leader Apprenticeship at Level 3 to support the Integrated Urgent Care service to strengthen its management capability.

NHS Staff Survey results show continued improvement
We had a great response to the 2025 Staff Survey and are grateful for 66% of colleagues sharing their valuable feedback and insights.

We have seen improvements across all People Promise themes, and this is fantastic to see, with the 'we are compassionate and inclusive' theme seeing our highest scores, just as it was in 2024. I am also delighted to share that YAS is the leading organisation in the ambulance sector across seven of the nine NHS Staff Survey areas.

In the 'we are always learning' theme, we have continued to see year-on-year improvements but there is clearly more we need to do. The survey highlighted that we need to strengthen colleagues' involvement in changes that affect their work area. This is an area I am keen that we show real improvement in, particularly as we continue to operate in a challenging

environment with increasing demands, which will involve further work to change and improve how we work.

The ‘we are safe and healthy’ questions are a key part of our understanding of things like burnout and stress, job satisfaction, and other workforce pressures. The insights we gather here will directly inform our work, especially as reducing sickness absence is one of our three top business priorities in the year ahead.

We continue to look closely at what our staff have told us and how we can make sure we are prioritising the support everyone needs.

Research, Innovation and Learning
Research and innovation remained integral to improving care. The Trust continued to grow its research capability, working with academic partners, clinicians and patients to inform practice and improve outcomes. Learning from patient safety incidents and research evidence supported service improvement and strengthened the Trust’s approach to quality and safety.

Sustainability

Significant progress was made towards the Trust’s environmental sustainability ambitions. Investment in electric vehicles, cleaner ambulance technology, solar energy and estate improvements supported the journey towards net zero, while also delivering operational efficiencies and financial savings that can be reinvested into frontline services.

Work also progressed on new and refurbished ambulance stations, improving staff welfare facilities and supporting more sustainable, resilient services for the future.

Importantly, this year the Trust adopted a new Green Plan which sets out ambitious actions and targets that encourage us go further in our work towards net zero, and which puts in place the supporting governance and delivery infrastructure needed to get us there.

Conclusion

Looking ahead, Yorkshire Ambulance Service enters the next year with a clear strategic focus: to build on the progress made, to continue improving patient experience and outcomes, to support colleagues to thrive at work, and to work collaboratively with partners to deliver safe, sustainable and high-quality urgent and emergency care for the population it serves.

On behalf of the Trust, thank you to all colleagues and volunteers for their remarkable efforts to care for patients across the Yorkshire and Humber region, and thank you to our partners and local communities for their ongoing support.

Peter Reading
Chief Executive

25 June 2026

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 more than 7,000 staff, who, together with around 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.

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 provide quality for patients.
4. Ability to strengthen 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 2025-26.

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

The Trust responded to a total of 909,386 emergency incidents through either a vehicle arriving on scene or by telephone advice. This was an increase from 908,663 emergency incident responses during 2024-25.

Clinicians and call handlers based in our Clinical Hub, which operates within the Emergency Operations Centre (EOC), triaged and helped 122,040 callers with their healthcare needs over the telephone. This was a decrease from 141,693 in 2024-25. However, it should be noted that while EOC transitioned to a new telephony and triage system (NHS Pathways) around 160,000 calls were outsourced to be answered by other trusts on our behalf. There will be calls within this dataset which were treated over the phone by those trusts and not sent to us, therefore, the difference between the two years is not directly comparable.

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.	30 mins for 2025-26 25 mins for 2026-27	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 2025-26 was as follows:

Mean Response Time

Response Category	Standard we aimed to achieve	Mean Response Time: 2024-25	Mean Response Time 2025-26
Category 1	7 mins	00:08:01	00:07:48
Category 2	30 mins	00:31:57	00:26:15
Category 3	60 mins	01:31:49	01:18:36
Category 4	Not applicable	01:29:48	01:51:26

90th Percentile Response Time

Response Category	Standard we aimed to achieve	90th Percentile Time 2024-25	90th Percentile Time 2025-26
Category 1	15 mins	00:13:59	00:13:32
Category 2	40 mins	01:12:02	00:55:20
Category 3	2 hours	03:31:40	03:03:41
Category 4	3 hours	03:43:48	04:05:21

During 2025-26 the work to improve response times continued to be a significant focus for the Trust, with business plan priority work programmes in place to target reduced demand, increased capacity, and improved efficiency. The Trust has taken the following actions to improve the mean and 90th percentile response time to protect the quality of its services:

- Work with acute trusts to reduce handover delays has continued in this year to ensure we have as many ambulance crews available as possible.
- Work to reduce crew clear times (the time required for an ambulance crew to become available after handing over a patient).
- Work to refer patients to alternative care pathways rather than sending an ambulance.
- Improvements in recruitment and retention of staff.
- Mobilising more ambulance crews and keeping more ambulance vehicles available for deployment.
- Operational managers remain focused on reducing sickness absence rates in both the Emergency Operations Centre (EOC) and 999 Operations.

Hospital Handover

Hospital handover times continued to have a big impact on ambulance availability and how quickly we could reach patients during 2025-26.

In partnership with acute trusts, the Trust rolled out the Transfer of Care model across Yorkshire and this is now operational at all emergency departments in the region. This model includes an

expectation that no patient handover should take more than 45 minutes, and this has had a significant positive impact on reducing delays for patients.

Handover delays improved across the region during 2025-26. For example, in March 2026 the average 'arrival to handover' time was more than five minutes faster than in March 2025.

Despite the improvements delivered in 2025-26 the Trust continues to treat hospital handover delay as a key risk, because these delays reduce ambulance availability and can slow down our responses to critically ill patients who are waiting for care. This risk was captured in our corporate risk reporting this year, which included specific risks about how we monitor handovers and the potential impact on patient response times.

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

System Working

Working With Partner Organisations
Working closely with partners was an important part of the improvements the Trust delivered in accident and emergency operations during 2025-26. Our local teams worked with acute trusts and other partners on each Integrated Care Board's urgent and emergency care plan. Together, we focused on patient flow, hospital handover, and being ready to respond, especially during winter pressures for which specific plans were prepared and mobilised.

This way of working helped all partners to see the same picture of the demand and pressures across our local urgent and emergency care systems and to collectively determine the best actions to take. This included clear escalation arrangements, shared expectations for transfer of care (hospital handover), and local operational updates to identify delays early and to resolve problems quickly as and when they arose.

Case Study: Partnership Grip on Category 2 and Hospital Handover in Bradford
Bradford and Craven was highlighted in our winter planning as an area where ambulance response performance could come under particular pressure, meaning that very poorly patients could be at risk of excessive waits to receive care. In response, the Trust worked even more closely with local partners on a day to day basis – bringing operational leaders, hospital teams and escalation arrangements together around one clear aim: keeping ambulances available so that patients could be reached quickly.

A big part of this was staying on top of hospital handover, including 'handover to clear', which is the time it takes for our ambulance crews to become available following the handover of a patient at a hospital. When handovers are delayed, ambulance crews are not available for the next patient. This creates delays in response to patients, and during busy periods the impact is felt even more keenly. A local operational situation report from March 2026 shows the kind of routine monitoring used to support this approach, including reporting on how many crews were waiting to hand over and the average handover-to-clear time in Bradford (for example, two crews waiting and a 32-minute handover-to-clear average at the time of reporting).

Three things made this approach work well: (1) clear expectations for transfer of care; (2) everyone sharing the same up-to-date view through regular reporting and escalation; and (3) quick joint problem-solving when patterns of delay started to appear. This helped tackle issues early, before they turned into longer-lasting constraints on frontline ambulance availability.

Work in Bradford continues to shape learning across West Yorkshire. It shows the value of clear information, shared ownership of patient flow, and practical actions on the day that protect turnaround and response capability – especially for category 2 performance, where ambulance availability and delays in urgent and emergency care are closely linked.

Remote Patient Care

Remote Patient Care
Two service-lines make up Remote Patient Care: Integrated Urgent Care (IUC, including the NHS 111 service) and the Emergency Operations Centre (EOC). 2025-26 marked year two of the Remote Patient Care Transformation Programme, with a continued focus on integration and improved service delivery across 999 and NHS 111.

The Trust monitors several national and local metrics in respect of our call-handling services. These metrics include 999 and NHS 111 call answering performance, timeliness of NHS 111 clinician call-backs, and the percentage of NHS 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
In 2025-26 our Emergency Operations Centre (EOC) received 1,253,289 emergency and routine calls, an average of 3,433 calls a day. This this was a 1.6% increase from the 1,233,967 calls received in 2024-25. The average time taken for 999 calls to be answered in 2025-26 was 10 seconds. The proportion of 999 calls answered within 5 seconds decreased from 90.3% in 2024-25 to 81.5% in 2025-26.

Demand and Performance Metrics

Activity / Performance Measures	2024-25	2025-26
Number of calls received	811,197	841,572
Average call answer time	4 seconds	10 seconds
Calls answered within 5 seconds	90.3%	81.5%

Please Note: 2025-26 includes approx. 160,000 outsourced calls which were answered on our behalf by other Trusts. The call answer times for these calls are not included. This was to enable call handlers to be trained on the newly introduced NHS Pathways system.

During 2025-26, we delivered a large-scale digital transformation project, to the NHS Pathways telephony and triage tool in the Emergency Operations Centre (EOC). To support safe implementation, a proportion of calls were handled by four other ambulance services for a seven-month period.

We maintained the national KPI for mean call answer time at 10 seconds; however, performance came under significant pressure at points following the cessation of outsourced support. This contributed to deterioration in the 90th, 95th and 99th centile measures and, at times, delays in call answering. Short-term mitigations were implemented and, through quarter four, we saw sustained improvement. The Trusts 2026-27 Business Plan priorities include a dedicated workstream for call handling recovery following this important digital transformation project.

Integrated Urgent Care

NHS 111 Call Handling

In 2025-26 the Trust's NHS 111 service received 1,910,756 calls, compared to 1,803,836 calls received in 2024-25.

The average time taken for NHS 111 calls to be answered in 2025-26 was, 39 seconds, and call abandonment rates were 2.58%. The proportion of calls answered within 60 seconds was 84.18%.

The telephony data shown below is for health advisors.

Demand and Performance Metrics

Activity / Performance Measures	2024-25	2025-26
Calls received (offered)	1,803,836	1,910,756
Patient calls answered	1,691,748	1,731,780
Calls abandoned	32,311	45,832
Calls answered within 60 seconds	1,508,393	1,457,771
Average call answer speed	00:00:26	00:00:39
Clinical call-backs within one hour (target 60%)	Not Available	Not Available
Core clinical advice provided (target 30%)	Not Available	Not Available
Emergency Department validations (target 50%)	Not Available	Not Available
999 Validations (target 95%)	Not Available	Not Available

Digital Transformation and Service Developments

During 2025-26 the Remote Patient Care service delivered large-scale digital transformation while maintaining its core service delivery functions. Examples of this include:

NHS Pathways Implementation
We delivered a large-scale digital transformation, transitioning to the NHS Pathways telephony and triage system. This is a core component of our Remote Patient Care transformation programme and supports the planned integration of 999 and NHS 111 by aligning services to the same triage platform.

We retrained more than 170 call handlers on the new tool and continued to recruit and retain staff throughout the transition, providing sustained pastoral and technical support during and after go-live. We also refreshed standard operating procedures and audit processes, laying the foundations to realise future benefits including a more flexible joint workforce and improved organisational resilience. This project was delivered on time and within budget, ensuring a foundation element of the Remote Patient Care transformation was in place to continue the transformation journey into 2026-27.

Phase one of the Integrated Clinical Assessment Service (ICAS)
Phase 1 of the Integrated Clinical Assessment Service (ICAS) was delivered, with the NHS 111 clinical team moving onto the new computer-aided dispatch (CAD) system. This is a key preparatory step for the 2026-27 CAD programme, when NHS 111 call handling will transition to the same CAD platform, further aligning NHS 111 and 999 services. The change was supported by robust clinical safety assurance, including updated processes, testing and governance.

Directorate Transformation and Strengthened Governance
We established clearer operational and transformation oversight for Remote Patient Care, including refreshed senior leadership forums and a dedicated oversight, transformation and governance group.

Clinical Safety and Effectiveness
Through the Remote Patient Care Clinical Governance Group we strengthened incident learning, increased audit capacity, and expanded multi-disciplinary reviews. This included targeted focus on high-risk themes such as delayed responses, patients on the floor and delayed dispatch.

Key improvements implemented during the year included:

- Revised ‘patient on the floor guidance’, supporting quality care for patients who have fallen. This has been recognised nationally by the Association of Ambulance Chief Executives.
- Enhanced ‘safety calling’ flowcharts and escalation plans, offering robust advice to patients and staff in times of escalation.
- Clearer ‘PUSH’ referral documentation, improving consistency and auditability.
- Updated ‘Clinical Support Desk’ in EOC to prepare for joint clinical service in 2026-27.
- Updated and strengthened the clinical calibration and supervision model.
- Enhanced ambulance and Emergency Department validation within NHS 111, supporting improved system outcomes and contributing to a 10% reduction in ambulance dispatch and unnecessary Emergency Department attendance.

Workforce and Clinical Capability

- Made strong progress in positioning remote patient care as a clinical speciality, launching cohort one of a new Specialist Practitioner pathway in partnership with Sheffield Hallam University.
- Maintained the NHS 111 Health Advisor workforce levels.
- Grew our clinical workforce during the year, with further expansion planned for 2026-27 to support high-quality triage and assessment and maximise hear and treat outcomes.
- Implemented the remote patient care wellbeing team, building on the established EOC model and integrating support into a single, joint service.
- Aligned training teams to improve consistency and parity across services, standardised trainer roles and skills, and implemented a revised structure to strengthen training capacity.

External Recognition and Awards
The directorate was recognised nationally through leadership and innovation awards across both service-lines, reflecting progress in transformation, integration, service improvement, staff wellbeing and culture. Recognition included the National Control Room Awards, UKCCF Control Room Awards and the Ambulance Leadership Forum Awards.

NHS 111 Contract Award
We successfully completed the Provider Selection Regime process across the three ICBs, securing the NHS 111 contract for a further 5+2 years. This provides service stability within an agreed performance and quality framework.

Workforce Outcomes: "Great Place to Work"
This was the second year of improvement in staff survey results, with higher response rates and more positive feedback, reflecting progress in leadership culture and behaviours. Recruitment and retention indicators also improved over the year, supporting sustained culture change. Improvements were made across both contact centres. New training facilities opened at Springhill 2 (Wakefield HQ), breakout areas were enhanced, and all desks and chairs were replaced within EOC. Plans are in place to complete replacements in IUC over the coming months.

Patient Transport Service

Our non-emergency Patient Transport Service (PTS) provides NHS-funded transport for eligible patients, to and from their healthcare appointments, treatments, discharges or transfers as a timely, caring and safe patient experience, for those unable to travel by other means due to their medical condition or mobility needs.

PTS saw material reductions in lower mobility demand with a phased downward trend of activity throughout 2025-26. This was due to delivering sustainable implementation of NHS England's revised national eligibility criteria on behalf of the ICBs that commission our services.

From 1 April 2025 to 31 March 2026, PTS operated 831,223 journeys (including aborts and escorts) which is a 15.1% decrease on the previous year. Of these journeys, 314,112 were for high acuity patients requiring a multi-crewed vehicle.

Call activity in 2025-26 reduced by 20% with our PTS Reservations team answering 401,334 calls over the year. The average for the number of calls answered within our KPI of 180 seconds was 84.5%, which is a 4.7% increase from the previous year.

PTS continued to be supported by over 120 PTS Volunteers and a framework of private ambulance and taxi providers. This partnership approach means patients benefit from quality assured NHS service levels combined with value for taxpayer money to meet fluctuating levels of demand and periods of pressure throughout the year.

Implementing the revised eligibility criteria drove a significant reduction in the number of journeys operated by taxis. In the previous year 24% of PTS journeys were delivered by taxis. This reduced to 11% in 2025-26 due to the decrease in demand for low acuity patients.

Implementing the revised national eligibility criteria for PTS
The eligibility criteria for PTS are set out nationally by NHS England.

YAS implemented the revised national eligibility criteria across Yorkshire from 1 April 2025 on behalf of the three ICBs who commission our services. These criteria were introduced in South Yorkshire on 1 April 2025, West Yorkshire on 28 April 2025 and Humber and North Yorkshire on 27 May 2025.

The purpose of these criteria is to ensure that NHS-funded transport is used appropriately and equitably, within the constraints of available funding. The overarching principle of the criteria is that most people should travel to and from hospital independently by private or public transport, with the help of relatives or friends if necessary. NHS-funded patient transport is reserved for when it is considered essential to ensuring an individual's safety, safe mobilisation, condition management or recovery.

By working collaboratively with ICBs, we developed clear and fair processes to determine if a patient is eligible for PTS. This included a new set of questions for our call handlers to ask patients, a method for directing non-eligible patients to suitable alternatives and a robust escalation process.

Our quality, equality and health impact assessments, alongside a comprehensive staff training programme ensured the revised national eligibility criteria was implemented effectively and consistently, safeguarding NHS resources for those who need them most.

Building on the lessons learned from this project, next year we will be reviewing the questions we ask about a patient's mobility. This is in line with the patient mobility codes set by NHS England to ensure a standardised approach across the country. This will further improve the quality of our service by ensuring we have accurate information about each patient to be able to allocate the most suitable vehicle.

PTS Contract Management and Procurement
Three new PTS contracts were directly awarded to YAS in South Yorkshire, West Yorkshire, and Humber and North Yorkshire under the new Health Care Services (Provider Selection Regime) Regulations 2023. YAS were the incumbent provider of these contracts.

The transparency and rigour of the Provider Selection Regime ensures that services are procured with patient experience and quality at the forefront.

This achievement marks a significant milestone for NHS Ambulance Trusts, as these are the first PTS contracts to be awarded in this way.

This outcome is the result of regional collaboration across PTS and effective partnership working with commissioners, demonstrating our shared long-term commitment to providing and investment in high-quality transport services for eligible patients across Yorkshire and Humber.

Enhancing Patient Safety: New Manual Handling Equipment
The introduction of new Compact PowerTraxx chairs this year has made patient transfers safer and more comfortable. These chairs provide a powered stair track system that reduces manual lifting and improves safety for both patients and staff.

Initially, PTS trialled these chairs which had been supplied as demonstration equipment to assess their suitability within our service. Staff provided excellent feedback highlighting the enhanced safety and comfort these chairs offer, particularly when moving patients round tight corners and through narrow staircases.

In response to the positive feedback from staff and patients, we invested in 25 new Compact PowerTraxx chairs which have become a valued addition to our service provision. With this equipment we are now able to safely move some patients who we previously could not accommodate, due to limitations in space and the number of staff required. This investment also resulted in improved efficiency by reducing the occasions where multiple crews are required to attend.

PTS Fleet: Award Winners
PTS received the Public Sector Commercial Fleet of the Year Award at the 2025 GREENFLEET Awards. This award recognised our pioneering introduction of 35 new electric vehicles (EVs) and estates charging infrastructure. This is the largest ambulance-sized electric PTS fleet in any NHS ambulance trust.

This project supports the Trust's Green Plan which sets out a phased transition to EVs, with a goal of meeting NHS England's 100% zero-emission trajectory for PTS vehicles by 2035.

Investment has been agreed for an additional 25 EVs to be added to our fleet, which shows our further commitment to a sustainable PTS improving patient experience through quieter, cleaner journeys.

Clinical and Quality

The Trust's main statement of performance and assurance regarding clinical effectiveness, patient care, and patient experience for 2025-26 is found in a separate publication, the Quality Account.

Improvement Priorities

For 2025-26 the Trust had three improvement priorities in the areas of clinical and quality, covering patient experience and involvement, clinical effectiveness, and patient safety. The following presents an overview of progress during the year.

Priority 1: Enhancing Patient Experience and Involvement
During 2025-26 significant progress was made to embed a new Patient Experience and Involvement Framework across the organisation. All service area presentations at the Patient Safety Learning Group now include a patient story, ensuring that learning from lived experience is systematically incorporated into the Trust's governance, assurance, and decision making.

The Patient Relations Team now collects demographic data from complainants. This provides foundations to help the Trust better understand the population groups represented or otherwise in complaints data, helping to identify inequalities and to develop better, more targeted feedback mechanisms.

Our patient experience surveys have undergone redesign with input from the Critical Friends Network to be more accessible, diverse and responsive to patients' needs. Early improvements have already been seen in complaints handling.

Engagement with the Critical Friends Network remains positive. New volunteers have engaged, recruitment has been aligned with wider Trust volunteer processes, and new training packages are being rolled out based on volunteer feedback. Patient experience considerations are now more visible within operational governance. For instance, patient experience insight has been critical in supporting the Trust's PTS teams to apply the national eligibility criteria fairly and consistently.

Area of limited progress: Training for frontline staff on patient experience principles has been inconsistent.

2025-26 Impact

- Increased visibility of patient voice within the Trust's governance and assurance arrangements, supporting more balanced and inclusive decision making.
- Strengthened complaints-handling processes, supporting earlier resolution and improved patient satisfaction.
- Enhanced co-production and volunteer involvement through the Critical Friends Network, increasing the quality and diversity of user insight.
- Improved use of data to identify health inequalities and gaps in patient feedback.
- Greater assurance that patient experience insight informs operational decisions, including PTS eligibility application.

Priority 2: Clinical Effectiveness – Clinical Supervision Framework
The continued roll-out of the Clinical Supervision Framework has progressed well during 2025-26. Twenty-five facilitators undertook professional advocacy training during the year, with a further thirty places scheduled. Embedding clinical supervision arrangements within operational team training and development days has commenced.

Six development events for Newly Qualified Paramedics were held across Yorkshire, offering capacity for 350 attendees. Feedback from participants indicated that the sessions had a positive impact resulting in enhanced confidence, strengthened reflective practice, and improved patient-care outcomes.

<u>2025-26 Impact</u>

- Expanded pool of trained facilitators able to deliver high quality, restorative clinical supervision.
- Positive impact reported by staff from Newly Qualified Paramedic development events, including improved clinical confidence and decision-making.
- Improved consistency and structure in supervision conversations captured through facilitator feedback and activity data.

Priority 3: **Patient Safety – Learning and Improvement Through PSIRF**
During 2025-26 the Trust further matured its implementation of the Patient Safety Incident Response Framework (PSIRF). The alignment of central and local governance structures with ICB footprints has strengthened local ownership of patient safety issues, enabling teams to more effectively identify, understand and respond to risks within their areas.

Central oversight through our central incident reporting system and the Patient Safety Learning Group supports triangulation of themes, monitoring of trends, and ensuring that learning is shared across the organisation.

The four priority themes for 2025-26 were:

- Patient Care and Safety Concerns – including no conveyance resulting in reattendance with harm, and patient deterioration during unplanned delays
- Communication and Documentation – miscommunication leading to major harm and delayed response due to incorrect patient location.
- Medication Safety Concerns – wrong drug, dose or route resulting in moderate or greater harm.
- Equipment Failures – unexpected incidents with potential for significant learning.
- Exceptional Patient Safety Events – emerging risks not fitting other categories but requiring rapid learning.

Progress against each theme is reviewed quarterly via the Clinical Governance Group and the Quality Committee.

2025-26 Impact

- Improved visibility of patient safety risks at local and central levels.
- Strengthened learning culture through proportionate learning responses and triangulated insights.
- Increased consistency in identifying themes and addressing systemic issues.
- Better alignment of local governance processes to geographical patient safety needs.-safety needs.

Clinical and Quality Developments in Service Areas

999 Operations
999 Operations continued to improve patient flow, clinical practice, and system collaboration. Implementation of the new Transfer of Care standard operating procedure across acute trusts resulted in improved handover times and Category 2 performance.

Workforce development remained central, with strengthened team leader recruitment processes, embedded mentor rotas for Newly Qualified Paramedics, and enhanced investment days incorporating clinical supervision and continuing professional development. Specialist Paramedic teams across urgent, critical and mental health care continued to mature.

Quality learning was driven through the weekly Learning from Incidents Review Group, leading to improvements in abdominal pain and hyperemesis assessment, frailty assessment, mental capacity and restraint decision making, medicines optimisation, clinical reasoning and documentation quality.

Operational improvements included increased fleet resilience, deployment of the control drugs app across operational areas, enhanced support to prisons through shared data insights, and strengthened student paramedic education with university partners. Staff wellbeing and local working environments also improved, including enhanced rest facilities and expanded quality governance support across regions.

Remote Patient Care
Progress continued towards a single remote patient care operating model, supported by integrated recruitment and training functions that improved staff experience and reduced turnover. National recognition and awards highlighted the strength of this model.

A strong learning culture was supported through the Local Incident Review Group and a new staff recognition scheme aligned with organisational values.

Emergency Operations Centre (EOC)
The EOC successfully transitioned to NHS Pathways, with all staff receiving retraining. Staff identified improvement opportunities were escalated through governance to influence national changes, including enhanced recognition of DNAR/ReSPECT documentation for end-of-life care

Clinical support structures were expanded, including strengthened clinical support desk arrangements, clinical navigators beginning Level 7 training, and implementation of clinical calibration as a formal reflective practice process. A 360-degree audit undertaken as part of PSIRF highlighted EOC as an example of best practice in supporting patient safety.

NHS 111 Integrated Urgent Care

Clinical staffing continued to grow, supported by successful recruitment and retention of international nurses. Performance improved following the 2024-25 Case for Change Programme, despite periods of exceptional demand.

A key development was the new Integrated Clinical Advice Service (iCAS) platform, enabling shared clinical queues between 999 and NHS 111. Clinical triage models were updated in line with the Urgent and Emergency Care Plan, enabling earlier identification of high acuity patients and reducing avoidable emergency department referrals and ambulance dispatches.

Patient Transport Service (PTS)

Our PTS continued to embed Quality Improvement (QI), with 34 staff completing QI training and sustained engagement with the PTS Fellowship Programme. Work to streamline operational risk assessments has identified opportunities to reduce assessment time, improve efficiency and support staff development.

The Trust successfully implemented the national eligibility criteria from 1 April 2025 through new question sets, escalation routes, equality impact assessments and staff training. This ensured a fair, consistent and sustainable approach to patient eligibility across the three commissioning ICBs.

Clinical Pathways

During 2025-26 the Trust continued to strengthen and develop clinical referral pathways to support improved patient outcomes, reduce avoidable conveyance, and ensure more patients access the right service first. Our work focused on enhancing care for time-critical conditions, expanding community-based alternatives to emergency department attendance, and improving staff access to pathways and decision-support tools.

Our approach is informed by staff feedback, stakeholder engagement, incident learning and routine monitoring data, with all developments progressed using quality improvement methodology.

Key Areas of Progress

- Time-critical conditions.
- Updated STEMI pathways, including new national criteria, improved ECG transmission processes, and strengthened post-ROSC referral guidance.
- Continued development of the stroke pathway, including support for pre-hospital video assessment and engagement in plans to expand regional thrombectomy provision.
- Improving staff access to pathways.
- Enhancements to the JRCALC Plus pathways directory, including new content for Remote Patient Care and app improvements based on staff feedback.
- Increasing access to Same Day Emergency Care (SDEC)
- Increased availability and visibility of priority referral pathways through the “Right Pathway First” internal communications campaign.
- Better use of data, including pathway utilisation dashboards, visualisation tools and reporting processes and engagement in the development of the new ePR to strengthen future data capture.

The Trust worked with acute partners across Yorkshire to expand direct ambulance access to SDEC services, including new frailty, medical, surgical and cardiology pathways. This work provides clinically appropriate alternatives to acute hospital conveyance and supports better patient flow.

Other Local Pathway Developments

Further improvements included:

- Expanded access to Urgent Community Response teams, frailty virtual wards and specialist assessment units.
- New referral routes into gynaecology, respiratory hubs, diabetic podiatry and DVT services.
- Pilots in Mid Yorkshire and Bradford to support real-time senior clinical input and improved access to community-based alternatives.
- Targeted admission-avoidance work in Mid Yorkshire and Leeds.
- Continued focus on falls prevention in West Yorkshire.

Quality Improvement

During 2025-26, the Trust continued to embed Quality Improvement (QI) as an organisation wide approach, guided by the QI Enabling Plan 2024-29 and aligned with NHS IMPACT (Improving Patient Care Together). Progress this year reflects growing capability, stronger governance, and increasing ownership of improvement across all services. The Trust exceeded QI training targets, expanded strategic and local capability, and delivered measurable improvements through Fellowship projects and staff generated ideas.

Building QI Capability
A total of 208 staff completed QI education, including 153 participants in QI Foundations training and 55 participants in the QI Leaders course. This strengthened our capacity to undertake structured improvement work and supported development of a shared methodology across the Trust. Training feedback remained positive, with continued sponsorship from senior leaders and collaboration with other NHS organisations.

The newly established QI Community of Practice provided peer-to-peer support, shared learning, and celebrated improvement successes. Two Trust-wide QI webinars attracted more than 400 virtual attendees, reinforcing engagement with continuous improvement principles.

QI Fellowship – Delivering Measurable Impact
The QI Fellowship programme continued to build advanced improvement skills while delivering demonstrable benefits, including:

- PTS Risk Assessments – redesigned pathway reducing assessment time by 40 minutes per case.
- IUC Printing Reduction – reduction from 680,424 pages (2024) to 12,001 pages (2025), saving £11,328 and supporting environmental aims.
- Safeguarding Referrals – targeted CPD and Level 3 training reducing returned referrals and supporting timely care.

- Early Pregnancy Referral Pathway – improved access to the right care at the right time for patients contacting 999.

These projects highlight the impact of the Fellowship model on patient outcomes, workforce development and system efficiency.

Embedding QI as a Strategic Asset
Quality Improvement was integrated into the 2026-27 business planning cycle using a dual approach:

- PMO delivery when solutions are already known.
- QI Pathway for issues requiring exploration, testing and innovation.

QI Leads supported directorates through a strengthened Business Partnership Model, embedding improvement in local objectives, onboarding processes and operational activity. Demand for QI support continued to grow.

The Improvement Hub matured as a Trust-wide platform for idea generation, with 202 ideas submitted and 53 proposals in the open challenge “Ideas to Deliver Our Ambitions”. Challenge campaigns supported local teams to test and refine solutions with greater visibility.

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's website.

During 2025-26 the Trust embedded 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 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 NHS England planning guidance and Integrated Care Board plans and priorities.
- The 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 Performance Review

Strategic Context

In 2025-26 there was a continued focus on reducing waste, increasing efficiency and improving productivity, whilst remaining within the allocated resources. Overall, national modelling indicated that that NHS organisations would need to reduce their cost base by 1% and achieve a 4% productivity improvement to meet demand growth.

National targets included:

- Improving A&E waiting times and reducing handover times.
- Improving ambulance response times.
- Delivering a balanced system financial position.

Specific ambulance sector performance measures included:

- Reducing category 2 response times to an average of 30 minutes or less.
- Increasing 'Hear and Treat' rates and reducing the proportion of patients conveyed to hospital.
- Reducing sickness absence rates.

2025-26 Financial Regime and Planning

The funding arrangements set out in the national planning guidance reflected:

- Net cost uplift factor (CUF) of 2.15% (*4.15% gross with 2% efficiency*).
- A convergence adjustment (additional income) of 0.11% (applicable only to the West Yorkshire ICB element of the contract) to move funding towards a fair share target.
- Ambulance capacity funding of £11.08m, subject to an improvement of category 2 response times.

Trusts were asked to deliver reductions in the use of temporary staffing:

- Agency expenditure reduction of 30% from 2024-25 outturn.
- Bank staff expenditure reduction of 10% from 2024-25 outturn.

As in previous years, commissioners agreed a consolidated global sum payment to cover all ICB-commissioned service contracts. NHS England continued the pause in the nationally mandated CQUIN Quality Incentive Schemes for 2025-26, removing the risk associated with 1.25% of the contract value.

Integrated Care Systems (ICSs) remained the key unit for financial planning. Whilst YAS holds contracts with multiple Integrated Commissioning Boards (ICBs), financial planning and reporting is undertaken wholly within the West Yorkshire ICB (WY ICB). Overall financial performance for both revenue and capital expenditure was monitored at system level.

The Trust set a break-even financial plan and set budgets within the parameters of this plan.

The opening plan reflected an increase to pay budgets to cover a 2.8% pay award and the full year effect of increased employers National Insurance contributions. The Agenda for Change (AfC) pay award was subsequently confirmed at 3.6%. The amended pay award was funded through an additional CUF of 0.68% to the contract value, transacted in August.

The plan included a £23.1m efficiency/cost reduction target, incorporating a £4.6m vacancy factor and an 'unidentified' element of £8.45m for which there were no plans developed at the time of submission.

The Trust's PTS and IUC contracts were due for renewal at the end of 2025-26. Throughout the year the Trust worked closely with its ICB partners to undertake detailed reviews of each service contract in accordance with the national Provider Selection Regime, which took into consideration: Quality and Performance, Value, Integration, Access and Social Value.
All service contracts were successfully renewed through this process; with new multi-year contracts being directly awarded to the Trust.

Income and Expenditure

The Trust delivered a £2.57m surplus in 2025-26 against a break-even plan. A high-level summary of total income and expenditure is shown below.

Income & Expenditure	Plan	Actual
	£000s	
Operating Income & Expenditure		
Income*	(476,099)	(476,380)
Pay*	378,623	373,257
Non pay	96,281	105,753
Finance Costs		
Finance Income	(2,751)	(2,351)
Finance Costs	693	871
PDC Dividend	3,553	3,834
Other (gains)/losses on disposal	(300)	(214)
(Surplus)/Deficit	**(0)**	**4,771**
Remove impact of I&E Impairment	-	(7,341)
Reported (Surplus)/Deficit	**(0)**	**(2,570)**

**Includes income and expenditure for central pension costs of £23,022 (9.4%).*

Income

The Trust received total operating income of £476.38m; of which £438.59m (92%) was contract income from NHS commissioners for the provision of 999, PTS and 111 services.

Included within the contract was:

- £11m of ambulance capacity funding to support improved category 2 response times of 30 minutes.
- £4.6m for the Mental Health Investment Standard.
- £1.37m interoperability funding the Emergency Capabilities Unit (ECU formerly NARU – National Ambulance Resilience Unit).
- An additional £4.4m to cover increased depreciation charges.

The Trust also recognises £23m of notional funding from NHS England to cover the increased staff pension contributions; an additional 9.4%, taking the total pension contribution to 23.78% of pensionable pay.

		2025/26		2024/25
Income		**£'000s**	**%**	**£m**
Patient Care Income	Integrated Care Boards*	440,032	91.9%	413,692
	NHSE**	23,053	4.8%	21,378
	Other	3,500	0.7%	3,356
Non-Patient Care	Education and training	6,237	1.3%	5,997
	Research & Development	1,261	0.3%	960
	Other	2,296	0.5%	2,378
Finance Income		2,351	0.5%	2,815
Total Income		**478,730**	**100%**	**450,576**

** of which, £438.59m is contracted income.*

*** £23.02m is income to cover central pension costs*

Other significant sources of income for the Trust include funding related to Education and Training (£6.24m), Research and Development (£1.26m) and Events and Commercial Services (£1.2m).

Finance income (£2.35m) was from interest receivable on the Trust's bank account.

Total income to the Trust was £478.73m.

Expenditure
Operating expenditure in 2025-26 was £479.0m, which is summarised below:

Pay Costs
Pay costs in 2025-26 were £373.3m.
This represents an increase of nearly 8% from the previous year, due to:

i) 3.6% AfC pay award and the part-year effect of increased employers' National Insurance contributions from 13.8% to 15%.
ii) Ongoing recruitment in 999 operations to support improved category 2 response times.
iii) However, in other operational areas and across some support services pay costs were lower than planned.

Non-pay Costs
Transport costs reduced to £23.4m, down £5.5m from 2024-25, due to:

- The implementation of eligibility criteria in PTS leading to lower taxi/saloon car expenditure (c. £2.2m).
- Lower costs of operating our own fleet due to lower fuel unit price (prior to February), reduction in fuel consumption and lower maintenance costs (£1.1m).
- Higher fleet insurance rebates.
- Lower travel and subsistence costs.

Depreciation charges (including amortisation and lease depreciation) increased due to inflationary price increases and higher levels of capital expenditure, made possible through the availability of additional funds.

Operating Expenditure	2025/26 £'000	%	2024/25 £'000
Pay Costs*	**373,257**	78%	**346,226**
Non Pay Costs			
Transport	23,356	4.9%	28,837
Depreciation & amortisation	21,872	4.6%	19,376
Premises	12,794	2.7%	11,995
Supplies & Services	14,486	3.0%	10,544
Non-NHS healthcare	7,430	1.6%	11,666
Establishment	4,248	0.9%	4,767
Impairment	7,341	1.5%	495
Other	14,226	3.0%	13,332
Total Expenditure	**479,010**	**100%**	**447,238**

**includes NHSE notional pension income £23m (£21.2m in 24/25)*

Within **Premises**; computer software/licence costs increased, reflecting the implementation of new systems such as NHS Pathways and Fleet Telematics, a higher number of users and a shift to cloud-based systems.

Supplies and Services expenditure increased by nearly £4m from the previous year due to:

- Third party call-taking support provided during the implementation of the Pathways project in EOC (£2.6m).
- The Trust accelerated the replacement of some fleet medical devices (£2.2m).
- Offset by a reduction in expenditure on staff uniform, closer to budgeted levels; £413k less than in 2024-25 when exceptional costs were incurred due to changing the supplier.

Efficiency Savings/Cost Improvement Plans (CIP)

The Trust set an efficiency/cost reduction target of £23.1m which equated to 5.1% of expenditure.

This efficiency plan included a £4.6m vacancy factor and an 'unidentified' element of £8.45m for which no plans existed.

48% of the programme was categorised as 'high-risk'.

Efficiency Programme within the Financial Plan:

Risk Profile

	REC	NON REC	TOTAL
LOW	-£ 5,179	-£ 290	**-£ 5,469**
MEDIUM	-£ 5,876	-£ 570	**-£ 6,446**
HIGH*	-£ 1,053	-£ 10,142	**-£ 11,195**
Total	**-£ 12,108**	**-£ 11,002**	**-£ 23,110**

**£8.45m unidentified CIP included within non-recurrent/high risk*

There was intense scrutiny on the achievement of cost improvement plans at national level. NHS ENGLAND mandated fortnightly monitoring and imposed two specific targets at the beginning of the financial year:

- No unidentified schemes by the end of May.
- No high-risk schemes by the end of June.

The Trust performed well in meeting the efficiency plan.
Savings on pay budgets were achieved recurrently as directorates reviewed workforce structures and removed long-held vacant posts. The vacancy factor was exceeded due to

underspends that emerged early in the year, particularly in EOC and 111.

The highest-value non-pay schemes were;

- Cessation of private provider use in 999 operations, saving £3.5m.
- Implementation of eligibility criteria within the PTS service, which resulted in a reduction of taxi journey expenditure exceeding the expected target (a £2.2m cost reduction against a planned saving of £1.2m).

Achievement of the Efficiency Programme:

	REC	NON REC	TOTAL
INCOME	-£ 1,045	£ -	**-£ 1,045**
PAY	-£ 7,598	-£ 6,279	**-£ 13,877**
NON PAY	-£ 6,793	-£ 1,395	**-£ 8,188**
Total	**-£ 15,436**	**-£ 7,674**	**-£ 23,110**

Overall, the Trust delivered the efficiency plan in full and exceeded the target for recurrent savings by £3.3m.

Underlying Position

The Trust started the year with an underlying deficit of £6.06m.

The success in delivering a higher level of efficiencies on a recurrent basis improved this position by £3.3m, although this was offset by slightly higher expenditure on the dividend payment.

The Trust recognises a current underlying deficit of £2.96m which equates to 0.6% of total expenditure in 2025-26.

Capital Funding

NHS England implemented changes to the capital planning regime for 2025-26:

- Trusts received a single-year core allocation for both leased and purchased assets to fund *business as usual* operational investments
- Several new national capital funding streams were introduced; YAS was eligible to bid for the *Estates Safety Fund* and the *Urgent and Emergency Care (UEC)* element of the *Return to Constitutional Standards (RtCS)* funds, some of which was held centrally by NHS England for improving double-crewed ambulance (DCA) age-profile.
- Bids were approved by NHS England according to alignment with both system and national strategic objectives for improving productivity and efficiency, creating additional capacity and generating revenue cost reduction.
- Throughout the year funds became available for *digital* and *net zero;* again, subject to a bidding process.

The Trust began the financial year with an opening capital allocation of £34.28m and received further funds in-year of £8.8m.

Most notably, due to significant underspends both regionally and nationally, the Trust was allocated a further £6.4m from national capital slippage by NHS England.

CAPITAL FUNDS 2025/26		£000s
ICB Core Allocation - Purchase & Lease	£	19,016
Estates Safety Fund	£	481
Return to Constitutional Standards - DCA replacement	£	13,074
GBE Solar Partnerships Scheme	£	1,452
Chargepoint Accelerator Scheme	£	309
CBRN Wet Decontamination Vehicles & Equipment	£	2,017
Decarbonisation Funding	£	168
Cyber Risk Funding	£	96
Energy Partnership Fund	£	6
NHSE Capital Expenditure Limit increase	£	6,434
Total	**£**	**43,053**

Total capital funds received in 2025-26 were £43m.

Capital Expenditure

The Trust completed a wide range of capital projects in 2025-26, covering both our ongoing operational requirements and transformational projects.

Our largest capital programme is the annual replacement of our ambulance fleet. The Trust currently deploys 512 DCAs across the region, and replacement and expansion of the fleet (with associated medical devices and ICT equipment) is a priority area for capital expenditure. The Trust has an annual replacement plan of 73 vehicles per year, and in 2025-26 received additional funds to replace a further 46 vehicles, incorporating five additional electric vehicles.

The Trust suffered a significant set-back to the replacement plan when our chosen vehicle converter went into administration during production, in early February. The Trust acted swiftly to find an alternative supplier and a contract was awarded in mid-March. Production resumed with minimal disruption or additional cost; however, delivery was delayed into quarter 1 of 2026-27.

Although the outcome was successful, it created considerable uncertainty in the last two months of the financial year, with a potential to underspend against our allocation if action wasn't taken. To mitigate this risk, the Trust was able to accelerate several projects from the 2026-27 capital plan, including the replacement of medical devices and numerous estates infrastructure projects.

Total capital expenditure for the year was £43m, as summarised below:

Capital Expenditure 2025/26		£000s
FLEET	DCA fleet replacement	16,707
	Other fleet	6,714
ESTATES	Estate refurbishment	5,802
	Estate safety backlog	2,493
	Net Zero & Environmental Sustainability	1,942
	Property leases	1,504
DATA, DIGITAL & TECHNOLOGY	Network infrastructure & hardware	1,129
	Systems, software & licences	722
	Pathways	482
	Cyber security	333
MEDICAL DEVICES	Defibrillators	3,219
	Stretchers	1,059
	Other equipment	946
Total		**43,053**

Other significant capital projects undertaken within the year included:

- Ongoing development of the new Hull hub station scheduled for completion in June.
- Acquisition and refurbishment of a new site for Scarborough Ambulance Station and completion of the new-build Thirsk Ambulance Station, both to modern standards.
- Completion of a number of environmental sustainability projects aligned to our Green Plan strategy to reduce our carbon footprint, including installation of solar panels and EV charging infrastructure.
- Significant reduction in critical infrastructure risk across the estate e.g. fire safety measures, security and roofing upgrades, replacement of on-site fuel storage systems.

- Introduction of the *ECOCool* system to the DCA fleet on a pilot basis, to provide cooled air without unnecessary engine idling; extending engine longevity, reducing maintenance costs and making a substantial contribution to reducing both CO_2 and NOx emissions, whilst improving the patient experience.
- Completion of the implementation of the Pathways call-triage system in our Emergency Operations Centre (EOC) and commencement of the Common CAD project to integrate 111 onto the same operating system as EOC.

NHS Oversight Framework (NOF)

Finance and Productivity is one of five domains included within the NHS Oversight Framework (NOF) Metrics Table, which is reassessed on a quarterly basis. The Trust's strong financial performance over the year has contributed to the current rating of '**1-High Performing'**.

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 2025-26 no strategic risk exposures increased, although one of the Trust's strategic risks was subject to sustained risk exposures higher than the forecast risk trajectory:

- 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, staffing capacity in the Emergency Operations Centre remained a challenge and for this reason the risk remained at a higher level.

Future risk outlook
The Trust's strategic risk outlook for 2026-27 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 2026-27, 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 2026-27 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 2026-27, including the need to identify and deliver cost improvements and operational productivity gains.
- Achievement of challenging performance expectations, including a reduced target time for Category 2 responses and other important National Oversight Framework targets relating to hear and treat, conveyance, call answering, and staff sickness.
- The continued impact of national and system-level restructuring and cost reduction programmes (NHS England, Integrated Care Boards).

The Trust's main approaches to mitigating the most significant risks during 2026-27 are set out in its five-year strategy for 2024-29 and its annual business plan for 2026-27, 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 or closer to home.

- Actions to reduce risk relating to quality and safety. This includes further strengthening the Trust's clinical response model, medicines management, and the Patient Safety Incident Response Framework (PSIRF), further developing the clinical supervision model, and delivering enhancements to 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. Reduction in staff sickness levels is a high priority for the Trust.
- 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 greater productivity, cost improvements, and careful management 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.

Our Planet: Environmental and Sustainability Priorities

Task Force on Climate-related Financial Disclosures (TCFD) report for Yorkshire Ambulance Service

Since 2010 the Trust has had plans in place for carbon reduction and sustainable development. During 2025-26 the Trust adopted a new Green Plan for the period 2025-26 to 2027-28.

Governance

Our Green Plan outlines the essential actions the Trust will undertake to reduce emissions and enhance resilience against climate impacts over the next three years. To successfully implement these actions, a strong governance process has been established, including identification of key accountability and assurance flows.

Strategic Leadership and Board Accountability

Effective governance of the Green Plan begins with clear strategic leadership from the Trust Board. The Board sets the direction for environmental sustainability, ensuring that carbon reduction and resilience objectives are embedded within the wider organisational strategy.

The Board's commitment ensures that environmental considerations are integrated into financial planning, operational priorities, and long-term service development. The Board also ensures that climate considerations are integrated into investment decisions, estates and fleet strategies, and business continuity and service resilience planning.

Executive responsibility for sustainability sits with the Director of Finance, supported by a structured governance framework that includes:

- An Environmental Sustainability Oversight Group (ESOG).
- An Environmental Sustainability Delivery Group (ESDG).
- Integration with existing finance, workforce, quality, estates and risk committees.

Executive and senior responsible owners are assigned to each of the Green Plan focus areas, ensuring clear accountability for delivery, escalation of risks, and benefits realisation. By assigning executive-level responsibility, the Board ensures that environmental ambitions are championed at the highest level.

Operational Governance and Oversight Mechanisms

Below the Board level, the Trust maintains a robust governance structure comprising executive groups, operational committees, and assurance forums that collectively ensure the delivery of strategic priorities. For the Green Plan, these structures provide the oversight necessary to coordinate sustainability initiatives across clinical operations, fleet and estates, digital services, and workforce.

The Environmental Sustainability Oversight Group monitors implementation, reviews performance data, and escalates risks or barriers. Integration with existing committees, such as those responsible for Quality, Finance, Workforce, and Risk, ensures that environmental considerations are embedded in routine decision-making rather than treated as standalone projects. This cross-functional approach ensures sustainability is addressed across service delivery, emergency response requirements, and regulatory compliance.

Assurance, Reporting, and Continuous Improvement
The Trust's governance and assurance frameworks provide a foundation for monitoring environmental risk, tracking progress against carbon reduction targets, and ensuring that actions are grounded in robust data. Continuous improvement is supported through annual reviews of the Green Plan, alignment with national NHS sustainability requirements, and internal audits that identify opportunities for innovation and efficiency.

These governance and assurance arrangements support:

- Regular monitoring of progress against climate actions and Green Plan objectives.
- Escalation of climate-related risks through existing risk management processes.
- Annual review and refresh of the Green Plan.

This approach reflects good practice by embedding climate oversight into business-as-usual governance rather than treating sustainability as a standalone programme. Through this structured assurance approach, the Trust can maintain momentum, respond to emerging environmental challenges, and demonstrate leadership in sustainable healthcare delivery.

Strategy for Assessing Climate Risk

Climate change poses risks to the Trust's operations and patients. The Trust's staff, patients, fleet and estate already feel the impact of climate change. In recent years extreme weather events including floods, 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 climate change.

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.

The Trust identifies and assesses climate-related risks using established NHS risk management frameworks. Key risk categories include:

Physical risks
- Acute risks: flooding (surface water, rivers/water courses and tidal), heatwaves, severe weather impacting response times, ambulance stations and fleet availability.
- Chronic risks: rising temperatures affecting estates, staff working conditions and equipment and vehicle performance.

Transition risks
- Policy and regulatory change associated with NHS net zero targets.
- Technological change affecting fleet, estates and digital infrastructure.
- Financial risks linked to energy prices, capital investment and carbon-intensive assets.

Service risks
- Increased demand on emergency services during extreme weather events.
- Interdependencies with partners and wider health system resilience.

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 the Green Plan, 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 Emergency Preparedness, Resilience and Response (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.

Climate Adaptation

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 the Trust and the delivery of its services, which is why the 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 / heatwave 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 2024-29 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 in to present day operations, estate and fleet.

The Trust recognises the need to assess future resilience under different climate futures. At present:

- Adaptation measures focus on near- and medium-term risks (e.g. flooding, overheating, extreme weather).
- Climate adaptation principles are being embedded into estates and business continuity strategies.

Future development: The Trust plans to strengthen its approach by:

- Reviewing recurring climate risks across local risk registers.
- Developing proportionate climate scenario analysis (e.g. 2°C and 4°C warming pathways).
- Using this analysis to inform long-term estates, fleet and service planning.

More detailed information about the Trust's approach to climate-related risks and opportunities are found in the Green Plan.

Net Zero Metrics

Carbon Footprint

Greenhouse gas emissions are conventionally classified into one of three 'scopes', depending on the emission source and the level of control an organisation has over the emission source. They are reported in 'tonnes of carbon dioxide equivalent' (tCO2e).

Scope 1 and 2 emissions are those that can be controlled and directly influenced by an organisation. Some Scope 3 emissions, such as waste and business travel, can be directly influenced, while others, like commissioned health services, cannot be directly controlled.

This Trust first measured its Scope 1, 2, and some Scope 3 emissions in FY2010 (1 April 2009 - 31 March 2010), utilising the data available at that time. Recently, the Trust has calculated its Scope 1, 2, and 3 emissions for FY2025, using additional data to create a more accurate representation of its carbon footprint. The data is provided to the Trust's third-party Environmental, Social and Governance (ESG) advisors (Inspired Limited) for evaluation in accordance with the Greenhouse Gas Protocol; however, no formal assurance is offered.

YAS's emissions are reported on a consolidated, operational control approach, as defined by the Greenhouse Gas (GHG) Protocol. All emissions have been calculated following the GHG Protocol's Corporate Accounting and Reporting Standard. All seven greenhouse gases defined by the Kyoto Protocol have been accounted for and reported on in tonnes of carbon dioxide equivalent (tCO2e) basis. All conversion factors are sourced from the UK Government Department for Energy Security and Net Zero (DESNZ) GHG Conversion Factors for Company Reporting 2024 v1.1 and include Scope 3 Well-to- Tank (WTT) and Transmission & Distribution (T&D) losses.

Emissions Measurement

YAS reports greenhouse gas emissions in line with the Greenhouse Gas Protocol and NHS Carbon Footprint and Carbon Footprint Plus categories. Emissions measurement is supported by:

- Local Scope 1 and 2 data.
- Selected Scope 3 categories where data is available.
- National NHS Carbon Footprint Plus estimates for benchmarking and hotspot identification.

YAS Greenhouse Gas Emissions Summary:

Emissions Scope	FY2025 GHG Emissions tCO_2e
Scope 1	7,028
Scope 2 (Location-based)	1,016
Scope 2 (Market-based)	0.3
Scope 3	2,836
Total GHG emissions (Location-based)	**10,881**
Total GHG emissions (Market-based)	**9,865**

Targets
The Trust's baseline year is FY2010, when 17,223 tCO2e were emitted. To reach the 2040 Carbon Footprint target, an annual emissions reduction of 2.7% was required.

To date, the Trust has reduced emissions by a total of 36.8%, falling slightly short of targets which forecast a reduction of 41.3%. However, it is important to note that the original baseline only included emissions from fuel and estates, not a full carbon footprint. Given current emission levels, achieving the 2040 targets will require a slightly more aggressive annual reduction rate of 4.6%.

The Trust aligns with national NHS targets:
- NHS Carbon Footprint (direct control): Net zero by 2040.
- NHS Carbon Footprint Plus (influence): Net zero by 2045.

Interim targets and pathways are articulated within the Green Plan, including:
- Accelerated fleet decarbonisation milestones.
- Progressive estate decarbonisation and renewable energy coverage.
- Targeted reductions in high-impact emission sources such as transport and energy use.

Performance Monitoring
Progress is monitored through:
- Defined KPIs and associated objectives across nine Green Plan focus areas, with progress monitored through Trust Dashboards.
- Annual reporting to the Trust Board.
- Use of national Greener NHS dashboards and tools.

Where limitations exist in data coverage (particularly Scope 3), YAS is transparent about assumptions and uses a continuous improvement approach to enhance future reporting.

More detail about the Trust's metrics, targets, and performance in this area are found in the 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 2025-26 the performance of the Trust against the NHS England Core Standards for EPRR was 93%. This means the Trust maintained a rating of 'substantial compliance'. 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.
- Special Operations Response Team.
- Mass Casualty Response.
- Joint Emergency Services Interoperability Principles (JESIP).

Business Continuity
During 2025-26 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.

EPRR / Exercising
In 2025-26, the EPRR team strengthened organisational preparedness through delivery of a comprehensive work programme aligned to NHS EPRR requirements. The team updated, published, and governed key organisational documents that underpin operational readiness and interoperability. Notable examples include:

- Incident Response Activation Procedure
- LRF Partner Notification Procedure
- Fuel Plan
- Debrief Policy.
- Site Specific Response Information Sheets

The EPRR team supported a broad exercising programme across Yorkshire and the Humber, including participation in the UK's Tier 1 national pandemic exercise, Exercise Pegasus. The exercise was delivered in three phases across September–November 2025 (Emergence / Containment / Mitigation), with national and local play elements and associated workbooks. In addition, EPRR supported the delivery of 42 additional multi-agency exercises focusing on a variety of scenarios from major incident to cyber.

Command Training
The EPRR and Special Operations team worked closely with the Trust's Command and Resilience Education team to deliver improved training to the commanders at all levels across the Trust. A new annual four-day command course replaced various one-day and two-day

courses that ran over a three-year period. The new course includes a virtual reality simulated scenario to allow commanders to exercise their skills in a realistic, but safe environment.

National Interagency Liaison Officers
National Interagency Liaison Officers (NILOs) are a group of highly trained specialist staff whose role it is to improve joint response of the emergency services to significant incidents, as well as providing specialist advice to commanders around high-risk incidents. A review of incidents requiring specialist response during 2025-26 has resulted in an increase in mobilisations of NILOs of over 25%. As well as responding to spontaneous incidents, NILOs often work with other emergency services to plan and support pre-planned operations and events.

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. The rating of 'High Developing' previously evidenced has been reaffirmed for 2025-26.
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), now Onvero, to assess and improve diversity, equality, and inclusion (DEI) maturity. For 2025-26 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. You can find out more about diversity at YAS on the Trust's website.

Workforce Equality Data
The Trust publishes annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports, which help us understand and address differences in experience and outcomes for staff from diverse ethnic backgrounds and for staff living with disabilities. For WDES, the Trust improved across eight of the ten indicators, including continued improvement in disabled staff reporting that reasonable adjustments are in place to support them at work. For WRES, the 2025 data showed improvements in several indicators, including progress towards parity in the relative likelihood of appointment from shortlisting and increased representation of staff from diverse ethnic backgrounds. Actions arising from WRES and WDES are aligned to, and delivered through, the Trust's Equality, Diversity and Inclusion Action Plan 2024-27, developed in engagement with staff support networks, trade unions and wider stakeholders.

Pay Gap Information
In compliance with the Public Sector Equality Duty (PSED) and the Equality Act 2010, the Trust publishes an annual gender pay gap report. The most recent published data (as of 31 March 2025) shows continued improvement, with the mean hourly pay gap reducing to 8.45% (2025) from 9.78% (2024) and the median reducing to 7.09% (2025) from 8.87% (2024). The Trust has also continued to develop and publish pay gap reporting for other protected characteristics, including Ethnicity and Disability pay gap reports, to increase transparency and support targeted action planning in conjunction with our Equality Support Networks, Trade Union and other key stakeholders. The Trust uses the findings to inform delivery of the Equality, Diversity and Inclusion Action Plan 2024-27.

Staff Support Networks
The Trust recognises the importance of equality support networks in promoting inclusion, improving staff experience, and strengthening organisational learning. The Trust has five established networks; Pride@YAS (LGBT+ Network), the Race Equality Network, the Disability Support Network, the Armed Forces Network and the Women and Allies' Network.

Through participation in equality and diversity activities and consultation, networks help to identify barriers, amplify staff voice, and contribute to the ongoing development and delivery of the Trust's equality, diversity and inclusion priorities. Recent examples of network activity include supporting Trust-wide awareness campaigns (e.g. National Inclusion Week, Black History Month, International Women's Day), engagement at regional Pride events, Armed Forces commemorations and community engagement activities, plus network contributions to inclusion-related policy and guidance development (e.g. workplace adjustments and support).

Equality Impact Assessments
Equality Impact Assessments (EIAs) are actively conducted on all appropriate policies, procedures, and service delivery changes, with a process in place to review 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. In 2025-26, an internal audit review was completed to review and improve the EIA process, strengthening efficiency and consistency. Policies promote zero tolerance for harassment, discrimination, or inappropriate behaviour toward patients and staff, and an Allyship campaign was launched in 2025-26 in partnership with equality support networks to raise awareness and tackle discrimination.

Accessible Services for our Patients

All staff complete the Accessible Information Standard training on Electronic Staff Records.

We have access to text relay service to assist in the assessment of callers.

We have access to translation service to assist in the assessment of callers.

We have access to the British Sign Language Service to assist in the assessment of callers.

Clinicians have access to a video triage consultation to assist in the assessment of callers.

999 have access to the Electronic Patient Records.

The NHS 111 Governance team can input patient specific information on to the Datix system to record how the patient wants responding e.g. font size and type, different paper colours etc., response types (letter, email, telephone), alternative languages and Braille. **This is not viable to implement in the 999 environment.**

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.

The Trust has implemented a 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 a Heart Day’ 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.

- Since 2024, YAS has supported 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.

Response to NHS England Statement on Information on Health Inequalities

Understanding population health needs for the Yorkshire region

Ethnic minority groups
In 2025, NHS England published an ethnicity recording improvement plan which emphasises that good quality data is essential for effective service planning, quality improvement and monitoring the equity of services.

However, in YAS, usage of the ethnicity field within the electronic patient record is declining over time, having dropped from 43.8% to 34.9% since April 2024.

YAS is working with NHS England to improve collection of this data field alongside the development of training and education in the significance of considering ethnicity when delivering safe and effective clinical care.

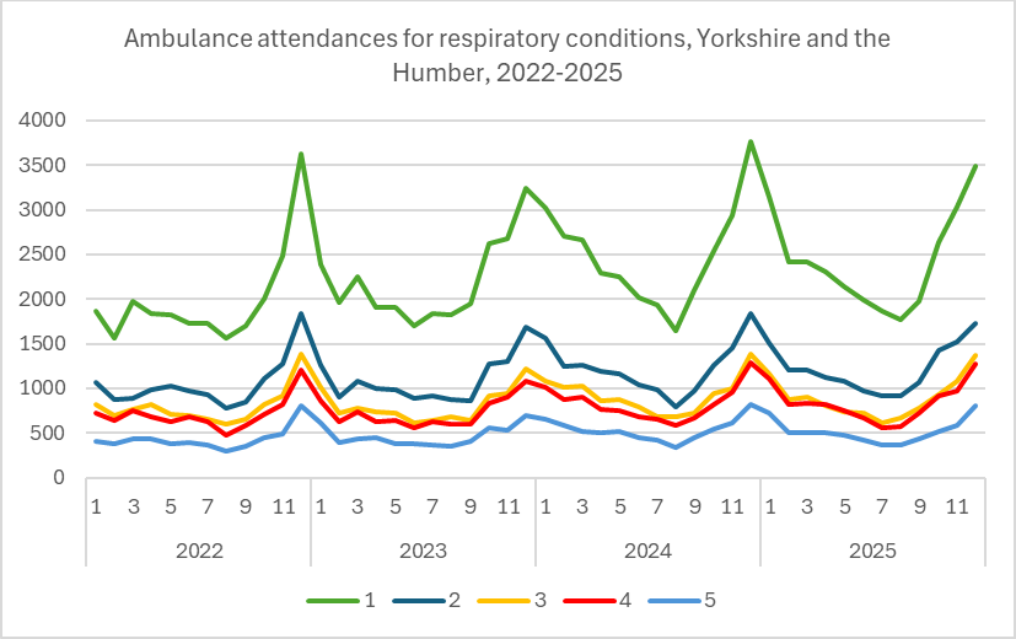
Drug and alcohol-related emergencies
In 2025, YAS received just over 8,000 calls related to drugs and alcohol, 5,063 (63%) of which were due to alcohol intoxication, 28% (2,273) concerned recreational drug use and a further 6% related to alcohol or drug induced seizures (546).

YAS provides Lower Super Output Area (LSOA) hotspot maps for local areas as part of its Population Health tool used locally to inform licencing decisions.

In recent years, incidents relating to new potent synthetic opioids have significantly increased. Close monitoring of this situation, including rapid identification and response to dangerous drug incidents, is a priority for the UK government. It has been recognised that data from ambulance trusts on calls for suspected opioid overdoses and/or administration of the life-saving medication naloxone has unique potential to rapidly identify these incidents. Ambulance trusts nationally, including YAS, now share weekly figures regarding incidents in which naloxone has been administered with the Office for Health and Disparities (OHID) and onward to local substance misuse service commissioners.

Respiratory emergencies
In 2025, the total number of ambulance attendances for breathing problems in the most deprived areas across the region was almost five times that in the least deprived areas. Trends in respiratory calls over time suggest that although the most deprived quintile has most attendances all year, the most significant spikes in attendances for this group are during the winter period.

Spikes in winter are likely to be related to increases in prevalence of respiratory disease alongside exacerbations of existing long-term respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD).



As part of the government's shift towards neighbourhood health, YAS is collaborating with West Yorkshire ICB to facilitate more proactive identification of at-risk COPD patients to optimise care and prevent unnecessary secondary care admissions. This work has already seen a reported 19% reduction in A&E admissions for COPD and a 9.8% reduction in appointments in General Practice for the Primary Care Network (PCN) involved. The work will be further evaluated to establish the impact on ambulance attendances.

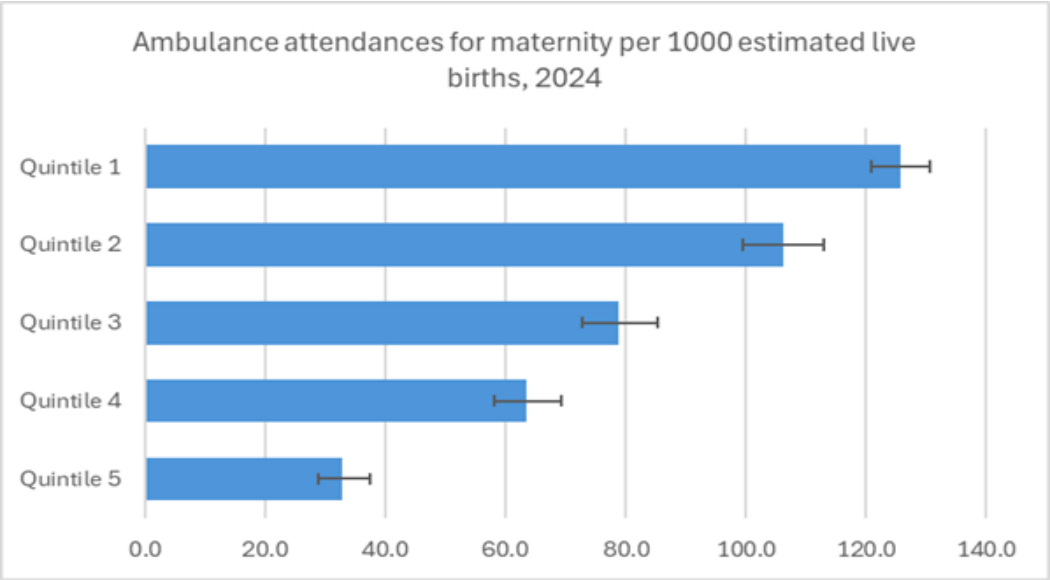
YAS is also working with The King's Fund, an independent charity working to improve people's health, to understand the emerging opportunities for further collaboration with local neighbourhood working, engage with and learn alongside system partners, and develop learning for the strategic planning of ambulance services and neighbourhood health.

Maternal health inequalities

Whilst most planned births in the pre-hospital setting are uneventful, births that require emergency assistance via the ambulance service are associated with adverse outcomes for women and babies. Not all maternity-related calls to ambulance services, however, relate to birth; some of the most complex cases attended by the ambulance service relate to emergencies throughout the childbearing continuum and following birth.

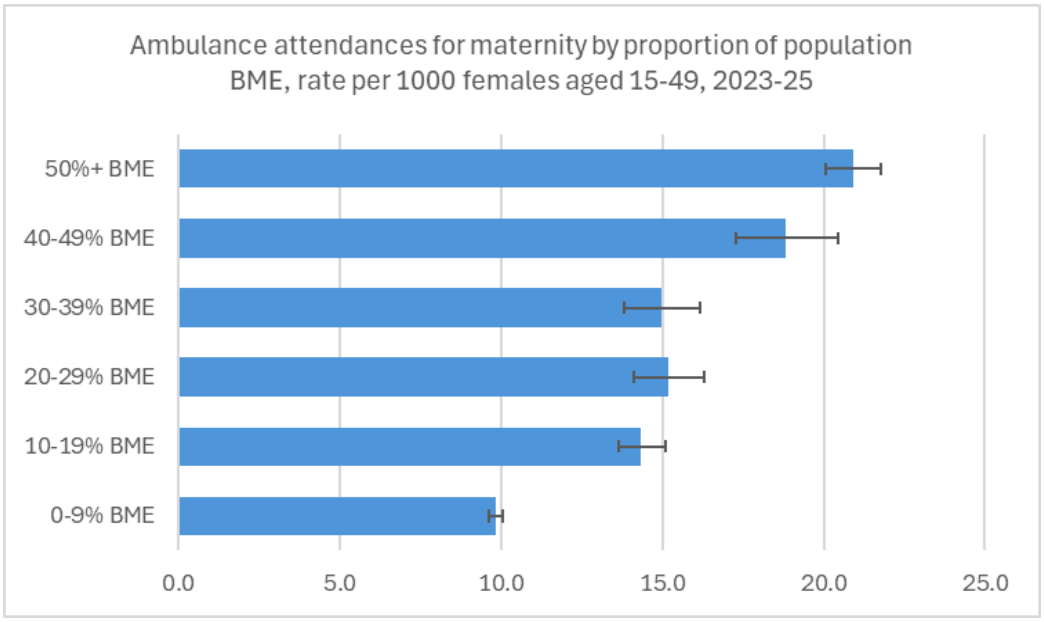
Despite ambulance services being required to provide urgent and emergency maternity and neonatal care, within national maternity reports little focus is paid to the care provided to this cohort of patients by the emergency services.

Using an estimate of the number of births in each deprivation quintile, the rate of ambulance attendances per 1,000 estimated live births in the most deprived areas of Yorkshire is estimated to be almost four times the rate in the least deprived.



Maternal health is one of the starkest examples of racial health inequalities in the UK. Black British mothers are up to four times more likely than white mothers to die during pregnancy or within the first six weeks after childbirth. The risk of dying from pregnancy-related causes is three times higher for mothers of mixed ethnicity than for white mothers and twice as high for women of Asian ethnicity. It is also known that women from all black and minority ethnic groups are at greater risk than their white counterparts of having their pregnancies result in pre-term birth, stillbirth, neonatal death, or a baby born with low birth weight.

The figure below shows the rate of ambulance attendances for maternity-related calls per 1,000 females aged 15-49 by the proportion of the population that is of Black and Minority Ethnic (BME) background from the Census. This analysis suggests that the rate of ambulance attendances for maternity-related calls in populations where more than half of the population is of a BME background is more than twice that in populations where less than 10% of the population are of a BME background. This analysis suggests that, although it cannot be inferred that there is a definitive link between ethnicity and high unmet need in terms of ambulance attendances, there does appear to be a correlation between high levels of attendance for maternity-related calls and higher levels of BME population.



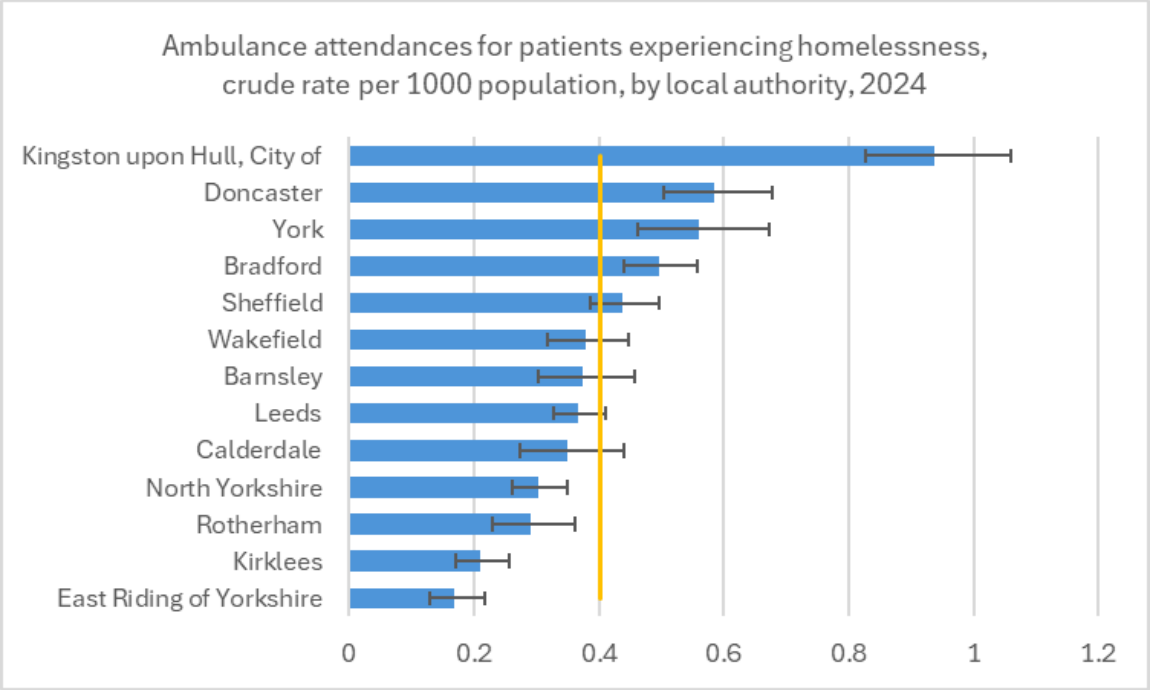
Additionally, analysis of the rates of ambulance attendances per 1,000 live births by ICB area reveals that the rate of attendances for maternity-related calls is significantly higher in West Yorkshire (104 attendances per 1,000 live births) compared to South Yorkshire (88 attendances) or Humber and North Yorkshire (79 attendances).

Evidence suggests that ambulance clinicians face significant challenges when managing high-risk, low-frequency events such as obstetric emergencies. In 2025, a specific deep-dive analysis of maternity-related demand was conducted alongside a programme of staff engagement to better understand the realities of responding to maternity-related emergencies across Yorkshire, the challenges faced and what support, training or system changes would better support the delivery of safe and effective care for this patient cohort. The learning from this will be used to implement improvements across the Yorkshire footprint.

Homelessness

Recent Office for National Statistics (ONS) data (Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)) shows that the mean age of death for homeless men is 44 years and even lower for homeless women at just 42 years. Data on patients experiencing homelessness is not well recorded in other health datasets. This, combined with the way that patients experiencing homelessness access healthcare, means that it is vitally important that we use data from the ambulance service to better understand the needs of this population.

The most recent available data shows that in 2024 there were 2,255 calls for patients experiencing homelessness. This is a very slight decrease on the previous year (-3%). However, there is significant variation in the number of calls received across Yorkshire. The rate in Hull was found to be significantly higher than all other local authorities. The rate of calls was also significantly higher than average in Doncaster, York and Bradford.



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 on the Healthwatch – Kingston upon Hull website.

Social Value: Working with our Communities

Community Engagement

Community Engagement at Yorkshire Ambulance Service is focused on raising awareness of our services, teaching life-saving skills, building trust with our communities and improving access to our services. At YAS we have a particular focus on engaging communities experiencing poor health outcomes and barriers to accessing services. We engage widely with communities across Yorkshire and have a particular focus on engaging with Inclusion Health Groups and people living in areas of deprivation.

Our community engagement activity is delivered by a core team plus 80 Community Engagement Volunteers. These are existing YAS staff and volunteers who undertake community engagement in their spare time.

As well as engaging communities directly, we also support individuals, volunteers and organisations outside of YAS to deliver interventions on our behalf. For example, our train-the-trainer programmes equip people outside of YAS to deliver their own life-saving skills training in their own communities.

Our community engagement objectives for 2024-26 have been:

- 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 2025-26 we delivered 360 community engagement events and activities, engaging around 18,000 people across Yorkshire. In addition to this, our flagship CPR campaign, Restart a Heart Day, trained 40,000 secondary school children in CPR in October 2025.

Our engagement activity in this period has reached into under-served and marginalised communities, including asylum seekers and refugees, people involved in the criminal justice system, people with multiple unmet needs, young people in care and a wide range of migrant communities where English is not the first language.

Over 2025-26 our employability and skills programmes, Achieve and Get Started with YAS, supported people from disadvantaged backgrounds into paid and voluntary roles with the Trust and with the wider NHS. These programmes teach life skills and employability skills alongside first aid for some of our most vulnerable and marginalised communities.

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

Community defibrillators
At the end of 2025-26, there were nearly 9,000 community defibrillators registered with Yorkshire Ambulance Service on The Circuit (www.thecircuit.uk). Many are public access defibrillators (available 24/7) while others are on restricted sites where the defibrillators are only available when premises are open. Static defibrillator sites include businesses, supermarkets, airports, railway stations, shopping centres, GP and dental practices, and police stations.

Volunteering

During 2025-26 volunteers continued to play a vital role in supporting Yorkshire Ambulance Service to deliver high-quality patient care, strengthen community resilience and improve engagement with the communities we serve. Across our voluntary programmes, approximately 1,000 volunteers collectively contributed around 528,000 hours, supporting emergency and non-emergency services, improving patient experience, community resilience, and bringing valuable community and lived-experience insight into service improvement activity.

During the year, significant developments have been made to strengthen leadership and governance for volunteering across the Trust, improving clarity, consistency and assurance. This includes clearer Trust-wide coordination of volunteering activity through established governance routes, and strengthened links between volunteering, policy development and operational teams. These arrangements support more consistent decision-making and clearer oversight of risk, safeguarding and quality across all volunteer programmes.

A key enabler of this improved governance is the refresh of the YAS Volunteering Policy. The updated policy sets out a clear, Trust-wide approach to involving volunteers and aligns with national guidance and best practice. The revised policy reflects YAS's commitment to equality, diversity and inclusion, ensuring that volunteering opportunities are fair, proportionate and accessible, and that volunteers are supported and treated consistently regardless of role, location or service area.

To support implementation of the refreshed policy, a suite of practical supporting assets have been developed for use across existing and future volunteering teams. These include a standardised volunteer recruitment process, role-specific risk assessment templates and volunteer programme guidance, helping to embed consistent practice and strengthen assurance across voluntary programmes.

Assurance arrangements for volunteer recruitment and records management have also been strengthened. This includes implementation of three-year employment history and reference checks for relevant volunteer roles, and closer working between volunteering teams, Recruitment and HR.

Recognition of volunteering reached an important milestone during the year. As part of National Volunteers' Week 2025, YAS formally launched its Volunteer Long Service Awards, the first Trust-wide scheme to recognise YAS volunteers for every five years of service. In-person events were held across the region, supported by Trust-wide communications, with almost 300 awards issued, including a 40 years' service award. This provides tangible recognition of long-term commitment and is intended to help strengthen volunteers' sense of belonging to the wider organisation.

YAS also developed a new Trust-wide volunteering website, funded by NHS Charities Together through the Yorkshire Ambulance Service Charity. The website provides a clearer, more accessible overview of volunteering opportunities and expectations into volunteering. Development of the site also generated a suite of new promotional assets, including digital content for use across social media and other communication channels, supporting more consistent messaging and wider reach in promoting volunteering across the Trust.

Together, these developments supported greater consistency, visibility and maturity in volunteering across YAS during 2025-26, strengthening the contribution that volunteers make to

patient care, staff wellbeing and community engagement, while continuing to lay strong foundations for future work on diversity, inclusion and access to volunteering opportunities.

Critical Friends Network

This year has seen strong and steady involvement from the Critical Friends Network (CFN) across a wide range of work. Members supported the mental health, learning disability and neurodiversity project, with some sharing lived experience as part of co-production. They contributed to the clinical response model alongside clinical leads and offered helpful comments on improving the mental health patient information leaflet. Their feedback has supported updates to the general quarterly YAS survey, the 111 and 999 patient experience surveys and the patient relations formal complaints survey, with some members creating example templates to guide future improvements. They have also given valuable insight during the roll-out of the PTS eligibility criteria by sharing experience and raising key points for consideration.

Many CFN members also contribute as Patient Safety Partners, taking part in safety discussions, reviewing materials and helping to strengthen the patient-safety focus across different programmes. Their involvement has extended to the NIHR Integrated Clinical Academy Programme and the medicines management thematic review, offering a patient view that supports clearer decision-making.

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.

Activities during 2025-26

During 2025-26 the Charity made progress on its 2024-28 strategy ambitions. Highlights included:

- Increased capacity with 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.
- Further development of the charity governance and compliance framework.
- Delivery of year one for the Charity's fundraising and communications strategy.
- Three further YAS Charity Champion volunteers recruited from 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 funding for the Achieve programme and The King's Trust partnership delivering life and employability skills to vulnerable groups including people recovering from drug and alcohol addition, serving prisoners, people with a learning disability and/or neurodivergent people and vulnerable women.

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 roadshow, bringing sweet treats and fruit to staff working in the Trust's four call centres and frontline staff.
- The Charity funded picnic tables, improving the outdoor spaces for staff at two stations.
- YAS support networks and sports teams received funding for equipment and events including:
    - League fees for the men's and women's football teams.
    - Sport recovery kit for the YAS Rugby team.
    - Kit for the YAS Hull and East Riding football team.
    - Basic lifesaving instructor courses for members of the Race Equality Network to support them to deliver lifesaving training in their communities.
    - Funding for a Remembrance Day event for the Armed Forces Network.
- The Charity funded refreshments and venue hire over 2025 Volunteer's Week supporting the first YAS volunteer long service awards.

Saving lives

- The Charity funded 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.
- The Charity supported the installation of 30 community Public Access Defibrillators (cPADs) across the region.
- The Charity funded equipment to support the 12th annual Restart a Heart Day campaign which saw more than 41,000 students learn CPR at 185 secondary schools in October 2025.

Make a donation

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

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, voting Executive Directors, other non-voting Directors, and 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 2025-26 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's website.

The Board of Directors 2025-26

The Board of Directors comprises the following:

Chair
Martin Havenhand

Chief Executive
Peter Reading

Deputy Chief Executive and Chief Operating Officer
Marc Thomas

Executive Director of Finance
Kathryn Vause

Executive Director of Quality and Chief Paramedic
Dave Green

Executive Medical Director
Dr Shona McCallum

Director of People and Organisational Development
Amanda Wilcock

Director of Strategy, Planning and Performance
Carol Weir

Chief Digital Information Officer
Samantha Robinson

Director of Corporate Services and Company Secretary
David O'Brien

During 2025-26 there were changes to the composition of Executive Directors on the Board. These changes are set out in the Annual Governance Statement.

Non-Executive Directors
Amanda Moat (Deputy Chair)
Andrew Chang (Senior Independent Director)
Saghir Alam OBE
Tabitha Arulampalam
Rebecca Malby BEM
Melanie Hudson

Associate Non-Executive Directors
Katherine Lees
Rebecca Randell

During 2025-26 Tim Gilpin and Anne Cooper retired as Non-Executive Directors. The Trust appointed Tabitha Arulampalam and Rebecca Malby as replacement Non-Executive Directors.

In addition, during 2025-26 the Trust received approval for a new Establishment Order which increased the number of Non-Executive Directors by one, from six to seven. The Trust appointed Melanie Hudson to this new Non-Executive Director position.

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 2025-26.

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.

Committee Membership 2025-26

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 Deputy Chief Executive and Chief Operating Officer
Audit and Risk Committee	Three Non-Executive Directors
Finance and Performance Committee	Three Non-Executive Directors Executive Director of Finance Deputy Chief Executive and 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 (for certain designated items only)

Board Members' Attendance at Meetings of the Board and Assurance Committees

The Board Members' attendance record for meetings of the Trust Board and the main assurance committees held during 2025-26 is as follows.

Meetings of the Board of Directors

Board of Directors: Meetings in Public		Dates of Board Membership (if not full year)	Meeting Dates					
			22-May-25	24-Jul-25	25-Sep-25	27-Nov-25	29-Jan-26	26-Mar-26
MEMBERS								
Martin Havenhand	Trust Chair		Y	Y	Y	Y	Y	Y
Anne Cooper	NED, Deputy Chair		Y	Y	Y	Y	Y	Y
Tim Gilpin	NED, Senior Independent Director	May to July	Y	Y	N/A	N/A	N/A	N/A
Rebecca Malby	NED	January to March	N/A	N/A	N/A	N/A	Y	Y
Amanda Moat	NED		Ap	Y	Y	Y	Y	Y
Andrew Chang	NED		Y	Y	Ap	Ap	Y	Ap
Saghir Alam	NED		Ap	Y	Y	Y	Y	Y
Peter Reading	Chief Executive		Y	Y	Y	Y	Y	Y
Nick Smith	Chief Operating Officer	May to November	Y	Y	Ap	Y	Y	Y
Kathryn Vause	Executive Director of Finance		Y	Y	Y	Y	Y	Y
Shona McCallum	Executive Medical Director	November to March	N/A			Y	Y	Ap
Dave Green	Executive Director of Quality and Chief Paramedic		Y	Y	Y	Y	Y	Y
Marc Thomas	Deputy Chief Executive and Chief Operating Officer	January to March	N/A	N/A	N/A	Y	Y	Y
Melanie Hudson	NED	January to March	N/A	N/A	N/A	Y	Y	Y
Tabitha Arulampalam	NED	January to March	N/A	N/A	N/A	Y	Y	Y

Audit and Risk Committee

Audit and Risk Committee		Membership dates (if not full year)	Meeting Dates				
			29-Apr-25	24-Jun-25	22-Jul-25	11-Nov-25	13-Jan-26
MEMBERS							
Amanda Moat	Member, NED April to June 2025 Chair, NED from July 2025		Y	Y	Y	Y	Y
Andrew Chang	Chair, NED	April to June	Y	Y	N/A	N/A	N/A
Anne Cooper	Vice-Chair, NED	April to June	Y	Y	N/A	N/A	N/A
Tabitha Arulampalam	Vice-Chair, NED	July to January	N/A	N/A	Y	Y	Y
Saghir Alam	Member, NED	July to January	N/A	N/A	Y	Y	Y

Finance and Performance Committee

Finance and Performance Committee		Membership dates (if not full year)	Meeting Dates									
			22- Apr-25	20-May-25	19-Jun-25	21-Jul-25	23-Sep-25	16-Oct-25	25-Nov-25	22-Jan-26	19-Feb-26	19-Mar-26
MEMBERS												
Amanda Moat	Chair, NED	April to June	Y	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Saghir Alam	Member NED until Nov 2025 Vice-Chair, NED from Jan 2026		Ap	Ap	Y	Y	Y	Ap	Y	Y	Y	Ap
Tim Gilpin	Member, NED	April to June	Y	Y	y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kathryn Vause	Executive Director of Finance		Y	Y	Ap	Y	Y	Y	Y	Y	Y	Y
Nick Smith	Chief Operating Officer	April to November	Y	Y	Y	Ap	Ap	Y	Y	N/A	N/A	N/A
Andrew Chang	Chair, NED	July to March	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y
Anne Cooper	Vice-Chair, NED	July to November	N/A	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A
Rebecca Malby	Member, NED	January to March	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y
Marc Thomas	Deputy CEO and COO	January to March	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y

People Committee

People Committee		Membership dates (if not full year)	Meeting Dates					
			06-May-25	08-Jul-25	09-Sep-25	18-Nov-25	20-Jan-26	17-Mar-26
MEMBERS								
Tim Gilpin	Chair, NED	May to July	Y	Y	N/A	N/A	N/A	N/A
Amanda Moat	Vice-Chair, NED		Y	Y	Y	Y	Y	Y
Saghir Alam	Member, NED	April to July	Ap	Ap	N/A	N/A	N/A	N/A
Andrew Chang	Member, NED	April to July	Ap	Ap	N/A	N/A	N/A	N/A
Amanda Wilcock	Director of People and Organisational Development		Y	Y	Y	Y	Y	Y
Nick Smith	Chief Operating Officer	May to November	Y	Y	Y	Y	N/A	N/A
Tabitha Arulampalam	Chair, NED	September to March	N/A	N/A	Y	Y	Y	Y
Anne Cooper	Member, NED	September only	N/A	N/A	Y	N/A	N/A	N/A
Melanie Hudson	Member, NED	November to March	N/A	N/A	N/A	Y	Y	Y
Marc Thomas	Member, Deputy Chief Executive and Chief Operating Officer	January to March	N/A	N/A	N/A	N/A	Y	Y

Quality Committee

Quality Committee		Membership dates (if not full year)	Meeting Dates										
			17-Apr-25	15-May-25	12-Jun-25	15-Jul-25	09-Sep-25	09-Oct-25	13-Nov-25	18-Dec-25	15-Jan-26	12-Feb-26	12-Mar-26
MEMBERS													
Anne Cooper	Chair, NED	April to November	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
Andrew Chang	Vice-Chair, NED	April to June	Ap	Ap	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Saghir Alam	Member, NED April to June Vice-Chair, NED July to Oct		Ap	Ap	Y	Y	Ap	Ap	N/A	N/A	N/A	N/A	N/A
Dave Green	Executive Director of Quality and Chief Paramedic		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Steven Dykes	Acting Medical Director	April to September	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A
Melanie Hudson	Vice-Chair, NED	November to March	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	Ap	Y
Amanda Moat	Member, NED	July to March	N/A	N/A	N/A	Ap	Y	Y	Y	Y	Y	Y	Y
Shona McCallum	Medical Director	October to March	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y
Rebecca Malby	Chair, NED	December to March	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	Y

Declaration of Interests for the Financial Year 2025-26

Board Members and Non-Voting Directors

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interests	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
VOTING MEMBERS									
Martin Havenhand	Chair	NIL						N/A	N/A
Andrew Chang	Non-Executive Director	NPL Management Ltd, the National Metrology Institute an arms-length body under the purview of the Dept of Science Industry and Technology	X					01 August 2022	Current
		York St John University, higher education provider		X				01 August 2022	Current
		Luminate Education Group, educational group consisting of Leeds City College, Keighley College, Harrogate College, University Centre Leeds, Leeds Conservatoire, Leeds 6th Form College, Pudsey 6th Form College; 6th form, further and higher education provider.		X				01 December2023	Current
		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.					X	18 May 2020	Current
Amanda Moat	Non-Executive Director	NIL						N/A	N/A
Saghir Alam	Non-Executive Director	NIL						N/A	N/A
Melanie Hudson	Non-Executive Director	AGH Solutions	X					06 January 2025	Current
		Kirklees Active Leisure	X					05 January 2011	Current

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interests	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
VOTING MEMBERS									
Tabitha Arulampalam	Non-Executive Director	Salis Consulting Ltd. Consultancy to NHS, local government and third sector organisations.	X					June 2013	Current
		The Whole System Partnership. Provides independent consultancy support to public sector agencies. Nature of relationship – sub-contractor.	X					August 2013	Current
		Wakefield Community Foundation. Supporting vulnerable people in Wakefield.		X				August 2024	Current
Rebecca Malby	Non-Executive Director	Providing consulting support to Middlesborough Primary Care Network, which is within the Humber and North Yorkshire ICB	X					14 January 2026	30 April 2026
Marc Thomas	Deputy Chief Executive	Pfizer, pharmaceutical company	X					26 April 2024	30 March 2026
Kathryn Vause	Executive Director of Finance	Brother-in-law is currently acting Director of Finance at West Yorkshire Integrated Care Board				X		16 April 2026	Current

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interests	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
VOTING MEMBERS									
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.	X					31 March 2003	Current
		Disabled NHS Directors Network - a group which advocates for the interests of disabled NHS staff			X			01 March 2021	Current
		Daughter works for Robert Walters Limited - a recruitment company				X		01 August 2024	Current
		Wife is Director of Catherine Reading Limited - a company which provide clinical psychology services				X		31 March 2003	Current
Dave Green	Executive Director of Quality and Chief Paramedic	Honorary Lecturer at University of Bradford				X		31 October 2023	Current
Shona McCallum	Executive Medical Director	Consultant Physician at Northern Care Alliance NHS FT	X					01 October 2025	Current
		Interim Independent Chair of Heywood, Middleton and Rochdale Local Care Organisation (HMR LCO) Partnership	X					14 October 2025	March 2026
		Trustee at Springhill Hospice, Rochdale		X				2023	Dec 2025

Name	Current position	Declared interest	Type of Interest					Date of interest	
			Financial interest	Non-financial professional interests	Non-financial personal interest	Indirect Interest	Loyalty interest	From	To
NON-VOTING MEMBERS									
Amanda Wilcock	Director of People and Organisational Development	NIL						N/A	N/A
Carol Weir	Director of Planning, Strategy and Performance	NIL						N/A	N/A
David O'Brien	Director of Corporate Services and Company Secretary	Related through marriage to two Labour Party Parliamentarians: Judith Blake, Baroness Leeds Lords), Olivia Blake, Member of Parliament, Sheffield Hallam				X		25 September 2023	Current
Samantha Robinson	Chief Digital Information Officer	Children's Heart Surgery Fund - a Yorkshire based charity. I am a Trustee and Deputy Chair.			X			09 June 2024	Current
		My husband, Dr Richard Robinson, is the Medical Director at Mid Yorkshire Teaching Hospitals Trust				X		09 June 2024	Current
Katherine Lees	Associate Non-Executive Director	GP, Local Care Direct	X					01 May 2020	Current
		GP, Northern Health		X				01 March 2026	Current
		GP, Well Life Clinic – ADHD Adult Right to Choose		X				01 April 2026	Current
Rebecca Randell	Associate Non-Executive Director	University of Bradford, HEI	X					01 January 2020	Current
Helen Edwards	Associate Director of Communications and Community Engagement	Husband employed by a technology company providing consultancy services to NHS England				X		09 August 2025	Current

Remuneration Report (subject to audit)
Salaries and allowances of Senior Managers 2025-26

Name	Title	Note	(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	400	-	45 - 50
Amanda Moat	Deputy Chair / Non-Executive Director	**1**	10 - 15	-	-	10 - 15
Anne Cooper	Deputy Chair / Non-Executive Director	**2**	5 - 10	-	-	5 - 10
Peter Reading	Chief Executive		225 - 230	6,900	-	235 - 240
Marc Thomas	Deputy Chief Executive and Chief Operating Officer	**3**	155 - 160	-	40 - 42.5	195 - 200
Kathryn Vause	Executive Director of Finance		145 - 150	1,500	47.5 - 50	190 - 195
Dr Shona McCallum	Executive Medical Director	**4**	90 - 95	-	95 - 97.5	190 - 195
Dr Steven Dykes	Executive Medical Director (Interim)	**5**	65 - 70	-	77.5 - 80	145 - 150
Dr Julian Mark	Executive Medical Director	**5**	0 - 5	-	-	0 - 5
Nick Smith	Chief Operating Officer	**6**	90 - 95	2,000	27.5 - 30	120 - 125
David Green	Executive Director of Quality and Chief Paramedic		120 - 125	2,100	47.5 - 50	175 - 180
Amanda Wilcock	Director of People and Organisation Development		135 - 140	-	67.5 - 70	205 - 210
Sam Robinson	Chief Digital Information Officer		130 - 135	-	42.5 - 45	170 - 175

Name	Title	Note	(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
David O'Brien	Director of Corporate Services and Company Secretary		120 - 125	-	30 - 32.5	150 - 155
Carol Weir	Director of Strategy, Planning and Performance		120 - 125	-	57.5 - 60	175 - 180
Jeevan Gill	Director of Partnerships and Operations	**7**	75 - 80	1,300	122.5 - 125	200 - 205
Rachel Gillott	Director of Partnerships and Operations	**8**	75 - 80	400	-	75 - 80
Adam Layland	Director of Partnerships and Operations	**9**	80 - 85	-	22.5 - 25	105 - 110
Tim Gilpin	Non-Executive Director	**10**	0 - 5	-	-	0 - 5
Saghir Alam	Non-Executive Director		10 - 15	-	-	10 - 15
Andrew Chang	Non-Executive Director		10 - 15	-	-	10 - 15
Melanie Hudson	Non-Executive Director	**11**	5 - 10	200	-	5 - 10
Tabitha Arulampalam	Non-Executive Director / Associate Non-Executive Director	**12**	10 - 15	-	-	10 - 15
Rebecca Malby	Non-Executive Director	**13**	0 - 5	-	-	0 - 5
Katherine Lees	Associate Non-Executive Director		5 - 10	400	-	5 - 10
Rebecca Randell	Associate Non-Executive Director		5 - 10	-	-	5 - 10

Salaries and allowances of Senior Managers 2025-26 – Notes

* Benefits in kind relate to use of vehicles provided by the Trust in 2025-26 and minimal taxable expenses (Total - £900)
There were no (c) Performance pay and bonuses or (d) Long-term performance pay and bonuses in 2025-26.

Note	Comment
1	Amanda Moat was appointed as Deputy Chair on 1 December 2025.
2	Anne Cooper left her role as Deputy Chair / Non-Executive Director on 30 November 2025. The full year equivalent annual salary is £10,000 - £15,000.
3	As a result of the review of the Trust Board structure during the first half of the financial year and the consequent reorganisation, Marc Thomas was appointed as Deputy Chief Executive and Chief Operating Officer with effect from 1 December 2025. The full year equivalent salary is £160,000 - £165,000.
4	Dr Shona McCallum commenced in post as Executive Medical Director on 1 October 2025. The full year equivalent annual salary is £185,000 - £190,000. Dr Shona McCallum also works as a consultant for the Northern Care Alliance for 2.5 Programmed Activity (PA) sessions per week. This is equivalent to £35,000 - £40,000 per annum.
5	Following the retirement of Dr Julian Mark as Executive Medical Director on 1 April 2025, Dr Steven Dykes was appointed at Executive Medical Director (Interim). He left the Trust on 28 September 2026. The full year equivalent annual salary is £130,000 to £135,000.
6	As a result of the review of the Trust Board structure during the first half of the financial year and the consequent reorganisation, the role of Chief Operating Officer is being undertaken by Marc Thomas, alongside his duties as Deputy Chief Executive, with effect from 1 December 2025. Nick Smith left his post as Chief Operating Officer on 30 November 2025 to take up the role of Associate Chief Operating Officer - 999 Operations (West Yorkshire and Central Services) in the Trust. The full year equivalent annual salary is £140,000 - £145,000.
7	As a result of the review of the Trust Board structure during the first half of 2025/26 and the consequent reorganisation, the three roles of Director of Partnerships and Operations were removed from the Senior Management structure with effect from 1 December 2025. Jeevan Gill left her role on 30 November 2025 and subsequently left the Trust on 19 January 2026. From 19 July 2025 to 19 January 2026, Jeevan Gill was seconded to NHS Humber Health Partnerships. The full year equivalent annual salary is £125,000 - £130,000.

Note	Comment
8	As a result of the review of the Trust Board structure during the first half of 2025/26 and the consequent reorganisation, the three roles of Director of Partnerships and Operations were removed from the Senior Management structure with effect from 1 December 2025. Rachel Gillott left her role on 30 November 2025 and subsequently left the Trust on 31 January 2026 under agreed redundancy terms. The full year annual equivalent salary is £120,000 - £125,000.
9	As a result of the review of the Trust Board structure during the first half of 2025/26 and the consequent reorganisation, the three roles of Director of Partnerships and Operations were removed from the Senior Management structure with effect from 1 December 2025. Adam Layland left his role on 30 November 2025 to take up the role of Associate Chief Operating Officer - 999 Operations (North, East and South Yorkshire) in the Trust. The full year annual equivalent salary is £120,000 - £125,000.
10	Tim Gilpin left his role as Non-Executive Director on 31 July 2025. The full year equivalent annual salary is £10,000 - £15,000.
11	Melanie Hudson commenced in post as Non-Executive Director on 22 September 2025. The full year equivalent annual salary is £10,000 - £15,000.
12	Tabitha Arulampalam was an Associate Non-Executive Director up until 31 July 2025. She was appointed as a Non-Executive Director with effect from 1 August 2025. The full year equivalent annual salary is £10,000 - £15,000.
13	Rebecca Malby commenced in post as Non-Executive Director on 1 December 2025. The full year equivalent annual salary is £10,000 - £15,000.

Salaries and allowances of Senior Managers 2024-25

Name	Title	Note	(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 and Operations		110 - 115	1,300	32.5 - 35	145 - 150

Name	Title	Note	(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
Rachel Gillott	Director of Partnerships and Operations		105 - 110	1,100	30 - 32.5	135 - 140
Adam Layland	Director of Partnerships and Operations		115 - 120	-	27.5 - 30	145 - 150
Saghir Alam	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	Former Chief Executive	11	25 - 30	900	-	25 - 30

Salaries and allowances of Senior Managers 2024-25 – Notes

* 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.

Note	Comment
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 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.

2025-26 Pension Entitlement Table

Name	Title	Note	(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 2026 (Bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 1 April 2025 £'000	(f) Real increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 31 March 2026 £'000	(h) Employer's contribution to stakeholder pension £'000	(i) All pension-related benefits (Bands of £2,500) £'000
Marc Thomas	Deputy Chief Executive and Chief Operating Officer		2.5 - 5	-	20 - 25	-	292	69	385	-	40 - 42.5
Kathryn Vause	Executive Director of Finance		2.5 - 5	0 - 2.5	50 - 55	130 - 135	1,166	56	1,259	-	47.5 - 50
Dr Shona McCullum	Executive Medical Director	2	2.5 - 5	7.5 - 10	70 - 75	180 - 185	1,479	110	1,747	-	95 - 97.5
Dr Steven Dykes	Acting Executive Medical Director	3	2.5 - 5	2.5 - 5	40 - 45	95 - 100	776	77	875	-	77.5 - 80
Dr Julian Mark	Executive Medical Director	4	-	-	40 - 45	105 - 110	1,347	-	-	-	-
Nick Smith	Chief Operating Officer	5	0 - 2.5	-	-	-	1,152	32	-	-	27.5 - 30
David Green	Executive Director of Quality and Chief Paramedic		2.5 - 5	0 - 2.5	35 - 40	80 - 85	701	47	775	-	47.5 - 50
Amanda Wilcock	Director of People and Organisation Development		2.5 - 5	2.5 - 5	55 - 60	140 - 145	1,249	83	1,370	-	67.5 - 70

Name	Title	Note	(a) Real increase in pension at pension age (Bands of £2,500)	(b) Real increase in pension lump sum at pension age (Bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2026 (Bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2025	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2026	(h) Employer's contribution to stakeholder pension	(i) All pension-related benefits (Bands of £2,500)
Sam Robinson	Chief Digital Information Officer		2.5 - 5	0 - 2.5	30 - 35	65 - 70	595	5	627	-	42.5 - 45
David O'Brien	Director of Corporate Services and Company Secretary		0 - 2.5	-	10 - 15	-	137	22	176	-	30 - 32.5
Carol Weir	Director of Strategy, Planning and Performance		2.5 - 5	2.5 - 5	40 - 45	95 - 100	767	57	852	-	57.5 - 60
Jeevan Gill	Director of Partnerships and Operations	6	5 - 7.5	0 - 2.5	35 - 40	70 - 75	557	87	683	-	122.5 - 125
Rachel Gillott	Director of Partnerships and Operations	7	-	2.5 - 5	35 - 40	115 - 120	963	-	-	-	-
Adam Layland	Director of Partnerships and Operations	8	0 - 2.5	0 - 2.5	-	-	348	15	-	-	22.5 - 25

2025-26 Pension Entitlement Table - Notes

Note	Comment
1	The above table only includes details for directors and senior managers who are currently contributing members of the NHS Pension schemes.
2	Dr Shona McCallum commenced in post as Executive Medical Director on 1 October 2025.
3	Following the retirement of Dr Julian Mark as Executive Medical Director on 1 April 2025, Dr Steven Dykes was appointed at Executive Medical Director (Interim). He left the Trust on 28 September 2026. The figures disclosed as at (c), (d) and (g) are as at 28 September 2026.
4	Dr Julian Mark retired as Executive Medical Director on 1 April 2025. The figures disclosed as at (c), (d) and (g) are as at 1 April 2025.
5	As a result of the review of the Trust Board structure during the first half of the financial year and the consequent reorganisation, the role of Chief Operating Officer is being undertaken by Marc Thomas, alongside his duties as Deputy Chief Executive, with effect from 1 December 2025. Nick Smith left his post as Chief Operating Officer on 30 November 2025 to take up the role of Associate Chief Operating Officer - 999 Operations (West Yorkshire and Central Services) in the Trust.
6	As a result of the review of the Trust Board structure during the first half of 2025/26 and the consequent reorganisation, the three roles of Director of Partnerships and Operations were removed from the Senior Management structure with effect from 1 December 2025. Jeevan Gill left her role on 30 November 2025 and subsequently left the Trust on 19 January 2026. The figures disclosed for (c), (d) and (g) are as at 19 January 2026.
7	As a result of the review of the Trust Board structure during the first half of 2025/26 and the consequent reorganisation, the three roles of Director of Partnerships and Operations were removed from the Senior Management structure with effect from 1 December 2025. Rachel Gillott left her role on 30 November 2025 and subsequently left the Trust on 31 January 2026 under agreed redundancy terms. The figures disclosed for (c), (d) and (g) are as at 31 January 2026.
8	As a result of the review of the Trust Board structure during the first half of 2025/26 and the consequent reorganisation, the three roles of Director of Partnerships and Operations were removed from the Senior Management structure with effect from 1 December 2025. Adam Layland left his role on 30 November 2025 to take up the role of Associate Chief Operating Officer - 999 Operations (North, East and South Yorkshire) in the Trust.

2024-25 Pension Entitlement Table

Name	Title	Note	(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

Name	Title	Note	(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
Jeevan Gill	Director of Partnerships and Operations		0 - 2.5	0 - 2.5	25 - 30	65 - 70	485	26	557	-	32.5 - 35
Rachel Gillott	Director of Partnerships and Operations		0 - 2.5	0 - 2.5	40 - 45	105 - 110	857	35	963	-	30 - 32.5
Adam Layland	Director of Partnerships and Operations		0 - 2.5	-	20 - 25	40 - 45	299	14	348	-	27.5 - 30
Rod Barnes	Former Chief Executive	5	0 - 2.5	-	70 - 75	185 - 190	1,663	-	-	-	-

Note	Comment
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.

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 was £240,000 - £245,000 (2024-25: £230,000 - £235,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below:

2025-26	25th percentile	Median	75th percentile
Total remuneration (£)	31,820	37,626	49,394
Salary component of total remuneration (£)	31,773	37,525	49,037
Pay ratio information	7.62 : 1	6.44 : 1	4.91 : 1

2024-25 (restated)	25th percentile	Median	75th percentile
Total remuneration (£)	29,809	36,263	47,857
Salary component of total remuneration (£)	29,775	36,115	47,586
Pay ratio information	7.80 : 1	6.41 : 1	4.86 : 1

In 2025-26 and 2024-25, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £14,825 - £240,175 (2024-25: £12,516 to £230,326).

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 4.3% on the last financial year. This is predominantly due to the senior management team pay increase of 3.25% and an increase in the benefit-in-kind value for 2025-26. The median total remuneration has increased by 3.8%, the majority of which is explained by the Agenda for Change pay award for 2025-26 of 3.6%.

Peter Reading
Chief Executive

25 June 2026

Staff Report - Our People

Our People 2025-26

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 2025-26 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, 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 2025-26 the Trust's overall headcount decreased by 24 (0.003%) from 7,682 to 7,658. Employee turnover was 8.0% on average during the year, down from 9.4% the previous year and below the ambulance sector average. 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 2025-26 the most important workforce trajectories were met, with a 98% 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 2025-26. 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 Higher Education Institutes began in November 2025, along with strategic course alignments and targeted regional recruitment campaigns. This greatly improved the number of high-quality applicants for core frontline roles, such as Newly Qualified Paramedics.

For remote care call handling centres, 117 health advisors were appointed for NHS 111 and 103 call handlers were appointed in for our 999 Emergency Operations Centre.

Our Workforce Profile (Headcount)

	2024 (31 March 2024)	2025 (31 March 2025)	2026 (31 March 2026)
Paramedics*	1,960	2,165	2,266
Ambulance Practitioners, Associate Ambulance Practitioners (Technicians)*	1,532	1,536	1,554
Ambulance Support Worker (incl. Emergency Care Assistants)*	235*	329	169
Other frontline staff (including Assistant Practitioners, A&E Support Assistants, Intermediate Care Assistants)	72	88	88
Patient Transport Service (Band 2, Band 3, and apprentices)	816	826	825
Emergency Operations Centre (EOC)	600	593	673
Integrated Urgent Care (NHS 111)**	781	901	755
Administration and Clerical staff	821	919	79
Managerial (including Associate Directors)	242	311	316
Other (Chief Executive, Directors, and Non-Executive Directors)	14	14	14
Total	**7,073**	**7,682**	**7,658**

* There has been an overall reduction of 39 headcount across frontline clinical staff (Paramedics, Technicians and Ambulance Support Workers). The number of Paramedics increasing with a corresponding decrease in non-professionally registered staff represents staff moving through the Trust career pathway. In addition, in 2024-25, the Trust was over-established, compared to the budget, hence the decrease was planned to bring the headcount in line with the operational plan.

** For NHS 111 - Planned staffing reductions and moving of some training roles into our 999 call centre as part of our Integration workstream has supported delivery of financial objectives as well as supporting our new delivery model.

Workforce Levels (Whole Time Equivalent (WTE)

Staff category	Establishment 31 March 2024		Establishment 31 March 2025		Establishment 31 March 2026	
	Headcount	WTE	Headcount	WTE	Headcount	WTE
999 Operations	3,854	3,369	4,109	3,637	4,062	3,648
PTS	750	590	826	640	824	638
EOC/IUC	1,387	967	1,592	1,194	1,595	1,262
Support staff	843	731	912	784	943	813
Management	239	225	243	230	234	218
Total	**7,073**	**5,883**	**7,682**	**6,485**	**7,658**	**6,579**

* The Trust has 673 staff who are undertaking apprenticeship programmes of study (9.2% 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)

	2024 (31 March 2024)	2025 (31 March 2025)	2026 (31 March 2026)
Male	3,103 43.87%	3,261 42.45%	3,185 41.59%
Female	3,970 56.13%	4,421 57.55%	4,473 58.41%

Staff Costs (subject to audit)

Cost type	2025-26			2024-25		
	Permanent £000	Other £000	Total £000	Permanent £000	Other £000	Total £000
Salaries and wages	277,385	1,541	**278,926**	259,992	947	260,939
Social security costs	34,032	-	**34,032**	25,347	-	25,347
Apprenticeship levy	1,367	-	**1,367**	1,288	-	1,288
Employer's contributions to NHS pension scheme	35,290	-	**35,290**	32,614	-	32,614
Pension cost - employer contributions paid by NHS ENGLAND on YAS's behalf (2025-26 9.4%; 2024-25 9.4%)	23,022	-	**23,022**	21,164	-	21,164
Termination benefits	732	-	**732**	126	-	126
Temporary staff	-	534	**534**	-	5,110	5,110
Total staff costs	**371,828**	**2,075**	**373,903**	**340,531**	**6,057**	**346,588**

Average number of employees - WTE basis (subject to audit)

Staff group	2025-26			2024-25		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	2	-	**2**	3	-	3
Ambulance staff	5,268	69	**5,337**	4,089	69	4,158
Administration and estates	1,111	19	**1,130**	2,010	92	2,101
Nursing, midwifery and health visiting staff	153	2	**155**	119	11	129
Scientific, therapeutic and technical staff	5	-	**5**	5	-	5
Total average numbers	**6,539**	**90**	**6,629**	6,225	171	6,396
Of which: Engaged on capital projects	**12**	**-**	**12**	13	-	**13**

Exit Packages (subject to audit)

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

Exit Packages agreed in 2025-26

Exit packages cost band *	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	7	1	1	2	8
£10,000 - £25,000	2	34	1	18	3	52
£25,001 - £50,000	3	79	-	-	3	79
£50,001 - £100,000	3	234	-	-	3	234
£100,001 - £150,00	-	-	-	-	-	-
£150,001 - £200,000	2	359	-	-	2	359
>£200,000	-	-	-	-	-	-
Total	**11**	**713**	**2**	**19**	**13**	**732**

***(including any special payment element)**

Exit Packages agreed in 2024-25

Exit packages cost band *	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**

***(including any special payment element)**

Exit Packages – other departures analysis

Other exit packages - disclosures (Exclude Compulsory Redundancies)	2025-26 Number of exit package agreements	2025-26 Total value of agreements	2024-25 Number of exit package agreements	2024-25 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	2	19	7	29
Exit payments following employment tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**2**	**19**	**7**	**29**
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 2025-26 or 2024-25.

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 £445k in 2025-26 (2024-25: £453k) 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.

Volunteers	Headcount
Community First Responder	900
Patient Safety Partner (PSP)	2
Volunteer Car Driver	152
Total	**1,054**

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.

Staff Health and Wellbeing
At YAS, we place great value on the dedication and expertise of our staff, recognising their vital role in delivering responsive and outstanding care to our patients whenever it is needed. We believe that to maintain the highest standards of service, it is essential to provide our employees with a safe and nurturing environment, supported by comprehensive education and skills training.

Central to our Trust Strategy is our ambition to prioritise 'Our People'. This commitment is reflected in our ongoing efforts to enhance staff health, wellbeing and attendance. Progress in these areas is tracked through an evidenced-based Health and Wellbeing Plan, which is carefully aligned with the NHS England Health and Wellbeing Framework to focus resources on areas of greatest need. We emphasise a holistic perspective on wellbeing, acknowledging that every aspect of an individual's health is interconnected and deserves equal attention and care.

Whilst this is not reflected in our sickness absence rates, the 2025-26 Trust Health and Wellbeing Plan has seen successes, positively impacting staff health and wellbeing. Achievements have included the introduction of reflective spaces, the pilot and subsequent embedding of the personal exercise plan programme and the start of the roll-out of the Avoidable Employee Harm model, an evidence-based approach focusing on improving our people practices. Additional successes have included a focus on preventative approaches such as increased awareness of wellbeing and interaction with self-care through wider access of resources and support, and a focus on enabling managers to make quality occupational health referrals where needed.

Sickness absence during 2025-26 was 7.56%, an increase from 7.1% in the previous year. Sickness absence levels have remained within an average of 7% for most of the year with a peak during December at 9.3% and thereafter absence remaining within the 8% range. Absence remains a priority for the Trust with a focus on understanding the root cause that will aid future direction of support.

	2025 / 04	2025 / 05	2025 / 06	2025 / 07	2025 / 08	2025 / 09	2025 / 10	2025 / 11	2025 / 12	2026 / 01	2026 / 02	2026 / 03
Sum of Absence FTE (Assignment)	13,264	13,647	13,611	14,645	14,331	13,301	14,519	15,268	18,919	17,948	15,154	16,557

Month	2025 / 04	2025 / 05	2025 / 06	2025 / 07	2025 / 08	2025 / 09	2025 / 10	2025 / 11	2025 / 12	2026 / 01	2026 / 02	2026 / 03
Sickness Percentage	6.8%	6.8%	6.9%	7.2%	7.1%	6.8%	7.1%	7.7%	9.3%	8.8%	8.2%	8.1%

The Trust is committed to creating a safer working environment for its staff. Evidence of progress in this area comes from the most recent NHS Staff Survey results which show increasingly positive scores regarding staff health, safety and wellbeing. The survey results for staff morale improved for the fourth consecutive year.

Culture Development

YAS Together is established as the Trust's framework for improving culture, staff experience and workforce outcomes, with 2025-26 marking a year of consolidation and demonstrable impact. The focus this year has been on embedding YAS Together as the Trust's *ways of working*, with delivery prioritised through a small number of agreed, high-impact areas including Inclusive Talent Development, the Behavioural Framework *Call to Action*, flexible working, the Inclusive Recruitment Review, and strengthened cultural governance.

Delivery has been guided by a clear and triangulated evidence base, drawing together NHS Staff Survey results, the Board-level Culture Maturity Framework assessment, the NHS England People Promise and Staff Experience self-assessment tools, and programme performance reporting. This approach has enabled more disciplined prioritisation and strengthened assurance, ensuring a clear line of sight between staff feedback, workforce risk and improvement activity.

NHS Staff Survey results demonstrate sustained and organisation-wide improvement. The 2024 survey established a positive direction of travel, while the 2025 results confirm that improvements have been embedded, with all People Promise themes improving and the highest response rate in the Trust's history. The results also provide clear insight into areas requiring continued focus, including staff involvement in change, team-based working, career development, and exposure to violence and unwanted behaviour from patients and the public.

In response, delivery during 2025-26 has deliberately focused on embedding and strengthening existing priorities rather than introducing new initiatives. This has included further roll-out of Inclusive Talent Development to improve the consistency and quality of appraisal and career conversations; phased implementation of the Behavioural Framework *Call to Action*, including the '*See Something Wrong, Do Something Right'* approach, to strengthen confidence to challenge inappropriate behaviour and support psychological safety; and the introduction of the Culture Dashboard to improve visibility of culture and workforce insight and support local action planning and assurance.

This marks a clear shift from programme delivery to embedded practice. YAS Together is now operating as a mature, organisation-wide framework, with clearer governance, stronger use of workforce insight, and an explicit line of sight between staff experience, cultural risk and effective Board oversight.

Safer Culture: Sexual Safety
The Trust remains committed to the provision of a safe working environment for all. During 2025-26 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 continues to embed the 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. Our Professional Standards Panel has been highlighted as an area of best practice by NHS Employers. Additionally, we trained over 60 more senior leaders with regard 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 is committed to working in partnership with recognised Trade Unions (UNISON, GMB, Unite the Union and the Royal College of Nursing) through established formal and informal engagement arrangements. This includes Directorate-level forums and the Joint Steering Group (JSG), which provides a key mechanism for regular dialogue between Trade Union leads and senior leaders. All policies and procedures with the potential to impact staff are reviewed in partnership with Trade Union colleagues. During summer 2025, a facilitated JSG development session, led by the Head of Leadership and Organisational Development, supported shared understanding of the purpose and function of the JSG and informed ongoing work to refresh its Terms of Reference.

Leadership and Organisational Development

Appraisal and Career Conversations
The Online Appraisal and Career Conversation has been further embedded in 2025-26 with a Robotic Process Automation (RPA) to record completion on Electronic Staff Record (ESR). A focused drive to achieve the 90% Trust compliance rate of appraisal completions by the end of March 2026, saw significant improvements at 89.1% (starting position was 70%) with four directorates over 90%.

Leadership Development
Our established Leadership Development Pathway, providing both the internal and external offer, was delivered during 2025-26:

Aspiring Leaders	6 programmes delivered with 63 participants
Lead Together	6 programmes delivered with 36 participants
Developing Leaders	2 programmes 20 participants ion total
Leadership Apprenticeships	1 x Level 5 Operations/Departmental Manager 1 x Level 6 Chartered Manager 10 x Level 7 Senior Leader

Additionally, two cohorts with 28 learners enrolled on a Level 5 Coaching Professional Apprenticeship to build our internal coaching network and enhance the experience of our leaders and provide robust leadership coaching.

Education and Learning

We are proud of the achievements of YAS Academy, our dedicated education teams equip staff, students and volunteers with the requisite knowledge and skills to be fully effective in their role and deliver great patient care. The initial classroom-based phases of the core workforce development apprenticeship programmes have been extended in response to feedback and to reduce the assessment burden when apprentices are working in their frontline roles. This demonstrates YAS's commitment to the People Bold Ambition. YAS was rated #12 in the Sunday Times Top 100 Apprenticeship Employers 2025, improving from #23 in 2024, with one in 9 of our colleagues on an apprenticeship programme.

The total number of apprentices in YAS at the end of March 2026 was 653, which equates to 8.5% of our workforce, maximising the apprenticeship levy funding available. We saw 300 new apprentices in 2025-26, which is a decrease from 523 in 2024-25 due to changes in the Trust workforce development requirement. We continue to utilise a range of standards including Coaching, Project Management, Customer Service, Team Leaders and Senior Leadership alongside the annual intake for Enhanced Clinical Practitioner apprenticeship to develop our Specialist Paramedics in mental health, critical care, urgent care and remote patient assessment.

We have also utilised the Business Analyst Level 4 apprenticeship for our AI (Artificial Intelligence) Academy with Multiverse for 27 staff members; a new addition in 2025-26.

The quality outputs of our apprenticeship programmes remain strong with 51% of our Ambulance Support Workers (Level 3) and 98% of our Associate Ambulance Practitioners (Level 4) achieving a distinction.

We are very grateful to our eight apprenticeship levy transfer partners where 2025-26 saw £2.9M received, representing a saving to the Trust of £145K (offsetting 5% co-investment) compared to £247K in 2024-25.

STARS Awards 2025

Inspirational Yorkshire Ambulance Service (YAS) staff and volunteers who have gone above and beyond for patients and colleagues were honoured at the Trust's annual STARS Awards in October 2025.

The event, held in Leeds, West Yorkshire, was an opportunity to celebrate outstanding achievements of colleagues from core services and support teams across the organisation, 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 200 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 went the extra mile to provide exemplary care to palliative patients, a Community First Responder who has volunteered at YAS for over ten years, and off-duty two colleagues who saved the life of a patient who went into cardiac arrest.

Long Service Awards

Our 2025 Long Service Awards recognised 128 colleagues with a combined service of over 5,560 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

Among the awardees were 14 colleagues who had reached an incredible 40 years' service, and one retired member of staff, Ian Horner, who had completed an amazing 50 years' service and received his award locally in South Yorkshire. North Yorkshire-based husband and wife Lee and Emma Davison, who have both served for 30 years, received their awards on the event day. They first met back in 1999 on their paramedic training course and got together ten years later.

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 potentially fraudulent activity or obtaining advice in 2025-26 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 for Provider Trusts (2023). The Trust undertakes an annual self-assessment of its compliance with the Code of Governance. The output of this is reported to the Audit and Risk Committee each year. For 2025-26 the Trust is declaring a position of full compliance apart from one element of the Code, as follows.

The Code of Governance states that ideally the Chair of the Trust's Audit and Risk Committee should not also be the Deputy Chair of the Trust. This is not an absolute requirement, but trusts are expected to declare and explain any divergence from this. In December 2025 Amanda Moat was appointed Deputy Chair of the Trust. At that time Amanda Moat was, and still is, the Chair of the Trust's Audit and Risk Committee. For the purposes of continuity, succession planning, and optimal distribution and application of Board member skills, knowledge, and experience, the Trust considers this arrangement to be appropriate. Any risks arising from this arrangement will be managed accordingly and in line with good practice.

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 previous areas of partial compliance and non-compliance had been addressed satisfactorily.

The NHS Code of Governance requires trusts to provide certain 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

Code of Governance Reference		Annual Report Disclosure Requirements	YAS Annual Report Section(s)
Section	**Para**		
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 collaboration with other providers into which the Trust has entered.	Our Partners System Working
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

Code of Governance Reference		Annual Report Disclosure Requirements	YAS Annual Report Section(s)
Section	**Para**		
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 2025-26.
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 2025-26
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 2025-26
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 2025-26

External Oversight

NHS National Oversight Framework

NHS England's National Oversight Framework is an 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 five 'segments' based on achievement against a set of performance metrics and standards. Segment one represents the highest level of achievement and is reserved for those trusts which perform best and have few support needs.

At the end of 2025-26 Yorkshire Ambulance Service NHS Trust was positioned in segment one, the highest of five available segments. In the ambulance sector, for 2025-26 quarter four the Trust was ranked highest of the ten NHS ambulance service trusts in England.

Alongside the National Oversight Framework, during 2025-26 NHS England introduced a new Provider Trust Capability Assessment which evaluates each NHS trust against a set of organisational standards and expectations. For 2025-26 the Yorkshire Ambulance Service was assessed by NHS England as 'amber-green', the second highest of four available ratings.

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 2025-26.
- YAS has not participated in any special reviews or investigations by the CQC during 2025-26.

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 2026 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The Board of Directors

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 and its committees receive 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.

Board Membership

The Trust Board membership is as follows:

- Chair*
- Six Non-Executive Directors*
- Chief Executive Officer*
- Deputy Chief Executive and Chief Operating Officer*
- Executive Director of Finance*
- Executive Medical Director*

- Executive Director of Quality and Chief Paramedic*
- Director of People and Organisational Development
- Director of Strategy, Planning and Performance
- Chief Digital Information Officer
- Director of Corporate Services and Company Secretary
- Two Associate Non-Executive Directors

(* denotes full / voting members)

Changes to Board Membership Positions.

During 2025-26 the following changes were made to Board positions:

- The Chief Operating Officer role was disestablished.
- The Deputy Chief Executive role was disestablished.
- A new role of Deputy Chief Executive and Chief Operating Officer was established.
- The three Director of Partnerships and Operations roles were disestablished.
- Ministerial approval was received for an amendment to the Trust Establishment Order which increased the number of Non-Executive Director positions on the Board from six (Chair plus five) to seven (Chair plus six).

Changes to Board Member Personnel

During 2025-26 the following changes were made to Non-Executive Director personnel:

- Tim Gilpin concluded his period in office as Non-Executive Director on 31 July 2025.
- Anne Cooper concluded her period in office as Non-Executive Director on 30 November 2025.
- Tabitha Arulampalam left the position of Associate Non-Executive Director on 31 July 2025.
- Tabitha Arulampalam commenced as Non-Executive Director on 1 August 2025.
- Melanie Hudson commenced as Non-Executive Director on 22 September 2025.
- Rebecca Malby commenced as Non-Executive Director on 1 December 2025.

During 2025-26 the following changes were made to Executive Director personnel:

- Julian Mark retired from the role of Executive Medical Director on 1 April 2025.
- Steven Dykes served as interim Executive Medical Director from 2 April 2025 to 28 September 2025.
- Shona McCallum commenced as Executive Medical Director on 1 October 2025.
- Nick Smith left the role of Chief Operating Officer on 30 November 2025.
- Marc Thomas left the role of Deputy Chief Executive on 30 November 2025.
- Marc Thomas commenced as Deputy Chief Executive and Chief Operating Officer on 1 December 2025.
- Adam Layland left the role of Director of Partnerships and Operations (South) on 30 November 2025.
- Jeevan Gill left the role of Director of Partnerships and Operations (North and East) on 30 November 2025.
- Rachel Gillott left the role of Director of Partnerships and Operations (West) on 30 November 2025.

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 conducted in accordance with the Trust Standing Orders (including the Standing Financial Instructions) and is managed via structured work plans co-ordinated across the Board and its assurance committees. This ensures appropriate focus on formal governance and assurance requirements and is sufficiently agile to flex in response to changing circumstances or urgent matters.

During 2025-26 the Board held six ordinary meetings in public, plus its Annual General Meeting held in September 2025. The Board also held formal sessions in private as appropriate. In addition, a planned programme of informal Board Strategic Forum sessions facilitated in-depth coverage of specific topics. Key items addressed during the 2025-26 programme of Board Strategic Forum sessions included:

- Business Planning Priorities
- Financial Planning
- Strategic Risk (Board Assurance Framework)
- Insightful Provider Board Guidance
- Data and Insights
- Quality Improvement
- Organisational Culture
- The 10-Year Health and Care Plan
- Trust Capability Assessment
- Organisational Governance
- Safeguarding
- Freedom To Speak Up (led by the Office of the National Guardian)
- Reducing Variation in Response Times
- Remote Patient Care Transformation
- Research
- System and Partnership Working.

During 2025-26 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.

Trust Executive Group

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 Executive Director of Quality and Chief Paramedic, who is responsible for maintaining effective and compliant quality governance systems, including patient safety, incidents, investigations and patient experience.
- The Executive Medical Director, who is responsible for clinical governance and clinical risk management, ensuring that clinical practice is appropriate and effective, compliant, and current.
- The Executive Director of Finance, who 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 Chief Digital Information Officer, who is the Trust's Senior Information Risk Owner (SIRO) and has overall responsibility for risk management relating to digital and cyber security.
- The Director of Corporate Services and Company Secretary, who is responsible for effective systems of board and committee governance, compliance with the NHS Code of Governance and other regulatory frameworks, legal risk, and strategic risk management. The Director of Corporate Services and Company Secretary is also the Trust's Deputy SIRO and supports the SIRO in the management of information governance risk.

Everybody's Business

The Trust considers risk management to be everybody's business. Directors and managers throughout the organisation 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 2025-26 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.

Risk Management and Assurance Strategic Framework

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.

The Risk Management and Assurance Strategic Framework aligns with the Trust's 2024-29 strategy and is updated to reflect changes to the Trust's leadership and governance structures.

Board Assurance Framework

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.

The strategic risks set out in the Board Assurance Framework are 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 deliver quality for patients
- Ability to strengthen 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.

These strategic risks were reviewed and refreshed during 2025-26 and mitigation plans were developed and implemented for each. 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.

Board committees have a key role in the monitoring and assurance of the Board Assurance Framework: each committee has oversight of designated strategic risks and these are built into the respective Terms of Reference, workplans, meeting agendas, and assurance reporting for each committee.

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 2025-26 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.
- Operational performance, particularly during winter pressures.
- Ambulance fleet availability.
- Eligibility criteria for the Patient Transport Service.
- Availability of capital funding, particularly for estates.
- Provision of clinician capacity, including on-call medical advisors and clinical staffing levels in call-handling operations.
- Staff sickness absence.
- Health and safety risks, including fire safety and incidents near water.

- 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 2025-26 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.
- Implementation 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 the Trust's Performance Management Framework. This review reported moderate assurance.
- Completion of the Trust Capability Assessment self-assessment.
- Implementation of a review of the Trust's senior leadership structure, including changes to the roles and responsibilities of directors.
- Recruitment to Executive Director and Non-Executive Director positions.
- An externally facilitated developmental review of Well-Led arrangements.

During 2025-26 the Board concluded 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. Additional Board development work will be undertaken during 2026-27,

in line with regulatory frameworks (such as the Care Quality Commission's Well-Led Framework) and good practice guidance (such as the Insightful Provider Board framework).

During 2025-26 the Trust commissioned a developmental review of its Well-Led arrangements, delivered by an external supplier (Advancing Quality Alliance). The review fieldwork took place during the period February 2026 to April 2026. The findings from the Well-Led review will inform the next phase of Board and corporate governance development in the Trust.

Strategic Risk Outlook

The Trust's strategic risk outlook for 2026-27 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 2026-27 the main areas of strategic risk to the Trust remain are set out in the Board Assurance Framework. Within that context, however, particular elements of risk are likely to be significant. Examples include:

- Operating within available revenue finances during 2026-27, including the need to identify and deliver cost reductions and productivity gains.
- Performance against national planning and oversight framework requirements, including key metrics relating to response times, hear and treat, conveyance rates, and staff sickness.
- The impact of national and system-level restructuring and cost reduction programmes affecting NHS England and Integrated Care Boards.
- Dependence on partner organisations in key areas of urgent and emergency care, including hospital handover and provision of alternative pathways for patients.
- Developments relating to the 10 Year Health and Care Plan, including the emergence of neighbourhood models.
- Strategic infrastructure developments, including major estates projects in Hull and Sheffield and new supply arrangements for double-crewed ambulance vehicles.

In addition, the Trust is assessing the potential impact of prolonged conflict in the Middle East and the financial and operational implications of this (for instance, fuel prices and availability; energy costs; technology supply and costs; equipment and consumables supply and costs).

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 2025-26 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 a Deputy), 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 2025-26 included:

- Compliance with the Cyber Assurance Framework 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 2025-26 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.
- Continued engagement and development of Information Asset Owners.
- 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.
- Commissioned an audit regarding Airwaves Code of Practice compliance.
- Appointed to a new Chief Clinical Information Officer role.
- Strengthened information governance assurance reporting to the Finance and Performance Committee.
- Reviewed and updated the Trust's Information Governance Framework.

The Trust complies with the requirements 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 2025-26 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 Trust's declared degree of compliance. For 2025-26 this exercise reported the highest level of assurance and the lowest level of risk, which is the best possible rating in the NHS England assurance model.

The Trust has a designated Caldicott Guardian (the Executive Director of Quality and Chief Paramedic) and upholds the Caldicott principles concerning the governance of patient identifiable information.

During 2025-26 the Trust experienced no information governance incidents of sufficient significance to merit reporting by the Trust to the Office of the Information Commissioner (ICO) or other statutory or regulatory bodies.

Data Quality and Governance

During 2025-26 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.
- Undertook a planned internal audit review of data quality relating to crew clear and handover metrics.
- Continued to provide general staff training in the use of data and systems, including on the importance of accurate data entry, data quality and reporting.
- Reviewed and updated the Trust's Data Quality Policy.
- Held Board and senior management development sessions on good practice in the use of data.

During 2025-26 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. During 2025-26 the Trust strengthened this area by establishing a new Strategic Workforce governance group with a direct managerial line to the Trust Executive Group and an assurance flow to Board committees.

In 2025-26 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.

The most recent NHS staff survey results demonstrate strong progress in the 'Our People' areas of activity. In the ambulance sector the Trust is now top in seven of the nine 'People Promise' domains in the survey.

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 twelve 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 2025-26 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 in 2025-26 developed a new 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 2025-26 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. The most recent NHS staff survey results demonstrate strong progress regarding speaking up culture: the Trust's scores for speaking up culture have improved for four consecutive years and the Trust is now top in the ambulance sector.

Chief Executive's 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 2025-26. The Trust has not been subject to any special reviews or investigations by the CQC during 2025-26.

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.

During 2025-26 the Trust commissioned an external developmental review of its Well-Led arrangements. The outcome of this review will be reported during 2026-27 Q1.

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 2025-26 were as follows:

- 2 reviews reported significant assurance.
- 1 review reported a split rating: mostly significant assurance with one element of moderate assurance.
- 4 reviews reported moderate assurance.
- 4 review reported limited assurance.
- 2 reviews were advisory.
- No reviews reported weak assurance.

'Limited assurance' indicates that 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 four reviews that reported limited assurance were:

- Patient Experience and Complaints
- Patient Safety Incident Response Framework: Moderate Harm
- Appraisals
- Policy Equality Impact Assessment Process.

Management action plans have been agreed to address the governance, risk management and control issues identified by all reviews. Assurance committees have a key role in monitoring progress on management actions arising from internal audit reviews and this has been included in their Terms of Reference for 2026-27.

The Trust considers that none of the individual matters identified by the 2025-26 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. Two reviews did identify similar issues regarding the capture and dissemination of learning. However, the Trust considers that these did not constitute a significant internal control issue and the relevant recommendations have been implemented in a timely manner and to the satisfaction of internal audit.

The Audit and Risk Committee is focussed on the timely completion of management actions arising from internal audit reviews. During 2025-26 the organisation performed less well overall than previously regarding the timely completion of audit actions. However, most of the under-achievement during 2025-26 focussed on challenging actions associated with two reviews only. During the later months of 2025-26 and early 2026-27 more than 90% of actions have been 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 governance, risk management and internal control. For 2025-26 the Head of Internal Audit has reported a moderate level of assurance, meaning that there are areas for improvement in the framework of governance, risk management and control and that there is some inconsistent application of controls that puts the achievement of the organisation's objectives at risk.

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

Head of Internal Audit Opinion

I am providing an opinion of moderate assurance that there are areas for improvement in the framework of governance, risk management and control and some inconsistent application of controls puts the achievement of the organisation's objectives at risk.

My opinion reflects the range of audit opinions provided in the year. Of the thirteen audits completed, nine have received either a moderate or limited assurance opinion. I t is acknowledged that of the four audits that received limited assurance, three were areas of known risk directed by the Trust: Patient Experience and Complaints, Appraisals and Policy Equality Impact Assessment Process.

I have considered the Trust's performance in implementing agreed internal audit actions. 60% of high and medium risk actions have been implemented in accordance with the agreed due date; 72% overall. This is a deterioration on the previous year (76% and 98% respectively) and falls below the expected standard. Further focus is required to ensure that agreed actions, particularly those addressing higher risk areas, are implemented in a timely manner.

Third party assurances received have been generally positive.

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 2025-26 the Audit and Risk Committee undertook effectiveness reviews of both internal audit and external audit and found both to be effective. In addition, the Trust, following a recommendation from the Audit and Risk Committee, triggered a two-year extension to the contract with its external auditor.

For the financial year 2025-26 the Audit and Risk Committee has not been required to deal with any significant issues relating to the Trust's financial statements.

During 2025-26 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

25 June 2026

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

25 June 2026

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 the 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

25 June 2026

Kathryn Vause
Executive Director of Finance

25 June 2026

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 2026, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' 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 2025-26.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 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 2025-26; 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 2025-26; 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 2025-26).

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 2026.

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 2026 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 2026.

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 Audit Limited
Chartered Accountants and Statutory Auditors

Bristol

25 June 2026

Annual accounts for the year ended 31 March 2026

Statement of Comprehensive Income

	Note	2025-26 £000	2024-25 £000
Operating income from patient care activities	3	466,585	438,426
Other operating income	4	9,794	9,335
Operating expenses	6,8	(479,010)	(447,238)
Operating (deficit) / surplus from continuing operations		**(2,631)**	**523**
Finance income	10	2,351	2,815
Finance expenses	11	(871)	(687)
PDC dividends payable		(3,834)	(3,365)
Net finance costs		**(2,354)**	**(1,237)**
Other gains	12	214	311
(Deficit) for the year		**(4,771)**	**(403)**
Other comprehensive income / (expense)			
Will not be reclassified to income and expenditure:			
Impairments	7	2,646	(4,055)
Revaluations	16	454	-
Total other comprehensive (expense) for the		**3,100**	**(4,055)**
Total comprehensive (expense) for the period		**(1,671)**	**(4,458)**

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	13	2,384	2,532
Property, plant and equipment	14	146,533	128,044
Right of use assets	17	24,047	25,890
Receivables	19	1,561	1,383
Total non-current assets		**174,525**	**157,849**
Current assets			
Inventories	18	3,516	2,657
Receivables	19	7,646	12,427
Non-current assets for sale and assets in disposal groups	21	442	-
Cash and cash equivalents	22	49,902	44,177
Total current assets		**61,506**	**59,261**
Current liabilities			
Trade and other payables	23	(38,546)	(33,850)
Borrowings	25	(8,627)	(8,297)
Provisions	26	(2,432)	(1,908)
Other liabilities	24	(294)	(56)
Total current liabilities		**(49,899)**	**(44,111)**
Total assets less current liabilities		**186,738**	**172,999**
Non-current liabilities			
Borrowings	25	(14,631)	(17,404)
Provisions	26	(6,857)	(6,877)
Total non-current liabilities		**(21,488)**	**(24,281)**
Total assets employed		**164,644**	**148,718**
Financed by			
Public dividend capital		113,434	95,837
Revaluation reserve		21,489	18,455
Income and expenditure reserve		29,721	34,426
Total taxpayers' equity		**164,644**	**148,718**

The notes on pages 142 to 186 form part of these accounts.

Name: Peter Reading
Position: Chief Executive
Date: 25 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025	**95,837**	**18,455**	**34,426**	**148,718**
Deficit for the year	-	-	(4,771)	**(4,771)**
Impairments	-	2,646	-	**2,646**
Revaluations	-	454	-	**454**
Transfer to retained earnings on disposal of assets	-	(66)	66	**-**
Public dividend capital received	17,597	-	-	**17,597**
Taxpayers' equity at 31 March 2026	**113,434**	**21,489**	**29,721**	**164,644**

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' equity at 1 April 2024	**94,362**	**22,510**	**34,829**	**151,701**
(Deficit) for the year	-	-	(403)	**(403)**
Impairments	-	(4,055)	-	**(4,055)**
Public dividend capital received	1,475	-	-	**1,475**
Taxpayers' equity at 31 March 2025	**95,837**	**18,455**	**34,426**	**148,718**

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	2025-26 £000	2024-25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(2,631)	523
Non-cash income and expense:			
Depreciation and amortisation	6.1	21,872	19,376
Net impairments	7	7,341	495
(Increase) / decrease in receivables and other assets		4,586	(3,714)
(Increase) / decrease in inventories		(859)	(255)
Increase / (decrease) in payables and other liabilities		6,223	(3,560)
Increase / (decrease) in provisions		323	(1,531)
Other movements in operating cash flows		-	(1)
Net cash flows from / (used in) operating activities		**36,855**	**11,333**
Cash flows from investing activities			
Interest received		2,323	2,921
Purchase of intangible assets		(1,062)	(872)
Purchase of PPE and investment property		(38,317)	(21,447)
Sales of PPE and investment property		357	383
Net cash flows from / (used in) investing activities		**(36,699)**	**(19,015)**
Cash flows from financing activities			
Public dividend capital received		17,597	1,475
Movement on loans from DHSC		(334)	(334)
Capital element of lease rental payments		(7,213)	(5,316)
Interest on loans		(42)	(54)
Other interest		(2)	(2)
Interest paid on lease liability repayments		(648)	(632)
PDC dividend (paid)		(3,789)	(3,485)
Net cash flows from / (used in) financing activities		**5,569**	**(8,348)**
Increase / (decrease) in cash and cash equivalents		**5,725**	**(16,030)**
Cash and cash equivalents at 1 April		**44,177**	**60,207**
Cash and cash equivalents at 31 March	22.1	**49,902**	**44,177**

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 2025-26 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 (up to 31 March 2025), 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 £49.9m and has sufficient liquidity with working capital (total current assets less current liabilities) of £11.6m and a cash ratio (cash and cash equivalents/total current liabilities) of 1.0.

Our going concern assessment is made up to 30 June 2027. 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 2026-27 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 the Trust, as a provider of ambulance services, the 'fixed' element of API contracts comprises the majority of income, with the 'variable' income element limited to Dental Services and the provision of additional Patient Transport Services only.

Revenue from NHS contracts (continued)
The fixed payment is a block value to fund an agreed level of activity at agreed performance standards. In 2025-26 the specific value of the fixed payment was agreed with commissioners through the annual planning and contract negotiation process, and based on the rules set out in the NHSPS. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the core fixed payments to reimburse specific costs incurred in 2025-26, 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 front-line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case, a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees 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	3	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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairment
Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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	3	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.

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 discharged, 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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.

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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
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 2.95% in real terms (prior year: 2.40%).

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 26.2 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 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 27, 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 GOV.uk.

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. The Trust does not hold any third-party assets.

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. The Trust has not received any gifts during 2025-26.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been adopted early in 2025-26.

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 2025-26.

- **IFRS 18 Presentation and Disclosure in Financial Statements**
  The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and 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 adaptations and interpretation of IAS 16 for the public sector**
  The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

  Changes to valuation of property, plant and equipment (PPE) assets

  The DHSC GAM for 2026-27 and associated consultation response document confirms future changes which will impact on the financial statements.

  From 2026-27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods.

  The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore, the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29.

  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 14, Property, plant and equipment, and Note 13 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 2026 with a prospective valuation date of 31 March 2026 (Note 16). These values and assets lives reflect both local and national property indices.

Provisions for early retirements and injury benefits (Note 26)
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 2.95% in real terms (prior year: 2.40%). 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 26)
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 19.2)
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)

	2025-26 £000	2024-25 £000
Ambulance services *		
A & E income	362,920	331,795
Patient transport services income	50,021	50,177
Other income	30,564	35,251
All services		
Private patient income	58	39
Additional pension contribution central funding**	23,022	21,164
Total income from activities	**466,585**	**438,426**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025-26 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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2024-25: 23.7%) and related NHS England funding (9.4%, 2024-25: 9.4%) have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025-26 £000	2024-25 £000
NHS England	23,053	21,378
Integrated care boards	440,032	413,692
Department of Health and Social Care	17	-
Other NHS providers	1,141	1,075
Local authorities	35	52
Non-NHS: private patients	58	39
Injury cost recovery scheme	838	748
Non-NHS: other	1,411	1,442
Total income from activities	**466,585**	**438,426**
Of which:		
Related to continuing operations	**466,585**	438,426

Note 4 Other operating income

	2025-26			2024-25		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	1,261	-	**1,261**	960	-	**960**
Education and training	4,211	2,026	**6,237**	4,649	1,348	**5,997**
Income in respect of employee benefits accounted on a gross basis	455	-	**455**	463	-	**463**
Other income	1,841	-	**1,841**	1,915	-	**1,915**
Total other operating income	**7,768**	**2,026**	**9,794**	**7,987**	**1,348**	**9,335**
Of which:						
Related to continuing operations			**9,794**			9,335

Note 5 Operating leases - Yorkshire Ambulance Service NHS Trust as lessor

Yorkshire Ambulance Service NHS Trust did not have any operating lease arrangements where it was the lessor in either 2025-26 or 2024-25.

Note 6.1 Operating expenses

	2025-26 £000	2024-25 £000
Purchase of healthcare from NHS and DHSC bodies	24	234
Purchase of healthcare from non-NHS and non-DHSC bodies	7,430	11,666
Staff and executive directors' costs	365,626	336,960
Remuneration of non-executive directors	155	128
Supplies and services - clinical (excluding drugs costs)	12,869	8,293
Supplies and services - general	1,617	2,251
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	405	403
Consultancy costs	445	453
Establishment	4,248	4,767
Premises	13,853	11,995
Transport (including patient travel)	23,356	28,837
Depreciation on property, plant and equipment	20,794	18,392
Amortisation on intangible assets	1,078	984
Net impairments	7,341	495
Movement in credit loss allowance: contract receivables / contract assets	122	10
Movement in credit loss allowance: all other receivables and investments	104	-
Increase/(decrease) in other provisions	645	(788)
Change in provisions discount rate(s)	(171)	195
Fees payable to the external auditor*		
audit services- statutory audit	150	176
Internal audit costs	129	134
Clinical negligence	2,776	3,030
Legal fees	770	437
Insurance (as a policy holder)	33	48
Research and development	1,203	1,151
Education and training	9,473	11,203
Expenditure on short term leases	2,465	3,303
Redundancy	732	126
Hospitality	39	58
Losses, ex gratia & special payments	87	14
Other	1,212	2,283
Total	**479,010**	**447,238**
Of which:		
Related to continuing operations	**479,010**	447,238

*The statutory audit fee is disclosed inclusive of irrecoverable VAT. The audit fee excluding VAT is £125k (2024-25 - £147k).

Note 6.2 Other auditor remuneration

No other auditor remuneration was paid to the external auditor in 2025-26 (2024-25: £nil)

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2024-25: £1 million).

Note 7 Impairment of assets

	2025-26 £000	2024-25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	3,450	(120)
Other	3,891	615
Total net impairments charged to operating surplus / deficit	**7,341**	**495**
Impairments charged to the revaluation reserve	(2,646)	4,055
Total net impairments	**4,695**	**4,550**

Note 8 Employee benefits

	2025-26 £000	2024-25 £000
Salaries and wages	278,926	260,939
Social security costs	34,032	25,347
Apprenticeship levy	1,367	1,288
Employer's contributions to NHS pensions	58,312	53,778
Termination benefits	732	126
Temporary staff (including agency)	534	5,110
Total staff costs	**373,903**	**346,588**
Of which		
Costs capitalised as part of assets	646	362

Note 8.1 Retirements due to ill-health

During 2025-26 there were 24 early retirements from the Trust agreed on the grounds of ill-health (15 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £2,477k (£1,154k in 2024-25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

NHS Pension Schemes

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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 at 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.

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 10 Finance income

Finance income represents interest received on assets in the period.

	2025-26 £000	2024-25 £000
Interest on bank accounts	2,351	2,815
Total finance income	**2,351**	**2,815**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025-26 £000	2024-25 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	40	53
Interest on lease obligations	648	632
Interest payable to HMRC	-	2
Interest on late payment of commercial debt	2	-
Total interest expense	**690**	**687**
Unwinding of discount on provisions	181	-
Total finance costs	**871**	**687**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2025-26 £000	2024-25 £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	2	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains / (losses)

	2025-26 £000	2024-25 £000
Gains on disposal of assets	214	311
Total gains on disposal of assets	**214**	**311**

Note 13.1 Intangible assets - 2025-26

	Software/ licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2025	**5,229**	**1,067**	**6,296**
Additions	83	847	**930**
Reclassifications	1,139	(1,139)	**-**
Disposals	(233)	-	**(233)**
Cost at 31 March 2026	**6,218**	**775**	**6,993**
Amortisation at 1 April 2025	**3,764**	**-**	**3,764**
Provided during the year	1,078	-	**1,078**
Disposals	(233)	**-**	**(233)**
Amortisation at 31 March 2026	**4,609**	**-**	**4,609**
Net book value at 31 March 2026	**1,609**	**775**	**2,384**
Net book value at 1 April 2025	**1,465**	**1,067**	**2,532**

From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 13.2 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**
Reclassifications	127	(127)	**-**
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 14.1 Property, plant and equipment – 2025-26

	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 2025	**20,564**	**53,794**	**23,568**	**16,486**	**59,805**	**12,846**	**285**	**187,348**
Additions	-	1,537	35,139	-	4	484	-	**37,164**
Impairments	-	(10,789)	-	-	(456)	-	-	**(11,245)**
Reversals of impairments	30	4,202	-	-	-	-	-	**4,232**
Revaluations	454	-	-	-	-	-	-	**454**
Reclassifications	280	4,553	(21,613)	275	13,580	2,925	-	**-**
Transfers to /from assets held for sale	(400)	-	-	-	(2,077)	-	-	**(2,477)**
Disposals / derecognition	-	-	-	(4,037)	(12,414)	(960)	(222)	**(17,633)**
Valuation/gross cost at 31 March 2026	**20,928**	**53,297**	**37,094**	**12,724**	**58,442**	**15,295**	**62**	**197,843**
Accumulated depreciation at 1 April 2025	**-**	**1**	**-**	**11,465**	**38,436**	**9,142**	**260**	**59,304**
Provided during the year	-	2,014	-	1,666	7,528	2,630	11	**13,849**
Impairments	-	(1,638)	-	-	(303)	-	-	**(1,941)**
Reversals of impairments	-	(377)	-	-	-	-	-	**(377)**
Transfers to /from assets held for sale	-	-	-	-	(2,035)	-	-	**(2,035)**
Disposals / derecognition	-	-	-	(4,015)	(12,293)	(960)	(222)	**(17,490)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**9,116**	**31,333**	**10,812**	**49**	**51,310**
Net book value at 31 March 2026	**20,928**	**53,297**	**37,094**	**3,608**	**27,109**	**4,483**	**14**	**146,533**
Net book value at 1 April 2025	**20,564**	**53,793**	**23,568**	**5,021**	**21,369**	**3,704**	**25**	**128,044**
Property, plant and equipment financing								
Owned - purchased	20,928	53,297	37,094	3,608	27,109	4,483	14	146,533

Note 14.2 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 15 Donations of property, plant and equipment

There were no donations of property, plant and equipment received during 2025-26 (2024-25 - £nil).

Note 16 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 value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case, a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) 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 2026 with a prospective valuation date of 31 March 2026.

Note 17 Leases - Yorkshire Ambulance Service NHS Trust as a lessee

The Trust has lease arrangements for both property and vehicles in line with the normal course of its business.

Note 17.1 Right of use assets - 2025-26

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025	**8,803**	**5,885**	**22,449**	**1,649**	**38,786**	**877**
Additions	1,504	1,059	2,539	-	**5,102**	93
Reclassifications	-	-	-	-	**-**	96
Disposals / derecognition	-	-	(555)	-	**(555)**	-
Valuation/gross cost at 31 March 2026	**10,307**	**6,944**	**24,433**	**1,649**	**43,333**	**1,066**
Accumulated depreciation at 1 April 2025	**2,292**	**1,139**	**9,420**	**45**	**12,896**	**401**
Provided during the year	949	1,164	4,262	570	**6,945**	219
Disposals / derecognition	-	-	(555)	-	**(555)**	-
Accumulated depreciation at 31 March 2026	**3,241**	**2,303**	**13,127**	**615**	**19,286**	**620**
Net book value at 31 March 2026	**7,066**	**4,641**	**11,306**	**1,034**	**24,047**	**350**
Net book value at 1 April 2025	**6,511**	**4,746**	**13,029**	**1,604**	**25,890**	**476**

Net book value of right of use assets leased from other NHS providers	282
Net book value of right of use assets leased from other DHSC group bodies	164

Note 17.2 Right of use assets – 2024-25

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £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	1,649	**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**	**1,649**	**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	45	**5,968**	135
Disposals / derecognition	(73)	-	(84)	-	**(157)**	-
Accumulated depreciation at 31 March 2025	**2,292**	**1,139**	**9,420**	**45**	**12,896**	**401**
Net book value at 31 March 2025	**6,511**	**4,746**	**13,029**	**1,604**	**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 17.3 Revaluations of right of use assets

The Trust did not undertake any revaluation of its Right of Use assets during 2025-26 or 2024-25.

Note 17.4 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 25.1.

	2025-26 £000	2024-25 £000
Carrying value at 1 April	**23,204**	**18,602**
Lease additions	5,102	9,918
Interest charge arising in year	648	632
Lease payments (cash outflows)	(7,861)	(5,948)
Carrying value at 31 March	**21,093**	**23,204**

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 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 17.5 Maturity analysis of future lease payments

	Total 31 March 2026 £000	Of which leased from DHSC group bodies: 31 March 2026 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	8,291	121	7,963	135
- later than one year and not later than five years;	11,093	323	12,527	323
- later than five years.	2,945	204	4,270	170
Total gross future lease payments	**22,329**	**648**	**24,760**	**628**
Finance charges allocated to future periods	(1,236)	(27)	(1,556)	(32)
Net lease liabilities at 31 March 2026	**21,093**	**621**	**23,204**	**596**
Of which:				
Leased from other NHS providers		369		366
Leased from other DHSC group bodies		252		230

Note 18 Inventories

	31 March 2026 £000	Restated 31 March 2025 £000
Drugs	151	179
Consumables	2,249	1,393
Other	1,116	1,085
Total inventories	**3,516**	**2,657**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £19,304k (2024-25: £18,859k). Write-down of inventories recognised as expenses for the year were £0k (2024-25: £0k).

The prior year comparative balances have been restated to allow comparability with the current year inventories analysis, following a classification review conducted during 2025-26.

Note 19.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	4,501	7,522
Allowance for impaired contract receivables / assets	(658)	(548)
Allowance for other impaired receivables	(104)	-
Prepayments (non-PFI)	2,033	3,661
Interest receivable	224	196
PDC dividend receivable	10	55
VAT receivable	801	829
Other receivables	839	712
Total current receivables	**7,646**	**12,427**
Non-current		
Contract receivables	1,561	1,383
Total non-current receivables	**1,561**	**1,383**
Of which receivable from NHS and DHSC group bodies:		
Current	1,854	5,538

Note 19.2 Allowances for credit losses

	2025-26		2024-25	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2025	**548**	**-**	**557**	**-**
New allowances arising	-	104	-	-
Changes in existing allowances	122	-	10	-
Utilisation of allowances (write offs)	(12)	-	(19)	-
Allowances as at 31 March 2026	**658**	**104**	**548**	**-**

Note 19.3 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 20 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 in 2025-26 and 2024-25.

Note 21.1 Non-current assets held for sale

	2025-26 £000	2024-25 £000
NBV of non-current assets for sale at 1 April	**-**	**-**
Assets classified as available for sale in the year	442	-
NBV of non-current assets for sale at 31 March	**442**	**-**

As part of the Trust's 2024-25 Estates strategy, the decision was made to relocate the services being undertaken at Wath Ambulance Station to Callflex Business Park. This was completed in the first half of 2025-26.

Due to the age and condition of the property, Wath Ambulance Station was considered to be surplus to the Trust's future operational requirements. The decision was therefore taken in 2025-26 to market the property. The site, carried at a value of £400k, is expected to be sold in the first half of 2026-27.

The Trust has a number of vehicles that are no longer operational. In order to maximise the return on these assets, they are placed with local auction houses to be sold. £42k of the Trust's fleet is currently being held ready for disposal.

Note 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025-26 £000	2024-25 £000
At 1 April	**44,177**	**60,207**
Net change in year	5,725	(16,030)
At 31 March	**49,902**	**44,177**
Broken down into:		
Cash with the Government Banking Service	49,902	44,177
Total cash and cash equivalents as in SoFP	**49,902**	**44,177**
Total cash and cash equivalents as in SoCF	**49,902**	**44,177**

Note 22.2 Third party assets held by the Trust

The Trust does not hold any cash and cash equivalents on behalf of patients or other parties in 2025-26 (2024-25 - £nil).

Note 23.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables		2,857
Capital payables	8,282	9,567
Accruals	14,959	10,983
Receipts in advance and payments on account	2	2
Social security costs	7,104	5,840
Pension contributions payable	4,824	4,536
Other payables	351	65
Total current trade and other payables	**38,546**	**33,850**
Of which payables to NHS and DHSC group bodies:		
Current	1,871	1,565

Note 23.2 Early retirements in NHS payables above

The payables note above includes £nil (31 March 2025 - £nil) in relation to early retirements.

Note 24 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	294	56
Total other current liabilities	**294**	**56**

Note 25.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from DHSC	336	334
Lease liabilities	8,291	7,963
Total current borrowings	**8,627**	**8,297**
Non-current		
Loans from DHSC	1,829	2,163
Lease liabilities	12,802	15,241
Total non-current borrowings	**14,631**	**17,404**

Note 25.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Lease Liabilities £000	Total £000
Carrying value at 1 April 2025	**2,497**	**23,204**	**25,701**
Cash movements:			
Financing cash flows - payments and receipts of principal	(334)	(7,213)	**(7,547)**
Financing cash flows - payments of interest	(42)	(648)	**(690)**
Non-cash movements:			
Additions	-	5,102	**5,102**
Application of effective interest rate	44	648	**692**
Carrying value at 31 March 2026	**2,165**	**21,093**	**23,258**

	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**

Note 26.1 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 2025	**422**	**4,951**	**215**	**110**	**3,087**	**8,785**
Change in the discount rate	(6)	(174)	-	-	9	**(171)**
Arising during the year	77	589	30	-	1,427	**2,123**
Utilised during the year	(92)	(602)	-	-	(1)	**(695)**
Reversed unused	(68)	(336)	-	(110)	(420)	**(934)**
Unwinding of discount	10	116	-	-	55	**181**
At 31 March 2026	**343**	**4,544**	**245**	**-**	**4,157**	**9,289**
Expected timing of cash flows:						
- not later than one year;	68	454	225	-	1,685	**2,432**
- later than one year and not later than five years;	219	1,691	20	-	1,440	**3,370**
- later than five years.	56	2,399	-	-	1,032	**3,487**
Total	**343**	**4,544**	**245**	**-**	**4,157**	**9,289**

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, tenancy properties, medical equipment and CBRN vehicles provisions for estimated deferred repairs and restoration costs as applicable £3,147k (2024-25 £2,494k); staff related claims and employment tribunals £719k (2024-25 - £488k).

Note 26.2 Clinical negligence liabilities

At 31 March 2026, £23,915k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Yorkshire Ambulance Service NHS Trust (31 March 2025: £24,284k).

Note 27 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(122)	(8)
Employment tribunal and other employee related litigation	(299)	-
Gross value of contingent liabilities	**(421)**	**(8)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(421)**	**(8)**
Net value of contingent assets	**-**	**902**

Note 28.1 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	3,677	6,677
Intangible assets	310	101
Total	**3,987**	**6,778**

Note 28.2 Leases: exposure to future cash flows not included in lease liabilities

	31 March 2026 £000	31 March 2025 £000
Commitments for leases not yet commenced to which the Trust is contractually committed	-	10,035
Total	**-**	**10,035**

Note 29 Other financial commitments

Other than the commitments disclosed in Note 28, the Trust is not committed to making payments under non-cancellable contracts which are not leases.

Note 30 Financial instruments

Note 30.1 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
The Trust has low exposure to credit risk as the majority of the Trust's revenue comes from contracts with other public sector bodies, 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 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	5,628	**5,628**
Cash and cash equivalents	49,902	**49,902**
Total at 31 March 2026	**55,530**	**55,530**

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**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	2,165	**2,165**
Obligations under leases	21,093	**21,093**
Trade and other payables excluding non-financial liabilities	23,099	**23,099**
Provisions under contract	4,401	**4,401**
Total at 31 March 2026	**50,758**	**50,758**

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**

Note 30.4 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 2026 £000	31 March 2025 £000
In one year or less	33,678	30,014
In more than one year but not more than five years	14,005	15,408
In more than five years	4,833	5,522
Total	**52,516**	**50,944**

Note 30.5 Fair values of financial assets and liabilities

The Trust considers that book value (carrying value) is a reasonable approximation of fair value.

Note 31 Losses and special payments

	2025-26		2024-25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	12	5	7	1
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	17	7	41	18
Stores losses and damage to property	-	-	9	3
Total losses	**29**	**12**	**57**	**22**
Special payments				
Compensation under court order or legally binding arbitration award	1	4	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	26	104	22	20
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**27**	**108**	**22**	**20**
Total losses and special payments	**56**	**120**	**79**	**42**
Compensation payments received	-	-	-	-

There were no individual losses or special payments exceeding £300,000 in 2025-26 (2024-25 - nil).

Note 32 Gifts

No gifts were received by the Trust in 2025-26 (2024-25 - nil).

Note 33 Related parties

The Department of Health and Social Care is the parent department of the Trust and is consequently 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.

NHS Integrated Care Boards
NHS Trusts
NHS Foundation Trusts
NHS Litigation Authority
NHS Resolution
NHS Property Services

In addition, the Trust has had a number of significant transactions with other government departments and their agencies e.g. HMRC and local authorities.

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

NHS England is leading the implementation of ICB mergers and boundary changes to take effect on 1 April 2026 and April 2027. NHS England will exercise its power to vary or revoke the Establishment Order, thereby abolishing or establishing ICBs or changing the boundaries of existing ICBs. This reorganisation is not expected to affect the Trust and its funding flows.

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 34 Events after the reporting date

There have been no non-adjusting events after the reporting date.

Note 35 Better Payment Practice Code

Non-NHS Payables	2025-26 Number	2025-26 £000	2024-25 Number	2024-25 £000
Total non-NHS trade invoices paid in the year	25,885	111,452	33,855	116,684
Total non-NHS trade invoices paid within target	25,170	107,772	32,777	111,911
Percentage of non-NHS trade invoices paid within target	97.2%	96.7%	96.8%	95.9%
NHS Payables				
Total NHS trade invoices paid in the year	609	11,928	542	9,142
Total NHS trade invoices paid within target	581	11,669	522	8,629
Percentage of NHS trade invoices paid within target	95.4%	97.8%	96.3%	94.4%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 36 Capital Resource Limit

	2025-26 £000	2024-25 £000
Gross capital expenditure	43,196	32,892
Less: Disposals	(143)	(72)
Charge against Capital Resource Limit	**43,053**	**32,820**
Capital Resource Limit	43,053	32,820
Under / (over) spend against Capital Resource Limit	**-**	**-**

Note 37 Adjusted financial performance

	2025-26 £000	2024-25 £000
Surplus / (deficit) for the period per SOCI	(4,771)	(403)
Remove net impairments not scoring to the departmental expenditure limit	7,341	495
Adjusted financial performance surplus / (deficit)	**2,570**	**92**

Note 38 Breakeven duty financial performance

	2025-26 £000
Adjusted financial performance surplus	2,570
Remove impairments scoring to Departmental Expenditure Limit	-
Breakeven duty financial performance surplus	**2,570**

Note 39 Breakeven duty rolling assessment

	1997-98 to 2008-09 £000	2009-10 £000	2010-11 £000	2011-12 £000	2012-13 £000	2013-14 £000	2014-15 £000	2015-16 £000	2016-17 £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 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	2022-23 £000	2023-24 £000	2024-25 £000	2025-26 £000
Breakeven duty in-year financial performance	10,154	9,250	5,524	(960)	8,203	236	51	92	2,570
Breakeven duty cumulative position	31,507	40,757	46,281	45,321	53,524	53,760	53,811	53,903	56,473
Operating income	269,451	281,698	288,172	334,125	359,194	382,208	405,520	447,761	476,379
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%	11.9%

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.

Events and Commercial Services	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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